



2018 Transformation and Quality Strategy Section 1

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:* Jackson Care Connect (JCC) is a nonprofit CCO with mission driven approach to managing care for our members. In our quality program, we hold the member experience and commitment to quality improvement principles to be priorities. As a wholly owned subsidiary of CareOregon, JCC has two contracts with CareOregon: one to provide administrative and health plan services to the CCO and the other to manage the insurance risk for physical and behavioral health services. Under the health plan services contract, the JCC Network & Quality Committee receives regular (at least semiannual) reports on process and performance from the CareOregon Quality Management Committee pertaining to activities related to JCC. *See Section C for details regarding the scope of the CareOregon QMC.*

ii. *Describe your CCO's organizational structure for developing and managing its quality and transformation activities (please include a description of the connection between the CCO board and CAC structure):* The JCC Board of Directors is composed of multiple stakeholders including community leaders with experience as clinicians, administrators, social service providers, and CCO members. We have an efficient business model that leverages our community board and staff to build strong relationships with service providers and members. These relationships allow us to provide technical assistance and capacity building support for local organizations who would not otherwise be exposed to the value of quality improvement principles. The CAC has direct responsibility for prioritizing CHIP related projects and the Board has designated funding for CAC allocation. In addition, we have two CAC members who sit directly on the Board of Directors.

JCC leverages the CareOregon Health Plan Quality Assurance department's structure and staffing to monitor its quality program (including the TQS) and ensure regulatory compliance, but the CCO has an independent governance structure that provides oversight on quality and transformation activities. The Network and Quality Committee of the Board receives updates on quality programs (such as the External Quality Review, the TQS, and CareOregon health plan functions), the Compliance Committee convenes annually to review any compliance findings, the CAC directs CHIP prioritization, the Clinical Advisory Panel directs clinical prioritization, and the Finance Committee reviews transformation project funding and ROI. The Director of HPQA sits on the JCC Network and Quality Subcommittee of the Board to provide alignment between JCC and CareOregon. All of these committees report directly to the Board of Directors and their recommendations require formal action by the Board.

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

Jackson Care Connect's Community Health Improvement Plan (CHIP) has 3 main priorities: (1) Healthy Beginnings, which focuses on the health of young people and particularly emphasizes projects to reduce ACEs or increase resilience, (2) Healthy Living, which focuses on supporting individuals in behaviors that improve emotional, physical and social well-being, and (3) Health Equity, which specifically looks to identify and address health disparities in our county. This CHIP is based on the Community Health Assessment conducted

in 2014. We are actively engaged in a new CHA for 2018, which will be a first ever collaborative effort including all 3 Rogue Valley CCOs, both hospital systems, and Jackson County Public and Mental Health Departments.

Our CAC is responsible for overseeing work related to the Community Health Improvement Plan. The Board of Directors has allocated resources to the CAC for review and funding of projects that advance the priority areas of the CHIP mentioned above.

The JCC Board undertakes strategic planning on a regular cycle, with annual retreats. The strategic direction incorporates feedback from all Board committees (including the CAC). As a result, our strategic direction incorporates the CHIP priorities and we have specific goals focused on equity, member experience, and access to quality services. Lastly, our staff and board hold a strong commitment to JCC's mission / vision / and values. Using these as guidelines for all of our strategic and programmatic planning ensures that we prioritize the serving our members' needs with quality in all aspects.

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:

Jackson Care Connect is committed to embedding TQS efforts with our clinical and community partners. Our work to build the quality improvement capacity of primary care homes and other key clinical providers is outlined elsewhere in this document. For community partners, we are asking all organizations supported through the CHIP work to report specific metrics and provide staff resourcing to help those nonprofits understand how best to gather and report the data. In addition, we provide nonprofit organizations the opportunity to specific quality improvement work in the following areas: effective contraceptive use, oral health assessments for kids, lifestyle patterns for young kids, tobacco cessation, and access to a medical home. These projects will receive additional technical assistance and support from JCC staff.

In addition to this capacity building work we do with our community partners, detail on the specific partners for our work is shared in the relevant TQS sections.

B. Review and approval of TQS

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

The 2018 TQS process is administered by CareOregon's Health Plan Quality Assurance department. Senior QA staff partner with JCC Leadership and department teams to interpret the TQS requirements, establish timelines for completion, and ensure that TQS projects, programs, and performance improvement activities are aligned with the applicable OHA guidance and CCO contractual language. The 2017-2018 TQS cycle began in September 2017. As the year ended, the JCC board finalized its 2018 goals. These goals have been incorporated into the programs and performance metrics listed in this report for the coming year. A multiple round review process was integrated into the project plan with executive leadership providing final evaluation before submission. The final report will be shared with the JCC board after completion. Throughout the year, the TQS Task Force will review the developed work plans and report on progress towards the stated goals in the September 2018 progress report.

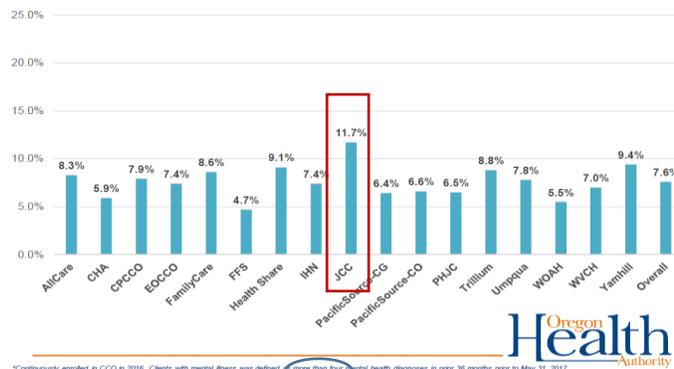
C. OPTIONAL

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:

OHP benefits are managed by 4 different entities in southern Oregon: Jackson Care Connect, AllCare, Primary Health of Josephine County, and FFS Open Card. JCC is responsible for managing care of approximately half the OHP membership in Jackson County. Having multiple CCOs in this region has led to complexities in leading health transformation. Even though we consistently work to identify opportunities for collaboration, our overlapping networks frequently serve OHP members under multiple CCOs and their relevant APMs. To help mitigate challenges related to having multiple CCOs in this relatively small county, Jackson Care Connect is working to convene network partners to build ownership for transformation and quality within the clinic setting (rather than just the CCO).

