OHA Transformation and Quality Strategy (TQS)  
CCO: InterCommunity Health Network CCO

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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 process for developing and implementing your TQS:

   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 health care 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 Program and Medical Management Plan are reviewed and updated annually and approved by the internal Quality Improvement Committee (QIC) and external Quality Management Council (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 health care 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 health care are identified.
      • Report results of monitoring member satisfaction and access to appropriate healthcare to the Quality Management Council 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 member education and case management programs.
      • Promote self-management of chronic diseases through member education and 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.

   ii. 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, aligns with the Community Health Improvement Plan (CHIP) Health Impact Areas of Access to Healthcare, Behavioral Health, Child and Youth Health, Healthy Living, Maternal Health, and Social Determinants of Health and Equity 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 to be considered for funding.

The CHIP is also used as an alignment tool internally. The CHIP provides essential guidance for the allocation, administration and coordination of Health-Related Services. Guided by the Community Advisory Council (CAC) strategies outlined in the CHIP, IHN-CCO leadership and Quality Improvement Committee determine targeted quality strategy investments. Investments are made in those initiatives that have demonstrated ability to improve services and supports for members and populations to address social determinants of health and health equity.

iii. 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:

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 (LBL) counties. Currently partners include, Linn Benton Lincoln Education Service District, mental health, health systems, clinics, public health/health and human services of the three counties, LBL Early Learning Hub, social service agencies, Community Advisory Council, oral health, housing providers, and other community-based organizations and social determinants of health organizations. The DST oversees pilot projects that must address at least one TQS area. There are currently 12 active pilots that address 1 or more TQS areas all of which are with different community, clinical, or health system partners.

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 Linn County Health Director. The Community (CAC) Chairperson and CAC Coordinator are members of the RPC, as are many community partners and stakeholders.

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, Medical Management, Pharmacy, Network Contracting and Strategy, Business Technology Services & Solutions, Transformation, Compliance, Plan Contract and Benefit Administration, and ad hoc as applicable. The QIC’s purpose is to utilize all areas
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of the health plan to consult, deliberate and facilitate the implementation of tactics that will lead to improved performance.

B. OPTIONAL: CCO characteristics
   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 over 72,000, unduplicated members throughout the year, 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 50% of IHN-CCO members live in rural areas (36,524), with a very small percentage (<1% living in frontier designated areas). 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 (3,688 IHN-CCO members). Less than 5% (3,330) of IHN-CCO members speak a household language other than English (a 5% drop from 2018 and may indicate underreporting).

   Specific demographics that are disproportionately impacted by disease and illness include those with mental illness and disabilities. Approximately 37% (26,474) of IHN-CCO members have been diagnosed with a mental illness with 17% (12,210) diagnosed with Severe and Persistent Mental Illness (SPMI). About 8% (5,571) of IHN-CCO members have at least one disability that limits their ability to work.

   IHN-CCO Member Demographic Source: OHA Dashboard December 2019.
## Section 2: Transformation and Quality Program Details

<table>
<thead>
<tr>
<th>Project and Component Crosswalk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access: Quality &amp; Adequacy of Services</strong></td>
</tr>
<tr>
<td><strong>Access: Cultural Considerations</strong></td>
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<tr>
<td><strong>Access: Timely</strong></td>
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<tr>
<td><strong>Behavioral Health Integration</strong></td>
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<td><strong>CLAS Standards</strong></td>
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<tr>
<td><strong>Grievance and Appeal System</strong></td>
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<tr>
<td><strong>Health Equity: Data</strong></td>
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<tr>
<td><strong>Health Equity: Cultural Responsiveness</strong></td>
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<tr>
<td><strong>Oral Health Integration</strong></td>
</tr>
<tr>
<td><strong>Patient-Centered Primary Care Home (PCPCH)</strong></td>
</tr>
<tr>
<td><strong>Serious and Persistent Mental Illness (SPMI)</strong></td>
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<tr>
<td><strong>Social Determinants of Health and Equity (SDOH-E)</strong></td>
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<tr>
<td><strong>Special Health Care Needs (SHCN)</strong></td>
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<tr>
<td><strong>Utilization Review</strong></td>
</tr>
</tbody>
</table>
A. **Project 01: ICT Model for FBDE Members**

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

B. **Components addressed**

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

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

**Background:** Samaritan Health Plans (SHP) is an integrated nonprofit organization that serves, on a monthly average, 57,000 Medicaid members through IHN-CCO and 5,490 Medicare members through Samaritan Advantage Health Plan, HMO (SAHP), and 1,500 Special Needs Plan (SNP) members dually eligible for Medicare and Medicaid coverage or full benefit dual eligible (FBDE). The SNP Model of Care (MOC) outlines components of our care coordination program, including support of a delegated entity, AxisPoint Health (APH). APH manages the Health Risk Assessment (HRA) process, development of care plans, facilitation of the interdisciplinary care team (ICT), care coordination, transition management and complex case management for SNP members. APH staff coordinate care with the member’s primary care provider and patient-centered primary care home (PCPCH) team.

**Problem:**

- In 2019, the average SAHP member engagement rate in care coordination services was 23%, falling short of the target set at 45%. As SNP care coordination services are primarily telephonic, SHP is exploring options to integrate care coordination within the PCPCH where members have face-to-face contact with providers and their integrated care team.
- FBDE members with multiple health and socioeconomic needs and are served by multiple providers, agencies and cross-system supports. Primary care providers often lack the infrastructure to coordinate these multiple services and supports and ingest member data, including risk assessments and care plans, which are often siloed in disparate organizations and not directly integrated in the member’s PCPCH health record.

Given the poor member response rate with the current care coordination model, and cross-system care coordination requirements for FBDE members, IHN-CCO will develop and pilot an alternate scalable model for ICT embedded within the PCPCH.

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

IHN-CCO has engaged Samaritan Lebanon Residency Clinic (SLRC) to partner in development of a scalable model for team-based care. This interdisciplinary care team (ICT) model will effectively coordinate multiple, cross-system services and supports for FBDE members with special health care needs. Development will begin with a cohort of FBDE members assigned to SLRC. This cohort will serve as the intervention population in which this ICT model will be tested.