In addition, we face potential adverse risk selection when delivering high quality care coordination and developing effective interventions for our most complex members. An example of this adverse risk selection is the high prevalence of SPMI diagnosis among our membership. According to OHA data showing mental illness prevalence across CCOs, Jackson Care Connect is estimated to have 41% more clients with mental illness (11.7%) than the other CCO in our county (AllCare 8.3%).

CCO Estimate of Clients with Mental Illness*



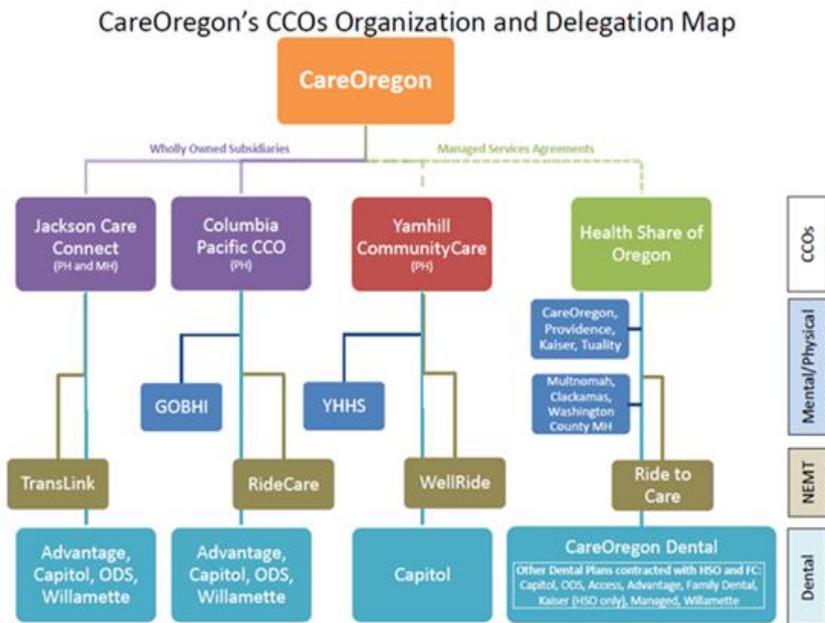
JCC integrated financial risk for mental health in 2017 so that we now have fully integrated administration of all services except for oral health (which remains delegated to DCOs). This allows us to develop payment models, technical assistance, and quality metrics that focus on integration of services. As a result, we have seen a nearly 25% increase in number of members receiving mental health services from 2016-2017. We are excited to continue evolving the integration work in 2018 in order to address the behavioral health conditions so many of our members experience.

As described above in Section 1A, JCC is wholly owned by CareOregon. Founded in 1993, CareOregon is a nonprofit, community benefit company serving approximately 200,000 Oregon Health Plan and Medicare members and their communities with integrated managed care services. CareOregon owns Jackson Care Connect (JCC) and Columbia Pacific CCO (CPCCO), partners as a risk-accepting entity with HealthShare CCO (HSO), and contracts to provide administrative services for Yamhill County CCO (YCCO). In addition to two Medicare plans and CareOregon Dental, Housecall Providers (HCP) is now part of the CareOregon family. HCP, located in Portland, delivers primary, palliative and hospice care to home-bound patients. Together, the collective organizations that comprise CareOregon focus on the total

health of members, over and above traditional health care. CareOregon connects with members, their families, providers and communities to help Oregonians prevent illness, respond effectively to health issues and live better lives.



In the context of the Transformation and Quality Strategy (TQS), Jackson Care Connect is accountable for the submission of the TQS as a CCO contractual requirement, but responsibility for each of the thirteen TQS components is determined by the administrative agreements between CareOregon and the CCO. CareOregon administers the following health plan services to JCC for physical and behavioral health: utilization monitoring (TQS 1d, 12), quality of care outcomes (TQS1c), member services including translation and interpreter services (TQS 2), grievance system inclusive of complaints, notices of actions, appeals and hearings (TQS 3), provider relations and quality monitoring (TQS 1c), monitoring and enforcement of consumer rights and protections (TQS 3), and assessment of the effectiveness of the fraud, waste and abuse program (TQS 4). CareOregon also supports and administers the JCC IT infrastructure (TQS 6a, 6b, 6c), assures and monitors network adequacy (TQS 1a, 1e), administers value-based payment models (TQS 13), and supports the Equity and Diversity strategy and organizational equity plan (TQS 5b). CareOregon is responsible for ensuring that delegates of all CCOs and lines of business are provided appropriate oversight and are operating in full compliance with state and federal regulations.



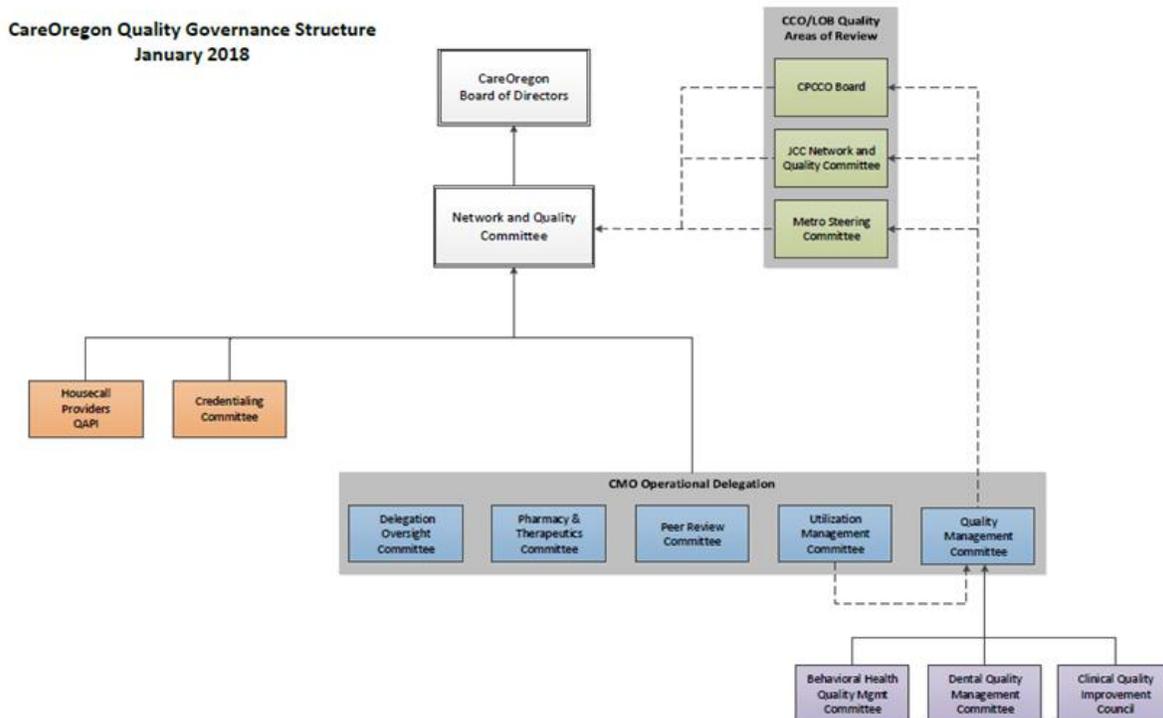
CareOregon's Quality Program is operationalized through the Health Plan Quality Assurance (HPQA) department at the direction of the Chief Medical Officer, who is delegated by the CareOregon Board of Directors to be the accountable executive of the quality program, and holds overall accountability for ensuring that all elements of the quality program are implemented in alignment with regulatory requirements and that performance is monitored and reported regularly. The overall quality work plan is reviewed through CareOregon's Quality Management Committee (QMC), a governance committee established at the direction of the CMO and Director of Quality Assurance.

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

The QMC reviews and approves the CareOregon annual quality work plan that includes all CareOregon quality program submissions, reviews current status and impact on members and the network, and monitors performance improvement projects. QMC ensures that CareOregon is continuously and systematically evaluating the adequacy and appropriateness of CareOregon’s operations through performance improvement processes and alignment with regulatory requirements. The scope of the QMC includes:

- Review and approve CareOregon’s Annual Quality Work Plan that includes all CCO quality program submissions, the grievance and appeals system, and performance improvement projects. Monitor their effectiveness and provide feedback on how to improve.
- Decision making authority for CareOregon medical policies relating to benefit management and quality of care.
- Review, approve, and ensure dissemination of practice guidelines. Bring forth other best practices based on various populations utilized in the network.
- Review how CareOregon structures its utilization management program and monitors for completeness and what impact, if any, relates to the network.
- Monitor subcommittees related to Dental and Behavioral Health and identify areas of integration.
- Monitor clinical performance metrics for 4 areas (governance, data collection, measurement system and interventions, and pathway for decision making)
- Review and add feedback to performance improvement projects related to OHA and CMS performance improvement projects

In addition to regulatory oversight and quality assurance, a system of clinical monitoring occurs in the CareOregon Quality Improvement Council (QIC), a workgroup that ensures that clinical programs and strategies are aligned with clinical performance goals and incentive measures. This workgroup has responsibility for identifying, prioritizing, and problem-solving cross-departmentally to improve performance of the CCO incentive measures and has CCO representation.





| A. TQS COMPONENT(S): 1a, e, 6a | | | |
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| Primary Component: | Access | Secondary Component: | Health information technology |
| Additional Components: | Access-Timeliness | | |
| Subcomponents: | Access: Availability of services | Additional Subcomponent(s): | HIT-HIE |
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | |
| <p>JCC has developed a formal Network Adequacy structure that includes a Steering Committee to oversee regular monitoring and reporting and updated policy and procedures used to guide activities related to monitoring CCO network adequacy and access. The policy includes a specific methodology used to assess CCO network adequacy and incorporates explicit standards, a measurement method and measurement frequency. The basic methodology and standards are those incorporated in CMS requirements and include calculations of ratios of providers by specialty type to numbers of members, tracking of distances from member residences to provider locations and the time of travel from member residence to provider locations. Network assessments are conducted at least annually.</p> <p>The customer service, quality assurance (QA), care coordination and provider services departments also provide real time responses to access issues that emerge through direct communications with members and/or providers. Quality assurance staff members track member complaints related to access and ensure that Provider Services representatives receive information when providers demonstrate a trend in poor access or access complaints.</p> <p>We ensure that our provider network has expertise that corresponds to our members' needs by including a breadth of physical health, dental health, and behavioral health providers on our network, including contracting with Federally Qualified Health Centers. These safety net clinics have expertise in working with vulnerable populations that are very linguistically and ethnically diverse, and work closely with the local community to coordinate social services. We also contract with every major hospital and health system within the communities we serve. In that way, we ensure that all specialized services are available to our members at participating network facilities.</p> | | | |
| C. QUALITY ASSESSMENT | | | |
| Evaluation Analysis: | <p>In 2017, the Network Adequacy Steering Committee approved an upgrade to Quest Analytics software to enable more accurate capture of its network data and support readily available reporting to our network and clinical teams. The committee also refined and updated internal policies and procedures relevant to network adequacy reporting.</p> <p>The Provider Services department monitors network partners for appointment availability; average wait time for a new PCP appointment among JCC providers was fourteen days in 2017, and established patient visits averaged 5 days. Complaints about access can reflect both actual member experience and member perception. CareOregon relies on strong relationships with network partners to identify access issues, and analyzes actual appointment availability from providers against access complaints received. Provider Services Representatives then work collaboratively with the provider to assess barriers to</p> | | |