This model will connect providers, cross-system services and supports through an ICT process. IHN-CCO and SLRC will convene regular ICT meetings with community behavioral health, dental and specialty providers, stakeholders, and Senior Disability Services (SDS) long-term services and supports (LTSS) to share information and align efforts in coordinating care for FBDE members. Members will be engaged in advance of their ICT meeting and encouraged to actively participate as they are able.
IHN-CCO will collaborate with stakeholders to design the ICT model to scale using holistic approach to effectively address the unique needs of individual members who have multiple chronic conditions, including behavioral health and socioeconomic needs. Once validated, the model can be shared across the IHN-CCO provider network.

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

**Activity 1 description:** Convene team of stakeholders and organize project structure.

☐ Short term or ☐ Long term

**Monitoring activity 1 for improvement:** Convene stakeholders, develop project.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convene stakeholders in planning meeting. Scope and develop project.</td>
<td>Assign Sponsor and project coordinator to sustain and support ongoing participation.</td>
<td>03/2020</td>
<td>Project plan development and launch.</td>
<td>04/2020</td>
</tr>
<tr>
<td>Identify and address barriers to convening and stakeholder participation in ICTs. Research engagement strategies.</td>
<td>Establish best practice methods in ICT scheduling to include members and key stakeholders involved in the member’s care, convening meetings, documenting plans and coordinating follow up care.</td>
<td>03/2020</td>
<td>Interdisciplinary care team engagement in bi-monthly ICT meetings.</td>
<td>09/2020</td>
</tr>
</tbody>
</table>

**Activity 2 description:** Develop member profile report to include comprehensive information for each member i.e., demographic information, race, ethnicity, language and disability, providers, services and supports involved, member risks and issues related to social determinants of health and health equity. Establish metrics and monitoring for FBDE cohort. Investigate multiple partner systems, EPIC, Unite Us, Collective Medical event notification systems.

☐ Short term or ☐ Long term

**Monitoring activity 2 for improvement:** Data integration, report development. Establish secure data system.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
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<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validate list of FBDE members assigned to SLRC PCPCH.</td>
<td>Design system for integration of data and comprehensive profile report for each member as well as aggregate report of the cohort.</td>
<td>03/2020</td>
<td>Comprehensive, secure information sharing among ICT. Care plans are shared and available to the ICT. ICT can track and monitor members and</td>
<td>09/2020</td>
</tr>
</tbody>
</table>
Establish metrics and monitoring for care activation. | intervente in real-time as appropriate.
---|---
FBDE member cohort developed. | Secure electronic data sharing among members of the ICT.
09/2020 | Shared member monitoring and tracking of activities and care plans among members of the ICT members. 09/2020

**Activity 3 description:** IHN-CCO and SLRC will jointly develop interdisciplinary care team (ICT) model to include development of team member roles and responsibilities, member tracking reports, care team meeting preparation, agenda management, individualized care plan development, and care coordination activities across multiple stakeholders. The ICT will initiate small tests of change to study, pilot tools, and document workflow activities, evaluate and revise as needed to refine and create an ICT model that is scalable and can be shared across the provider network.

☐ Short term or ☒ Long term

**Monitoring activity 3 for improvement:** Cross-system team engaged. Components of the Interdisciplinary Care Team Model documented.

<table>
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<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHN-CCO and SLRC have convened ICT meetings. Piloting format and documentation tools.</td>
<td>Comprehensive ICT Model developed, implemented and serving FBDE members.</td>
<td>12/2020</td>
<td>Model documented and toolkit developed.</td>
<td>12/2021</td>
</tr>
<tr>
<td>Stakeholders representative of community providers, LTSS, and other cross system supports attending ICT meetings.</td>
<td>Team-based cross-system care coordination model developed.</td>
<td>12/2020</td>
<td>Data and analytics support care team in shared platform, with multiple systems connected through referrals and event notification.</td>
<td>12/2021</td>
</tr>
</tbody>
</table>

**Activity 4 description:** Study outcomes of FBDE member cohort served by ICT. Develop summary report.

☐ Short term or ☒ Long term

**Monitoring activity 4 for improvement:** Develop and finalize ICT Model evaluation and report.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohort baseline report developed. Set up research model to collect data for summary report.</td>
<td>Establish data integration and cohort development model to support multiple ICTs. Analysis of cohort</td>
<td>03/2021</td>
<td>FBDE members served through ICT model show improved health outcomes and reduction of</td>
<td>12/2021</td>
</tr>
<tr>
<td>served through ICT model. Research methods documented.</td>
<td>avoidable costs as compared to control population.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A. **Project 02: Gender Identity and Pronouns**
Continued or slightly modified from prior TQS?  ☒Yes  ☐No, this is a new project or program

B. **Components addressed**
   i. Component 1: Health equity: Data
   ii. Component 2: Health equity: Cultural responsiveness
   iii. Component 3: Social determinants of health & equity
   iv. Does this include aspects of health information technology?  ☒Yes  ☐No
   v. If this component addresses social determinants of health & equity, which domain(s) does it address?
      ☐Economic stability  ☐Education
      ☒Neighborhood and build environment  ☒Social and community health

C. **Background and rationale/justification:**
Gender identity definitions and pronouns are varied among cultures, communities, and individuals. Gender identities include but are not limited to: female, genderfluid, genderqueer, male, non-binary, trans, transgender, and two-spirit. Misgendering, referring to someone as a gender that is not their affirmed gender (especially pronouns or other terms of address), is very harmful to the person, especially for trans and non-binary persons.

Numerous studies show that transgender, or trans, people are at a much higher risk for suicidal ideation and suicide. Other studies show over half of transgender people face family rejection and harassment or disrespect in the community. A study on discrimination and avoidance of healthcare showed that nearly 50% of transgender people avoided healthcare in the past year and 45% experienced discrimination in healthcare in their lifetime (The National LGBT Health Equity Center of the Fenway Institute). These statistics show a profound disparity in the healthcare system.