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| | access for members. HPQA tracks this data for Provider Services and reports regularly to Quality Committee, and, as appropriate, to Peer Review Committee. In evaluating complaints related to access, complaints in 2017 related to access decreased slightly from 2016; CareOregon QA will be prioritizing that analysis in 2018 and continue to partner with local Provider Services Representatives to outreach to provider groups who demonstrate trends in access complaints. (See TQS Component 3) |
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D. PERFORMANCE IMPROVEMENT

Activity: Access Complaint Tracking and Improvement

| 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) |
|---|--|---|----------------|---|----------------|
| Access complaint report is sent to Provider Services to assess providers with repeated access issues; number of complaints only | Report is generated but only contains number of complaints | Expand reporting capabilities to include more detail about complaint and identification of unmet gaps in care for meaningful intervention | 12/31/2018 | Expand reporting capabilities to include more detail about complaint and identification of unmet gaps in care for meaningful intervention | 12/31/2018 |

Activity: Improve availability of dental services by enabling PCP request for dental outreach: Jackson Care Connect has implemented an electronic form on its provider portal website whereby a medical provider can request their patient receive outreach and care coordination by the dental plan. Each morning at 6:00am, forms submitted during the day before are compiled into a spreadsheet, the members' DCO is added, and the spreadsheet is sent to the CareOregon dental team. The next morning, the dental team divides the list by DCO and sends the applicable member information to each dental plan. The dental plan then conducts outreach to their members and schedules dental appointments.

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) |
|--|---------------------------|------------------------|----------------|---------------------------|----------------|
| Provider groups identified, trained and implement use of e-form | 0 | TBD PCPs trained | 6/30/2018 | X PCPs trained | 12/31/2018 |
| Monthly monitoring to determine number and percentage of medical providers using the form. | Not currently reviewed | | | Review monthly | 6/30/2018 |

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| A. TQS COMPONENT(S): 1c, 3 | | | |
| Primary Component: | Access | Secondary Component: | Grievance and appeal system |
| Subcomponents: | Access: Quality and appropriateness of care furnished to all members | Additional Subcomponent(s): | |
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | |
| <p>As described in Section 1 of the TQS, JCC leverages the CareOregon Quality Management Committee (QMC) to monitor quality and appropriateness of care delivered to its members through its grievance and appeals monitoring process, provider monitoring, regional utilization monitoring workgroups, and performance on CCO incentive measures. JCC receives reports from CareOregon HPQA at least semi-annually that include but are not limited to: Appeals and Grievance analysis, Delegation Oversight status and any relevant Corrective Action Plans, outcomes of the state External Quality Review and the progress of the TQS. The Director of HPQA sits on the JCC Network and Quality Subcommittee of the Board to provide alignment between JCC and CareOregon.</p> <p>Although not a TQS component, CCO performance on the CCO incentive metrics is an indicator of how well the CCO meets the needs of its members across validated measures of appropriate care, access, and outcomes. JCC is consistently among the highest performing CCOs in the state and has a robust quality improvement structure to support attainment of JCC’s clinical performance goals.</p> | | | |
| C. QUALITY ASSESSMENT | | | |
| Evaluation Analysis: | <p><u>Grievance and Appeals Monitoring</u></p> <p>In accordance with applicable OARs and CFRs, CareOregon’s grievance and appeal process includes an accessible grievance process, appeals process, and a mechanism for quality improvement through aggregate data tracking. The grievance and appeal system is supported by written policies and procedures. Aggregate JCC data is submitted to OHA quarterly. Please find additional detail and performance improvement activities in the Grievances and Appeals TQS component (see TQS 3).</p> <p><u>Provider Monitoring</u></p> <p>To close the gap between the member complaints and providers, the Peer Review Committee reviews each complaint that meets a certain threshold. The CareOregon process for monitoring of providers (includes physical, behavioral, and dental) consists of a system of Levels of Status and/or Action to inform providers of their standing with CareOregon, alert providers of possible impending action, and guide the Peer Review Committee (PRC) in its monitoring of providers. Progression through levels by providers places a provider’s status with CareOregon entities at risk of sanctions up to and including termination of contracts or credentialing status. Peer Review Committee may take the following actions: Letter to the provider for additional information, chart audits, site visit for office quality, Medical Director review for clinical quality, or recommendation to credentialing committee for panel review. Peer Review Committee actively monitored 26 providers in 2017; 3 were escalated to tier level monitoring but as of this submission have been removed from monitoring and are in good standing.</p> | | |

To ensure providers are acting in the best interest of the member, CareOregon and its affiliated CCOs have a process of allowing for Peer to Peer consultation calls for appeals. Provider education takes place through collaboration between the Appeals team and Provider Customer Service. There are between 5-10 requests a month. CareOregon has an expanded Quality of Care policy and procedure it uses to identify, document, and analyze quality of care events concerning care to members that are potentially outside the standards of practice. In 2017 there were 18 events, six of which were referred to Peer Review.

Quality Improvement

JCC has a well-rounded team to support the development and implementation of regionally specific quality improvement strategies and to monitor how well the CCO meets the needs of its members across validated measures of appropriate care, access, and outcomes, as indicated by achievement of CCO metrics. The team includes a Quality Improvement Analyst to understand CCO clinical metric performance and patterns and provide analytic support, a Primary Care Innovation Specialist to support clinics in developing, implementing, and refining workflows that support the achievement of the metrics, and a Provider Relations Specialist to support general provider education and problem solving.

At JCC, we partner with health care providers and incentivize them to improve member health. We work closely with them to learn what support and funding they need to achieve the incentive metrics and provide technical assistance, alternative funding pathways, and data to drive high-level performance improvement. One such program starting in 2018 is the Panel Coordinator program. The Panel Coordinator Program has dedicated JCC staff in clinics ensuring all JCC members have their routine preventive and chronic disease health maintenance needs met, and that providers have all the information needed for the visit. Panel Coordinators identify health care needs and gaps for patients who come in for routine follow up visits (scrubbing) and conduct proactive outreach to our members who have known gaps in their care. This not only improves health outcomes and access, but also ensures all visits are utilized to their maximum capacity. The aim of the program is that all clinics who have a Panel Coordinator achieve 100% of target goals for actionable CCO metrics, as well as strive to engage fragile members to get the services they need, and connecting them to available community and clinic resources. The Panel Coordinators serve as 'bridges' to the member's health care system needs, clinical needs, and provide basic care coordination between their care team and other outside agencies. Panel Coordinators provide individualized support to each member they engage, but common service components include:

- Gaps in care
- Health system navigation
- Clinic navigation
- Connection to community resources
- Preventative care

| D. PERFORMANCE IMPROVEMENT | | | | | |
|--|----------------------------------|------------------------|----------------|--|----------------|
| Related activities: <i>See TQS 3 for performance improvement activities related to Grievance and Appeal Systems, TQS 6b for HIT analytic activities to deepen QI analysis</i> | | | | | |
| Activity: Panel Coordinator Program | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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) |
| Documentation is made in PreManage, PopIntel, QNXT, Clinic EMRs: Gaps are closed by appointment completion with proper coding or if what was scrubbed for was completed with proper coding | 0 gaps closed/month (no program) | 300 gaps closed/month | 12/2018 | 300 gaps closed/month | 12/2018 |

| A. TQS COMPONENT(S): 1d | | | |
|-------------------------------|-------------------------|------------------------------------|-----------------|
| Primary Component: | Access | Secondary Component: | Choose an item. |
| Additional Components: | Add text here. | | |
| Subcomponents: | Access: Second opinions | Additional Subcomponent(s): | |

B. NARRATIVE OF THE PROJECT OR PROGRAM

A second opinion by a qualified healthcare professional is available with or without an authorization based on the JCC authorization guidelines posted on the JCC website. JCC arranges for second opinions when providers are unavailable or inadequate to meet a member’s medical need as indicated by the member and/or their provider. Because JCC provides seamless access to members, it does not track second opinions through a prior authorization process and there is not a capability to capture the data with claims. Instead we utilize member grievance system to monitor second opinions. We also ensure member customer service, care coordination staff and the member handbook have the knowledge of this benefit to share with members as needed. We find this area compliant through our external quality reviews.

| C. QUALITY ASSESSMENT | |
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| Evaluation Analysis: | Because JCC provides seamless access to members, it does not track second opinions through a prior authorization process and there is not a capability to capture the data with claims. Instead we utilize member grievance system to monitor second opinions. We also ensure member customer service, care coordination staff and the member handbook have the knowledge of this benefit to share with members as needed. We find this area compliant through our external quality reviews. |

| D. PERFORMANCE IMPROVEMENT | |
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| Activity: Monitor second opinions via grievance process | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> |

| | | | | <input type="checkbox"/> 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) |
| Regular grievance reports | Complaints related to second opinions = 0 | Maintain current performance | 12/31/2018 | Maintain current performance | 12/31/2018 |

A. TQS COMPONENT(S): 3, 1c

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|-------------------------------|--|------------------------------------|----------------|
| Primary Component: | Grievance and appeal system | Secondary Component: | Access |
| Additional Components: | Add text here. | | |
| Subcomponents: | Access: Quality and appropriateness of care furnished to all members | Additional Subcomponent(s): | Add text here. |

B. NARRATIVE OF THE PROJECT OR PROGRAM

JCC’s grievance and appeal system is administered and managed by CareOregon. In accordance with applicable OARs and CFRs, JCC’s grievance and appeal process includes an accessible grievance process, appeals process, and a mechanism for quality improvement through aggregate data tracking. The grievance and appeal system is supported by written policies and procedures. Aggregate data is submitted to OHA quarterly.