These disparities are partially due to lack of cultural competence in the system, including the collection and utilization of gender data. The U.S. Department of Health and Human Services: Office of Minority Health supports the need for gender identity data collection to better inform improvements in the healthcare system for transgender people. Trans people have different experiences and needs in health care. Simply addressing the member with correct name and pronouns can help improve the member experience. From the first contact with IHN-CCO throughout their entire experience with the system needs to be improved to support proper pronoun and name use. IHN-CCO will create a welcoming and patient-centered environment to reduce the disparate access to healthcare for transgender members.

References


D. **Project or program brief narrative description:**
IHN-CCO is implementing the Gender Identity and Pronoun project to ensure that our members feel and are treated in a respectful and affirming manner. Project goals are threefold:

1. Explore capabilities and development of Facets, IHN-CCO’s software that holds member information and that customer service references with any contact with an IHN-CCO member or provider, to include gender identity and pronoun fields.
2. Create workflows and processes to ensure all members are addressed by their appropriate name and pronoun.
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3. Collect and analyze baseline data to determine where there is disparity data; where these members live and receive care in order to better evaluate our provider network and services.

E. Activities and monitoring for performance improvement:

**Activity 1 description:** Develop business requirements for implementation of gender identity and pronoun fields in core system, Facets.

☑️ Short term or ☐ Long term

**Monitoring activity 1 for improvement:** Business requirements implementation.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not developed.</td>
<td>Business requirements developed.</td>
<td>05/2020</td>
<td>Business requirements approved.</td>
<td>06/2020</td>
</tr>
</tbody>
</table>

**Activity 2 description:** Design core system, Facets, to store gender identity.

☑️ Short term or ☐ Long term

**Monitoring activity 2 for improvement:** Fields in Facets implemented.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fields not in Facets.</td>
<td>Fields built in Facets.</td>
<td>08/2020</td>
<td>Fields validated through testing and promoted to production environment.</td>
<td>09/2020</td>
</tr>
</tbody>
</table>

**Activity 3 description:** Develop pronoun-specific policy and procedures (including workflows) for all staff that has contact with IHN-CCO members.

☑️ Short term or ☐ Long term

**Monitoring activity 3 for improvement:** Policies are developed, and staff are trained.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No current policy.</td>
<td>Policy developed.</td>
<td>06/2020</td>
<td>Policy fully implemented.</td>
<td>09/2020</td>
</tr>
<tr>
<td>No current procedure for customer service representatives’ reference and training.</td>
<td>Procedure and reference documents developed.</td>
<td>06/2020</td>
<td>100% of staff trained.</td>
<td>10/2020</td>
</tr>
</tbody>
</table>
**Activity 4 description**: Create reports and analyze data to determine disparities, e.g. where these members live and receive care in order to better evaluate our provider network and services.

- Short term or ☑ Long term

**Monitoring activity 4 for improvement**: Report development and evaluation

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reporting capabilities.</td>
<td>Report developed.</td>
<td>10/2020</td>
<td>Report reviewed.</td>
<td>10/2020</td>
</tr>
<tr>
<td>Unknown number of members with a non-binary gender.</td>
<td>Baseline number of non-binary members identified.</td>
<td>12/2020</td>
<td>Baseline number of non-binary members identified.</td>
<td>12/2020</td>
</tr>
<tr>
<td>No report to evaluate.</td>
<td>Report evaluated and next steps determined to address disparities identified.</td>
<td>12/2020</td>
<td>Report evaluated and next steps determined to address disparities identified.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>
A. Project 03: Oversight Development of Standard Access Monitoring

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

B. Components addressed

i. Component 1: Access: Timely
ii. Does this include aspects of health information technology? ☐ Yes ☒ No
iii. If this component addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability
   ☐ Neighborhood and build environment
   ☐ Social and community health

C. Background and rationale/justification:

Prior Year Evaluation – No data available. IHN-CCO identified this as a gap through the 2018 External Quality Review. Prior attempts to meet this standard have been unsuccessful. No formal data has been collected to create a baseline at this time.

Problem Statement (identify population) – IHN-CCO currently does not have a framework in collecting access to care data; specifically, regarding access based on urgency of IHN-CCO member need.

Root Cause Analysis – IHN-CCO identified this as an operational gap through the 2018 External Quality Review (standards set forth in OAR 410-141-3515). Currently, grievances regarding access is the only monitoring tool used to measure access within IHN-CCO. The grievance analysis gives little insight regarding CCO-wide access and is not sufficient to meet monitoring standards for OAR 410-141-3515.

Desired Outcome – IHN-CCO implements an effective monitoring program to determine access review categorized by service type, member need/urgency, and clinic and/or provider; from the collection of this data, IHN-CCO aims to achieve 100% of targeted providers are compliant with the defined access standards.

D. Project or program brief narrative description:

IHN-CCO will be implementing and formalizing a monitoring program to ensure data regarding timely access to care and services is being collected, analyzed, and acted upon. Timely access standards are outlined within OAR 410-141-3515 and based on urgency of the need for the following service types: Physical Health, Oral Health, and Behavioral Health. In addition to the required monitoring set by OHA, IHN-CCO will also include monitoring access for Non-Emergent Medical Transportation (NEMT) services.

E. Activities and monitoring for performance improvement:

Activity 1 description: Collecting data to monitor access to services.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: A sample size of all provider types will be asked to fill out a standardized access survey. We will require a quarterly submission and hope to work towards a monthly submission as the future benchmark.

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<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% of providers are delivering access data.</td>
<td>100% of targeted providers are delivering data quarterly.</td>
<td>06/2020</td>
<td>50% of targeted providers are delivering data monthly.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>
Activity 2 description: Analyze access to physical health services.

☑️ Short term or ☐ Long term

Monitoring activity 2 for improvement: After collection of data is complete, IHN-CCO will compile and analyze the data to determine if the targeted providers are compliant with the defined access standards. Physical health analysis has three standards for access, (1) emergent need, (2) urgent need, and (3) routine care.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No baseline data available.</td>
<td>50% of targeted physical health providers give instructions for access to emergency services.</td>
<td>06/2020</td>
<td>100% of targeted physical health providers give instructions for access to emergency services.</td>
<td>12/2020</td>
</tr>
<tr>
<td>No baseline data available.</td>
<td>50% of targeted physical health providers have urgent needs availability no more than 72 hours from the date the survey was filled out.</td>
<td>06/2020</td>
<td>100% of targeted physical health providers have urgent needs availability no more than 72 hours from the date the survey was filled out.</td>
<td>12/2020</td>
</tr>
<tr>
<td>No baseline data available.</td>
<td>50% of targeted physical health providers have routine care availability no more than 4 weeks from the date the survey was filled out.</td>
<td>06/2020</td>
<td>100% of targeted physical health providers have routine care availability no more than 4 weeks from the date the survey was filled out.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>

Activity 3 description: Analyze access to oral health services.

☑️ Short term or ☐ Long term

Monitoring activity 3 for improvement: After collection of data is complete, IHN-CCO will compile and analyze the data to determine if the targeted providers are compliant with the defined access standards. Oral health analysis has three standards for access, (1) emergent need, (2) urgent need, and (3) routine care.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No baseline data available.</td>
<td>50% of targeted oral health providers have emergent need availability no more than 24 hours from the date the survey was filled out.</td>
<td>06/2020</td>
<td>100% of targeted oral health providers have emergent need availability no more than 24 hours from the date the survey was filled out.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>
No baseline data available. | 50% of targeted oral health providers have urgent need availability no more than 1 week from the date the survey was filled out. | 06/2020 | 100% of targeted oral health providers have urgent need availability no more than 1 week from the date the survey was filled out. | 12/2020

No baseline data available. | 50% of targeted oral health providers have routine care availability no more than 8 weeks from the date the survey was filled out. | 06/2020 | 100% of targeted oral health providers have routine care availability no more than 8 weeks from the date the survey was filled out. | 12/2020

Activity 4 description: Analyze access to behavioral health services.

☑ Short term or ☐ Long term

Monitoring activity 4 for improvement: After collection of data is complete, IHN-CCO will compile and analyze the data to determine if the targeted providers are compliant with the defined access standards. Behavioral health analysis has three standards for access, (1) urgent need, (2) specialty behavioral healthcare for priority populations, and (3) routine care for non-priority population.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No baseline data available.</td>
<td>50% of targeted behavioral health providers give instructions for access to emergency services.</td>
<td>06/2020</td>
<td>100% of targeted behavioral health providers give instructions for access to emergency services.</td>
<td>12/2020</td>
</tr>
<tr>
<td>No baseline data available.</td>
<td>50% of the targeted specialty behavioral health providers are compliant with priority population access standards outlined in OAR 410-141-3515.</td>
<td>06/2020</td>
<td>100% of the targeted specialty behavioral health providers are compliant with priority population access standards outlined in OAR 410-141-3515.</td>
<td>12/2020</td>
</tr>
<tr>
<td>No baseline data available.</td>
<td>50% of targeted behavioral health providers have routine care availability no more than 7 days from the date the survey was filled out.</td>
<td>06/2020</td>
<td>100% of targeted behavioral health providers have routine care availability no more than 7 days from the date the survey was filled out.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>

Activity 5 description: Analyze access to NEMT services.
**Monitoring activity 5 for improvement:** After collection of data is complete, IHN-CCO will compile and analyze the data to determine if the NEMT provider is compliant with offering same day trip request by mode of transportation. NEMT analysis has four modes of transportation to consider; (1) sedan transport, (2) wheelchair transport, (3) secured transport, and (4) stretcher transport.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No baseline data available.</td>
<td>50% of sedan transport providers have availability for same day access.</td>
<td>06/2020</td>
<td>100% of sedan transport providers have availability for same day access.</td>
<td>12/2020</td>
</tr>
<tr>
<td>No baseline data available.</td>
<td>50% of wheelchair transport providers have availability for same day access.</td>
<td>06/2020</td>
<td>100% of wheelchair transport providers have availability for same day access.</td>
<td>12/2020</td>
</tr>
<tr>
<td>No baseline data available.</td>
<td>50% of secured transport providers have availability for same day access.</td>
<td>06/2020</td>
<td>100% of secured transport providers have availability for same day access.</td>
<td>12/2020</td>
</tr>
<tr>
<td>No baseline data available.</td>
<td>50% of stretcher transport providers have availability for same day access.</td>
<td>06/2020</td>
<td>100% of stretcher transport providers have availability for same day access.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>
A. **Project 04: Grade A CLAS**
Continued or slightly modified from prior TQS?  ☐ Yes  ☒ No, this is a new project or program

B. **Components addressed**
   i. Component 1: CLAS standards
   ii. Component 2: Health equity: Cultural responsiveness
   iii. Does this include aspects of health information technology?  ☐ Yes  ☒ No
   iv. If this component addresses social determinants of health & equity, which domain(s) does it address?
      ☐ Economic stability  ☐ Education  ☐ Neighborhood and build environment  ☐ Social and community health

C. **Background and rationale/justification:**
IHNC-CCO recognizes that racial and linguistic diversity is increasing in Linn, Benton, and Lincoln Counties:

<table>
<thead>
<tr>
<th>% Change from 2013 – 2017</th>
<th>Race</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Race</td>
<td>English only</td>
</tr>
<tr>
<td></td>
<td>Black / African American</td>
<td>Other than English</td>
</tr>
<tr>
<td>Linn</td>
<td>-18%</td>
<td>+5%</td>
</tr>
<tr>
<td>Benton</td>
<td>-1%</td>
<td>+9%</td>
</tr>
<tr>
<td>Lincoln</td>
<td>+47%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

IHNC-CCO views integration of The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as critical to developing the framework necessary for delivering effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

According to the literature on The Case for National CLAS Standards, 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 there are meaningful trainings and educational activities offered to develop a culturally responsive workforce. The expected benefits of having a culturally responsive workforce includes 1) increases in member engagement and health literacy, and 2) better health outcomes for IHN-CCO member populations.

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.