C. QUALITY ASSESSMENT

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| Evaluation Analysis: | <p>Two areas of focus with regard to grievances and appeals emerged in 2017 that will be key improvement activities in 2018.</p> <p>(1) <u>Overtured Appeals and Post-Service Clinical Review</u> JCC had seen consistent rates of appeal overturns, averaging around 38% over the prior two years (2015 and 2016). JCC tracks appeals overturns and uses identified trends to make decisions about benefit changes, prior authorization requirements and engagement with the provider network about clinical guidelines or prior authorization submission documentation.</p> <p>In 2017, HPQA and the Prior Authorization teams identified that the cause of overturns in the majority of cases is new documentation that was made available for inclusion in the appeals review process that was not available in the initial review. Another contributing factor was the need for more precise reasons for appeals overturns in order to more accurately identify the root causes of overturned appeals. Several process improvements are being made on the front end and the back end to try to reduce overturns and identify which of these contributing factors can actually reduce the overturn rate and translate to an achievable goal. At the end of 2017 the overturn rate for OHP appeals was down to 28%, but there is a desire to reduce it even further through additional improvement efforts and better analysis, highlighted in the next paragraph.</p> <p>(2) <u>Provider Reconsiderations</u> Prior to a QNXT upgrade in 2017, it was not possible for JCC to link clinical data from the prior authorization system with manual data from the appeals team, making it impossible to</p> |
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| | <p>draw conclusions about the connection between certain providers and frequent appeal requests. Provider reconsiderations create redundancies for appeals staff, unnecessarily burdens members with possible delays in care, and impedes positive relationships with network providers. The QNXT upgrade is allowing JCC to construct a pivot table that will link provider and clinical data to accurately assess trends by provider, which allows for initiatives to be developed to help address trends identified in the provider appeals data. These initiatives can include but are not limited to provider education, education of plan staff, education of provider office staff, and review of internal plan processes for opportunities.</p> <p><u>(3) Access Complaints</u></p> <p>Complaints about access can reflect both actual member experience and member perception. JCC relies on strong relationships with network partners to identify access issues, and analyzes actual appointment availability from providers against access complaints received. Provider Services Representatives then work collaboratively with the provider to assess barriers to access for members. HPQA tracks this data for Provider Services and reports regularly to Quality Committee, and, as appropriate, to Peer Review Committee. In evaluating complaints related to access, complaints in 2017 related to access decreased slightly from 2016; JCC QA will be prioritizing that analysis in 2018 and continue to partner with local Provider Services Representatives to outreach to provider groups who demonstrate trends in access complaints.</p> |
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| D. PERFORMANCE IMPROVEMENT | | | | | |
|---|--|---------------------------------|----------------|--|----------------|
| Activity: Overturned Appeal Process Improvement | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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) |
| Overtured rates are reviewed monthly by the QA Operations Manager, and the appeals and Prior Authorization teams meet bi-monthly to assess workflow, challenges, and look for efficiencies. On a monthly basis, Prior Authorization staff, HPQA and Medical Directors review specific cases for discussion. | Baseline is TBD; it is unclear if driver of overturns are front-end (lack of documentation) or back-end) | Identify baseline and benchmark | 05/2018 | Meet benchmark identified | 12/31/2018 |
| Activity: Construct Appeals Pivot Table | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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) |
|---|--|---|----------------|---|----------------|
| Is pivot table constructed and in use? | No | Yes | December 2017 | Yes | 09/2018 |
| Activity: Access Complaint Tracking and Improvement | | | | | |
| 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) |
| Access complaint report is sent to Provider Services to assess providers with repeated access issues; number of complaints only | Report is generated but only contains number of complaints | Expand reporting capabilities to include more detail about complaint and identification of unmet gaps in care for meaningful intervention | 12/31/2018 | Expand reporting capabilities to include more detail about complaint and identification of unmet gaps in care for meaningful intervention | 12/31/2018 |

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| A. TQS COMPONENT(S): 4 | | | |
| Primary Component: | Fraud, waste and abuse | Secondary Component: | Choose an item. |
| Additional Components: | Click here to enter text. | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s) | Click here to enter text. |
| B. B1-NARRATIVE OF THE PROJECT OR PROGRAM-2017 | | | |
| <p>CareOregon acts in the capacity of a third-party administrator for Health Share of Oregon CCO, Columbia Pacific CCO, and Jackson Care Connect CCO and is vested with the day-to-day operation of these entities Compliance and Fraud, Waste, and Abuse (FWA) program.</p> <p>CareOregon’s Compliance and FWA program has been designed to address the core elements identified by the Federal Sentencing Guidelines and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) that are required for the implementation of an effective compliance and ethics program. It is the policy of CareOregon to comply with all applicable federal and state laws pertaining to in federally-funded health care programs.</p> <p>Effective training and education is provided to CareOregon employees, Board members and temporary and contract employees at the time of hire and annually thereafter. CareOregon makes available multiple mechanisms for employees to report suspected or actual FWA, including:</p> <ul style="list-style-type: none"> • An open-door policy to the Compliance Officer to report the incident; • Reporting any concerns to the employee’s supervisor, manager, or director; and • Submitting the report to EthicsPoint, our secure anonymous reporting vendor. | | | |