IHNC-CCO will create cultural responsiveness training and an associated training program that will be deployed to IHN-CCO’s provider network, provider network staff, and employees. Successful completion of the training program is expected to result in a workforce that performs culturally responsive job duties.

D. **Project or program brief narrative description:**
Samaritan Health Services Equity and Inclusion Council (EIC) in partnership with IHNC-CCO has created a Training Sub-Workgroup of EIC focusing on development and roll out of CLAS (culturally and linguistically appropriate services) standards and other culturally competent trainings and educational activities. Using IHNC-CCO’s contract and the Equity and Inclusion Plan as guidelines, the EIC Training Workgroup will develop and implement cultural competence continuing education activities and trainings across IHNC-CCO, the provider network and staff. The EIC Training...
Workgroup consist of IHN-COO leadership, community and internal experts, along with the departments that will help roll out the trainings.

E. Activities and monitoring for performance improvement:

Activity 1 description: Roll out CLAS and other culturally competent trainings and educational activities to IHN-COO Provider Network and Provider Network staff.

☐ Short term or ☐ Long term

Monitoring activity 1 for improvement: Approve and implement the trainings and educational activities

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider manual outlines required trainings.</td>
<td>Approve trainings and educational activities.</td>
<td>08/2020</td>
<td>Implement trainings and educational activities.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>

Activity 2 description: Roll out CLAS and other culturally competent trainings and educational activities to IHN-COO employees during the year and new employee orientation.

☐ Short term or ☐ Long term

Monitoring activity 2 for improvement: Approve and implement the trainings and educational activities and develop new employee orientation trainings and educational activities.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One computer-based learning (CBL) on a cultural competence topic.</td>
<td>Two CBL trainings and educational activities are launched.</td>
<td>05/2020</td>
<td>CBL and at least one in-person trainings have taken place.</td>
<td>12/2020</td>
</tr>
<tr>
<td>CLAS and other culturally competent trainings/educational activities during New Employee Orientation.</td>
<td>Roll out the trainings/educational activities in New Employee Orientation.</td>
<td>04/2020</td>
<td>Complete a PDSA on the New Employee Orientation trainings/educational activities.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>

Activity 3 description: Reviewing and completing the Protocol for Culturally Responsive Organization to find areas of opportunities within IHN-COO.

☐ Short term or ☐ Long term

Monitoring activity 3 for improvement:

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Complete the Protocol for Culturally Responsive Organization.</td>
<td>06/2020</td>
<td>Start a strategic plan to work towards areas of opportunities.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>
A. **Project 05: Grievances and Appeals**

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

B. **Components addressed**

i. Component 1: Grievance and appeal system

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

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

☐ Economic stability  ☐ Education

☐ Neighborhood and build environment  ☐ Social and community health

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

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 year. An internal year-end analysis is also completed by IHN-CCO. The analysis details the top three grievance categories as well as rates per thousand for both grievances and appeals. For 2018 year, grievances for these three categories were:

- Access, Interaction with Plan and Provider, and Quality of Care continue to rise. The average enrollment for 2018 was 55,027.
- For Access, IHN-CCO received 171, which calculated to be 3.1 per thousand members. Interaction with Plan and Provider, IHN-CCO received 193, which calculated to 3.5 per thousand members.
- For Quality of Care, IHN-CCO received 124, which calculated to 2.25 per thousand members.

IHN-CCO has identified specific subcategories that relate to Access issues:

- A.d) Unable to schedule appointment in a timely manner,
- A.e) Unable to be seen in a timely manner for urgent/emergent care,
- A.f) Provider’s office closed to new patients, and
- A.i) Provider not available to give necessary care.

IHN-CCO reported 53 out of the 171, grievances were related to service types Dental, PCP, and NEMT.

For 2019 year, IHN-CCO continues to see a significant increase in these three categories. The average enrollment for 2019 was 57,004.

- Interaction with Plan and Provider, IHN-CCO received 311, which equates to 5.5 per thousand members.
- For Access, IHN-CCO received 180, which is calculated to be 3.2 per thousand members.
- For Quality of Care, IHN-CCO received 168, which calculated to 3.0 per thousand members.

IHN-CCO has continue to monitor access issues for the following subcategories:

- A.d) Unable to schedule appointment in a timely manner,
- A.e) Unable to be seen in a timely manner for urgent/emergent care,
- A.f) Provider’s office closed to new patients, and
- A.i) Provider not available to give necessary care.

These subcategories continue to show upward trend from 53 in 2018 to 101 in 2019, as they relate to Dental, PCP, and NEMT service types. Attachment: GA-02 IHN Grievance Complaints Policy
OHA Transformation and Quality Strategy (TQS)  CCO: InterCommunity Health Network CCO

D. Project or program brief narrative description:

Appeals and Grievances Department tracks and trends the issues that our members face when receiving health services or the lack of services from providers. Grievance categories tracked are access, interaction with provider and plan, consumer rights, quality of care, quality of service, and client billing issues. Reports are evaluated yearly and presented to various internal committees, as well as our external Quality Management Council, which is comprised of providers and key IHN-CCO management staff. IHN-CCO continues to explore opportunities for improvement to ensure the three top categories are trending downward. IHN-CCO continues to work with our contracted providers regarding Access, Interaction with Providers, and Quality of Care. IHN-CCO’s Director of Network-Strategy and Contracting has developed the Provider Network Taskforce to address these three categories. IHN-CCO’s Provider Network Taskforce includes the following department: Appeals and Grievances, Finance, Medical Management, Pharmacy, Plan Contract and Benefit Administration, Network Relations and Contracting, and Transformation. This taskforce will focus on continuation of provider education and other strategies in getting more providers to contract with IHN-CCO.

E. Activities and monitoring for performance improvement:

**Activity 1 description:** Track, trend, and analyze grievances according to OHA categories.

☐ Short term or ☒ Long term

**Monitoring activity 1 for improvement:** Monthly Provider Network Taskforce meeting to review plan status.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHN-CCO is very optimistic in reducing the number of grievances for these three categories by the rate of 1.0 per thousand members.</td>
<td>IHN-CCO has developed Provider Network Taskforce to address the top three categories by rate of .5 per thousand members.</td>
<td>06/2020</td>
<td>IHN-CCO will continue to engage the Provider Network Taskforce to address these top three categories by rate of 1.0 per thousand members.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>
OHA Transformation and Quality Strategy (TQS)  CCO: InterCommunity Health Network CCO

A. Project 06: Operational Integration of Traditional Health Workers in Community-Based Organization Settings

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

B. Components addressed

i. Component 1: Social determinants of health & equity
ii. Does this include aspects of health information technology?  ☐Yes  ☒No
iii. If this component addresses social determinants of health & equity, which domain(s) does it address?
   ☒Economic stability  ☐Education
   ☒Neighborhood and build environment  ☐Social and community health

C. Background and rationale/justification:

Traditional Health Workers (THWs) are members of the community who promote healthy behaviors and link community members in need with local resources. Common types of THWs include: Doulas, Community Health Workers, Peer Health Navigators, Peer Support Specialists and Peer Wellness Specialists. Oftentimes, THWs perform their work through either clinical or Community-Based Organization (CBO) settings.

While services provided by THWs in both settings are of equal quality and value to IHN-CCO members, there are noticeable differences in organizational governance, as well as technical and financial resources between the two settings. Such differences have resulted in unequal levels of operational integration into the healthcare delivery system that IHN-CCO is a part of. For instance, the operational integration of THWs in clinical settings into IHN-CCO’s healthcare delivery system was simplified by leveraging financial resources (i.e., Behavioral Health Fee Schedule) and is a straightforward process, regarding data collection to facilitate financial stability for reimbursement purposes. However, the operational integration of THWs in CBO settings is a complex narrative that requires exploration of reimbursement methodologies, experimentation, and collaboration between IHN-CCO, CBOs and THWs. IHN-CCO recognizes the critical role THWs in CBOs play in impacting IHN-CCO member’s access to care, health, and overall quality of life. IHN-CCO also recognizes the need to establish a collaborative and sustainable reimbursement model with contracting CBOs who provide THW services to fully integrate these community partners into the healthcare delivery system.

By collaborating with contracted CBOs and THWs, IHN-CCO can meet these community partners where they are technologically, financially and physically in the healthcare delivery system to establish a framework for (financial) equity among settings that provide THW services. This mutual effort will allow for the complete and successful operational integration of these community partners into the integrated healthcare delivery system.

D. Project or program brief narrative description:

The major outcome of this project is to establish a framework for (financial) equity among the different settings that provide THW services. This program will focus on contracted CBOs that provide THW services to IHN-CCO members.

A Traditional Health Worker Liaison (THW Liaison) is needed to execute the collaborative approach (created by IHN-CCO, CBOs and THWs) that will facilitate financial stability for reimbursement purposes. This is necessary for CBOs who provide THWs, to achieve complete and successful operational integration into the healthcare delivery system. Once fully integrated into the healthcare delivery system, (financial) equity among the different settings that provide THW services can be achieved.

E. Activities and monitoring for performance improvement:

Activity 1 description: Hire and onboard a THW Liaison for IHN-CCO. In addition to other duties, the THW Liaison will collaborate with providers and community stakeholders, as well as advocate for THWs in Clinical and CBO settings, to improve the integration and availability of THW services and to advance continuous improvement of THW services.
OHA Transformation and Quality Strategy (TQS)  CCO: InterCommunity Health Network CCO

☒ Short term or ☐ Long term

**Monitoring activity 1 for improvement**: Oversee hiring and onboarding process of THW Liaison.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>THW Liaison position posted.</td>
<td>Hire an appropriate candidate to serve as a THW Liaison.</td>
<td>06/2020</td>
<td>Complete onboarding of THW Liaison.</td>
<td>08/2020</td>
</tr>
</tbody>
</table>

**Activity 2 description**: Establish unique payment models for each CBO to accurately identify a threshold for mutual, financial stability as a CBO transitions from a startup to a matured operational relationship with IHN-CCO.

☐ Short term or ☒ Long term

**Monitoring activity 2 for improvement**: Track progress and completion of establishing preliminary reimbursement models for each contracted CBO that provides THW services. Monitor changes to reimbursement models over time using Plan, Do, Study, Act cycles.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluating previous reimbursement models between IHN-CCO and contracted CBOs that provide THW services; Exploring THW Best-Practices for reimbursement (OHA).</td>
<td>Establish preliminary reimbursement models in collaboration with contracted CBOs that provide THW services.</td>
<td>08/2020</td>
<td>Enter a regular PDSA cycle to begin numerical goal setting for each contracted CBO that provides THW services.</td>
<td>01/2021</td>
</tr>
</tbody>
</table>
A. **Project 07: Wellness to Smiles**

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

B. **Components addressed**

i. Component 1: Oral health integration  
   ii. Does this include aspects of health information technology?  ☐ Yes  ☒ No  
   iii. If this component addresses social determinants of health & equity, which domain(s) does it address?  
   ☐ Economic stability  ☐ Education  ☐ Neighborhood and build environment  ☐ Social and community health

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

Poverty is strongly linked to poor health outcomes, including oral health outcomes. In Lincoln County, approximately 20% of the population lives below the federal poverty line, compared to 13% of Oregon’s total population. This is one of the reasons that Lincoln County was specifically chosen for this pilot. Additional reasons include alignment with the Lincoln County Oral Health Coalition’s goal to expand community-based prevention and intervention to underserved and disadvantaged adults, the region’s historically high cavity rates, and Emergency Department use for nontraumatic dental pain.

Lincoln County has an overall shortage of health care providers, including oral health providers, to the general population, which contributes to access to care barriers. Access to care barriers are further compounded by the geographic distribution of providers. Due to lack of providers in rural areas of the region, Lincoln County qualifies as a Health Care Professional Shortage Area (HPSA) for dental health. This designation means there is an increased risk of poor access to oral health providers. A community-based dental care team including an Expanded Practice Dental Hygienist (EPDH), Dental Assistant/Community Health Worker (CHW) and teledentist will provide oral health services, education, and navigation, and also utilize teledentistry, which provides the means for a patient to receive services when the patient is in one physical location and the dentist overseeing the delivery of those services in another location.