| C. QUALITY ASSESSMENT | |
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| <p>Evaluation Analysis (e.g. target population, root cause analysis):</p> | <p>In 2016, CareOregon received a total of 16 reports of incidents of actual or suspected FWA. Three of these incidents were sent to the Medicaid Fraud Control Unit as required by Oregon Health Authority regulations. This compares to 21 reports of incidents of actual or suspected FWA received in 2017, of which three were submitted to the Medicaid Fraud Control Unit.</p> <p>In 2017, CareOregon initiated a Payment Integrity Workgroup to enhance program integrity and minimize FWA. The Payment Integrity Workgroup reviews issues involving overutilization of services or other practices that directly or indirectly result in unnecessary costs. Examples of items which will be discussed and reviewed, include:</p> <ul style="list-style-type: none"> • Improper payment for services; • Provider payment concerns identified through Quality of Care investigations; • Payment for services that fail to meet professionally recognized standards/levels of care; • Excessive billed charges or selection of the wrong code(s) for services or supplies; • Billing for items or services that should not have been or were not provided based on documentation supplied (validation that the medical records support the claim submitted by the provider); • Unit errors, duplicate charges and redundant charges; • Lack of sufficient documentation in the medical record to support the charges billed; • Experimental and investigational items billed; • Lack of medical necessity to support services or days billed; and • The records and/or documentation to substantiate the setting or level of service that was provided to the patient. <p>CareOregon is committed to preventing, detecting and correcting areas of non-compliance and/or FWA related to health care benefits, regardless of whether those benefits are paid by a commercial health plan or the government.</p> <p>In accordance with the Oregon Health Plan Provider Services Contract (Exhibit B, Element f) and 42 CFR 455.20 and 433.116(e) and (f), Jackson Care Connect, in conjunction with CareOregon, has implemented a process to send verification letters to a sample of JCC members to confirm that the member has received the billed medical services.</p> <p>On a monthly basis, CareOregon sends a ‘Verification of Medical Services’ letter to a sample of JCC members who received health related services. The ‘Verification of Medical Services’ letter specifies:</p> <ol style="list-style-type: none"> 1. The services furnished, 2. The name of the Provider furnishing the services, 3. The date on which the service was furnished, and 4. The amount of the payment made by the Member, if any, for the service. |

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| | <p>The sample does not include claims from specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS.</p> <p>Upon CareOregon’s receipt of a ‘Verification of Medical Services’ letter from the member indicating that services have not been received, the Compliance Officer, or another person as designated by the Compliance Officer, will coordinate a reasonable inquiry into the matter. Other department personnel may be required to assist and will conduct portions of the inquiry as applicable and as directed by the Compliance Officer. In 2017, a total of 708 ‘Verification of Medical Services’ letters were sent to members in CCOs affiliated with CareOregon (to include Columbia Pacific CCO, Health Share CCO, Jackson Care Connect CCO, and Yamhill CCO). As of December 14, 2017, CareOregon has received 154 responses from members for the 2017 reporting period. Of the 154 responses received, there were no responses from JCC members which required additional follow-up.</p> <p>In 2018, we will explore methods to increase response rates from JCC members, to include revision of the verbiage in the ‘Verification of Medical Services’ letters.</p> |
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D. PERFORMANCE IMPROVEMENT

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| Activity: Monitor ‘Verification of Medical Services’ letter response rates. See attached OHP Verification of Services Policy and Procedure. | | | | <input type="checkbox"/> Short Term Activity <u>or</u> <input checked="" type="checkbox"/> Long Term Activity | |
| Monitoring: | Baseline or current state | Benchmark or future state | Time (MM/YY) | Target or future state | Time (MM/YY) |
| ‘Verification of Medical Services’ letter response rates annually. | 22% Response Rate (annual) | 25% Response Rate (annual) | 06/2018 | ≥ 25% Response Rate (annual) | 12/2018 |

A. TQS COMPONENT(S) 5a, 5b, 1b, 2

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|-------------------------------|--|------------------------------------|---------------------------------------|
| Primary Component: | Health equity and data | Secondary Component: | CLAS standards and provider network |
| Additional Components: | Subcomponents: 6b-HIT: Analytics; Health Equity: Data; Access: Cultural Considerations | | |
| Subcomponents: | Health Equity: Cultural competence | Additional Subcomponent(s): | 1c: Quality & Appropriateness of Care |

A. NARRATIVE OF THE PROJECT OR PROGRAM

JCC is committed to section 1557 of the Affordable Care Act of 2010, which prohibits discrimination on the basis of race, color, national origin, sex, age or disability. It is the policy of JCC not to discriminate on the basis of race, color, national origin, sex, age or disability. Through CareOregon, JCC has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. JCC’s policies and operational plans provide culturally and linguistically appropriate services to our members, whether through the provision of interpreters, materials in alternate languages or in formats for visually and/or hearing-impaired members. JCC and CareOregon have dedicated significant time and resources to understanding how cultural competency can contribute to members’ experience of the health care system and how an individual’s culture can impact access, compliance, follow-through, satisfaction, and provider retention (burnout). JCC is a key stakeholder in the CareOregon Health Equity & Diversity department lead by a Health Equity Advisor, whose leadership guides the organization’s journey of continued growth in our appreciation, celebration, and understanding

of the diverse communities we serve. The department identifies, cultivates and maintains strategic and robust community-based organization partnerships, and, with JCC clinical and provider network partners, identifies and collaboratively designs strategies to address racial healthcare disparities and improve cultural responsiveness. The department has created an accountability pathway for JCC Leaders and staff to render culturally responsive services and healthcare to populations historically burdened by health inequities.