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

Wellness to Smiles will implement SDoH screenings and referrals using Unite Us platform. The screenings and referrals will focus on transportation, food assistance and housing/shelter and will be conducted by an Expanded Practice Dental Hygienist (EPDH) and/or Dental Assistant/CHW. The sites will be in partnership with the Housing Authority of Lincoln County allowing Wellness to Smiles to be where IHN-CCO members are.

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

**Activity 1 description:** Increase oral health care access points in Lincoln County using teledentistry.

☒ Short term or ☐ Long term

**Monitoring activity 1 for improvement:** Work with Housing Authority of Lincoln County to increase to five sites.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two sites</td>
<td>Three sites</td>
<td>07/2020</td>
<td>Five sites</td>
<td>12/2020</td>
</tr>
</tbody>
</table>

**Activity 2 description:** Implement social determinants of health screening and referral pathways.

☒ Short term or ☐ Long term

**Monitoring activity 2 for improvement:** Training and implementing Unite Us, certifying Community Health Worker, and roll out screening/referral pathways.
<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None.</td>
<td>Three sites using social determinants of health screening and referral pathways.</td>
<td>07/2020</td>
<td>All sites using social determinants of health screening and referral pathways.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>
A. **Project 08: PCPCH VBP Model**

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

### B. Components addressed

1. Component 1: Patient-centered primary care home
2. Does this include aspects of health information technology?  ☒ Yes  ☐ No
3. If this component addresses social determinants of health & equity, which domain(s) does it address?
   - ☐ Economic stability
   - ☐ Education
   - ☒ Neighborhood and build environment
   - ☒ Social and community health

### C. Background and rationale/justification:

IHN-CCO has a goal to improve the PCPCH tier level of all PCPCH’s in our network. There are approximately 57 distinct PCPCH’s in the network with 276 PCPs. Of these, 47 PCPCHs are tier 2 or higher. IHN-CCO recognizes that a robust PCPCH network is required to fully serve the community health goals. Many PCPCHs do not have the resources to achieve increases in tier level on their own. IHN-CCO will be there to support them financially, educationally, and technologically to achieve our PCPCH goals.

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

Beginning in 2020, IHN-CCO will pay PCPCHs a Per Member Per Month (PMPM) based on their tier level. Each PCPCH will receive a higher PMPM as it increases in tier level. The purpose of this Value Based Payment (VBP) is twofold. First to support the infrastructure required to maintain the PCPCH level, and secondly to incentivize tier level improvement.

IHN-CCO has set aside funding, starting at $200,000, and internal resources to help PCPCH’s achieve higher tier levels. IHN-CCO will provide education and training to PCPCHs in the network. This will be done by having a dedicated PCPCH Coordinator at IHN-CCO. This person will serve as a PCPCH subject matter expert, network connection, and educator. The Coordinator will develop an educational curriculum and programs. IHN-CCO’s goal is to become a central resource or hub to our network. IHN-CCO can provide direct guidance to PCPCHs or connect PCPCHs to other peers for best practices. IHN-CCO will leverage existing Oregon Health Authority (OHA) and other resources for this training.

IHN-CCO will host another PCPCH summit for the region. This brings together PCPCH office managers in the three counties to receive training presentations, best practices, and cross-collaboration opportunities.

Electronic Health Record (EHR) adoption is another hurdle facing some clinics. IHN-CCO is prepared to support clinics in EHR adoption as part of the Health Information Technology (HIT) roadmap through platforms, funding, and guidance.

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

**Activity 1 description:** Increase tier level of IHN-CCO’s PCPCH network.

☐ Short term or ☒ Long term

**Monitoring activity 1 for improvement:** Monitor the improvement of PCPCH’s tier level.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 2019 PCPCH Tier level</td>
<td>Improve 20% PCPCH’s up 1 tier level</td>
<td>01/2021</td>
<td>Improve 40% of PCPCH’s up 1 tier level</td>
<td>01/2022</td>
</tr>
</tbody>
</table>

**Activity 2 description:** Achieve a PCPCH Network predominately tiers 4 and 5.
OHA Transformation and Quality Strategy (TQS)  CCO: InterCommunity Health Network CCO

☐ Short term or ☒ Long term

**Monitoring activity 2 for improvement:** Tier level of PCPCH’s.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
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<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 PCPCHs at Tier 2 or lower.</td>
<td>0 PCPCHs at Tier 2 or lower.</td>
<td>01/2022</td>
<td>80% of PCPCHs Tier 4 or higher.</td>
<td>01/2023</td>
</tr>
</tbody>
</table>
A. Project 09: Warm Handoffs
Continued or slightly modified from prior TQS? ☐ Yes ☒ No, this is a new project or program

B. Components addressed
   i. Component 1: Serious and persistent mental illness
   ii. Component 2: Behavioral health integration
   iii. Does this include aspects of health information technology? ☐ Yes ☒ No
   iv. If this component addresses social determinants of health & equity, which domain(s) does it address?
      ☐ Economic stability ☒ Education
      ☐ Neighborhood and build environment ☒ Social and community health

C. Background and rationale/justification:
   • The Oregon Health Authority has included Warm Handoff’s as part of the discharge planning process for individuals (18 or older) with an SPMI diagnosis in the Oregon Performance Plan.
   • Through the support of our Behavioral Health Quality Committee, IHN-CCO has identified Care Coordination as a need for our Members with complex issues and who have Serious Mental Illness.
   • IHN-CCO seeks to ensure that Warm Handoffs’, as part of Care Coordination efforts, are occurring during the discharge planning process to increase successful community integration following hospitalization in an acute care psychiatric facility.

D. Project or program brief narrative description:
   • Assess current processes involved in Warm Handoff’s to identify and address gaps.
   • Determine and establish desired practices for CCO, Acute Psychiatric Facility and Community Mental Health Programs (CMHP).
   • Assess care coordination and communication between physical and behavioral health providers to standardize processes and improve outcomes.
   • Identify measures that monitor warm handoff performance to establish a baseline for year two and promote quality improvement/assurance.

E. Activities and monitoring for performance improvement:

Activity 1 description: Assess current process involved in Warm Handoffs inclusive of responsibilities, communication efforts and documentation

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Document current processes identifying provider involvement

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processes mapped.</td>
<td>Mapping completed.</td>
<td>06/2020</td>
<td>Mapping completed.</td>
<td>06/2020</td>
</tr>
<tr>
<td>Barriers identified.</td>
<td>Barriers identified.</td>
<td>07/2020</td>
<td>Barriers identified.</td>
<td>07/2020</td>
</tr>
</tbody>
</table>

Activity 2 description: Evaluate gaps to prioritize initiatives.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Review OAR and OHA standards for Warm Handoffs. Assess current processes to determine gaps prioritizing possible initiatives for implementation.
<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review OAR’s and OHA standards.</td>
<td>Review completed.</td>
<td>08/2020</td>
<td>Review completed.</td>
<td>08/2020</td>
</tr>
<tr>
<td>Assess current processes to determine gaps.</td>
<td>Assessment complete.</td>
<td>08/2020</td>
<td>Assessment complete.</td>
<td>08/2020</td>
</tr>
<tr>
<td>Convene involved Providers to prioritize initiatives for implementation.</td>
<td>Initiatives prioritized.</td>
<td>09/2020</td>
<td>Initiatives prioritized.</td>
<td>09/2020</td>
</tr>
</tbody>
</table>

**Activity 3 description:** Establish and maintain new Warm Handoff practices.

☐ Short term or ☒ Long term

**Monitoring activity 3 for improvement:** Review available data to project completion of Warm Handoff’s.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify measures that monitor warm handoff performance.</td>
<td>Tool available.</td>
<td>09/2020</td>
<td>Tool available.</td>
<td>09/2020</td>
</tr>
<tr>
<td>Quarterly audit of available data.</td>
<td>Audits scheduled.</td>
<td>10/2020</td>
<td>Audits scheduled.</td>
<td>10/2020</td>
</tr>
<tr>
<td>Establish a baseline for year two and promote quality improvement/assurance</td>
<td>Baseline established</td>
<td>02/2021</td>
<td>Baseline established</td>
<td>02/2021</td>
</tr>
</tbody>
</table>
A. Project 10: Correlation between utilization of Psychiatric Residential Treatment Services (PRTS) for youth and availability of Intensive Outpatient Treatment and Supports (IOSS).

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

B. Components addressed

i. Component 1: Utilization review

ii. Component 2: Access: Quality and adequacy of services

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

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

☐ Economic stability ☐ Education

☐ Neighborhood and build environment ☐ Social and community health

C. Background and rationale/justification:

• IHN-CCO has identified in our Strategic Plan the need to provide access to full array of services that are responsive to member needs. IHN-CCO recognizes that we lack adequate IOSS and over rely on PRTS as an alternative in order to meet the needs of youth.

• Report received from Oregon Health Authority supports concern that IHN-CCO is a higher utilizer of PRTS than approximately half of other CCOs based on utilization per 1,000.

• Local System of Care System of Care has created a collaboration across child-serving agencies, community partners, families and children for the purpose of helping children thrive at home, in school, in the community, and throughout life. The System of Care has identified access to PRTS and community mental health services as a barrier to our members receiving the care they need.

• CCO seeks to understand whether lack of access to PRTS can be mitigated by increasing our array of Intensive In-Home Behavioral Health Services.

• Our goal is to determine capacity need for IOSS and decrease utilization of PRTS.

D. Project or program brief narrative description:

• Analyze utilization patterns to determine if community-based alternatives were appropriately utilized before and after PRTS and whether barriers to utilization exist.

• Determine adequacy of current intensive outpatient services available to youth who have received PRTS.

• Increase capacity for IOSS to meet the needs of youth so they remain in the community and decrease reliance on PRTS.

E. Activities and monitoring for performance improvement:

Activity 1 description: Identify current utilization patterns for PRTS for 2018 and 2019 (with additional focus on readmission) and the services that were provided pre admission and post discharge.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Report will be developed and compared to statewide utilization patterns.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRTS and IOSS Utilization reports to be developed.</td>
<td>Reports developed.</td>
<td>06/2020</td>
<td>Reports developed.</td>
<td>06/2020</td>
</tr>
</tbody>
</table>

Activity 2 description: Analyze service utilization pre and post Psych Residential.
OHA Transformation and Quality Strategy (TQS)  CCO: InterCommunity Health Network CCO

☑ Short term or ☐ Long term

**Monitoring activity 2 for improvement:** Determine utilization and utilization disparities for PRTS and IOSS.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
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<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sort data by demographics including county of residence, age, and whether the youth is in DHS Custody.</td>
<td>Reports broken out by demographic criteria.</td>
<td>07/2020</td>
<td>Reports broken out by demographic criteria.</td>
<td>07/2020</td>
</tr>
<tr>
<td>Identify utilization patterns for PRTS and services provided pre and post PRTS.</td>
<td>Utilization patterns evaluated and described.</td>
<td>07/2020</td>
<td>Utilization patterns evaluated and described.</td>
<td>07/2020</td>
</tr>
</tbody>
</table>

**Activity 3 description:** Complete analysis to identify gaps in service continuum.

☐ Short term or ☑ Long term

**Monitoring activity 3 for improvement:** Identify trends in utilization based on PRTS admissions, member demographics, and patterns of outpatient utilization.

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target/future state</th>
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<th>Benchmark/future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present data on utilization patterns to Behavior Health Quality Committee (BHQC).</td>
<td>Report written.</td>
<td>09/2020</td>
<td>Report written.</td>
<td>09/2020</td>
</tr>
<tr>
<td>Determine community resource needs based on type and location.</td>
<td>Recommendation for service development delivered to BHQC.</td>
<td>10/2020</td>
<td>Recommendation for service development delivered to BHQC.</td>
<td>10/2020</td>
</tr>
</tbody>
</table>