B. QUALITY ASSESSMENT

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| Evaluation Analysis: | <p>JCC underwent an External Quality Review in 2017 and had no findings relevant to its policies and processes for ensuring access to linguistically and culturally appropriate materials for members. 2017 was the first full operational year of the Health Equity and Diversity department established in late 2016; a key driver of the creation of a Health Equity and Diversity department was to establish a centralized home for equity and diversity work throughout CareOregon and its CCOs, and to formalize JCC’s commitment to equity and diversity.</p> <p>During 2017, JCC Board members and senior leadership members underwent training to advance their personal and leadership capabilities to lead their respective organizations using principles of equity, cultural responsiveness, and diversity. JCC also conducted an organization-wide equity self-assessment to determine priorities at the organizational, departmental and CCO levels for equity, diversity, and inclusion. These 2017 activities resulted in a comprehensive 2018 Strategic Plan and the development of an Equity Lens that will provide a framework for activities and programs developed at JCC.</p> |
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C. PERFORMANCE IMPROVEMENT

| Activity: Implement use of the Equity Lens across JCC programs and services via the JCC strategic planning process | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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) |
| Documented evidence of equity lens in project and program evaluation | Equity Lens still in development and not routinely applied to project evaluation | Equity Lens brought to Quality Management Committee for committee education | 3/1/2018 | Equity Lens will be incorporated into evaluation framework of performance improvement projects | 7/31/2018 |
| Activity: Complete Language Accessibility Improvement Plan | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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) |
| Monitoring of 2017-2018 Health Equity and Diversity Work Plan | Effective and compliant policies and | -Form Language Access | Complete by 6/30/2018 | Objectives, Measures, Strategies | 12/30/2018 |

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| | procedures related to availability of interpreter services, but no formal assessment process in place | Improvement Committee -Conduct Language Accessibility Assessment -Conduct Value Stream Map of member language access experience | | written for Language Access Plan with specific plans for top 4 non-English languages | |
| Activity: Identify healthcare disparities using data, metrics, and continuous quality improvement (also TQS Component 1c, 6b) | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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) |
| Monitoring COBI Dashboards to confirm utilization of race and ethnicity data | 0% | Disaggregate healthcare data by race, ethnicity, and language and provide data on 100% of provider dashboards | Complete by 3/31/2018 | Disaggregate healthcare data by race, ethnicity, and language and provide data on 100% of provider dashboards | Complete by 3/31/2018 |

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| A. TQS COMPONENT(S) 6a | | | |
| Primary Component: | Health information technology | Secondary Component: | Utilization review |
| Additional Components: | 1c-Quality and appropriateness of care | | |
| Subcomponents: | HIT: Health information exchange | Additional Subcomponent(s): | Add text here. |
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | |
| <p>In the 2013-2015 Transformation Plan, Jackson Care Connect focused its Benchmark on work related to the Jefferson Regional Health Information Exchange (now Reliance, supported jointly by hospital systems and CCOs). This work continued for the duration of our 2015-2017 plan. While Reliance is a superb conduit that has improved connectivity tremendously, the functionality is currently limited and other programs are required to be fully effective in caring for our high-risk members. At this point, there is no single data-sharing solution, and in response we are pleased to have received Epic access from the hospitals for our direct service staff, and have focused our attention on working with our Network partners to operationalize and spread PreManage.</p> <p>Dental issues account for up to two percent of ED visits and is the 12th most common ED discharge diagnosis. An emergency room physician is not equipped to provide dental care, so often only prescribes antibiotics for dental infection and opioids or other medications for pain. With the implementation of PreManage, Jackson Care Connect</p> | | | |

now has an efficient and effective way of identifying members who are inappropriately using the ED and who need dental navigation and care coordination services.

This project will measure:

- Number of members going to the ED for non-traumatic dental issues
- Number non-traumatic dental ED visits
- Number of members with follow up appointment within 30-days
- Number of members returning to the ED for non-traumatic dental issues

C. QUALITY ASSESSMENT

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| Evaluation Analysis: | The ongoing challenge we face integrating and coordinating care for our members is communicating essential information across organizations and entities. PreManage is offering the best platform for this work over the coming year. Challenges we are facing moving the dial on this project are twofold: local ED physicians have not been consistently willing to review and consider Care Recommendations, and Leadership in clinics is slow to roll-out / adopt, although direct service staff recognize the benefit of this shared platform. Jackson Care Connect defined a cohort for non-traumatic dental issues in the ED, so receives notifications each time a member is admitted or discharged from an ED for non-traumatic dental issues. Jackson Care Connect began notifying its dental plan partners of members who went to the ED for non-traumatic dental issues in November 2016. DCOs could then provide navigational support to their assigned members and work with their dental providers to schedule follow up dental appointments. In 2017, JCC worked with its DCOs to reproduce this cohort within their own contracts with CMT. DCOs are now notified directly by PreManage of their members going to the ED for non-traumatic dental issues. |
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D. PERFORMANCE IMPROVEMENT

| Activity: Convene and engage local PreManage Steering Committee to include leadership from critical network partners: mental health and addiction service providers, hospital partners and ED Directors, our top 5 clinic systems, and Collective Medical Technologies (CMT) on a quarterly basis to increase adoption and spread of platform as well as standardization of workflows. | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity | |
|---|--|---|----------------|--|----------------|
| How activity will be monitored for improvement | Baseline or current state | Target or future state | Time (MM/YYYY) | Benchmark or future state | Time (MM/YYYY) |
| Number of clinics that have operationalized PreManage. | Providence has implemented PreManage in local clinics that provide case management services. | Columbia Care, Addictions Recovery Center, La Clinica, Rogue Community Health and Asante Physicians Partners will be live on PreManage. | By 9/30/18 | Partners are receiving notifications and working in concert managing needs of population of focus | 12/31/18 |
| Key tasks for high utilizers before, during and after ED visits will be developed and | No current community agreement on roles and | Determine participants for workgroup(s) to work through | 9/30/18 | Roles and responsibilities of partners to address high ED | 12/31/18 |

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| adopted by above partners. | responsibilities to manage high utilizers. | before, during and after high utilizer ED visit. | | utilization have been developed and adopted (see attached). | |
| Activity: Work with the DCOs to reduce the number of members returning to the ED for non-traumatic dental issues through outreach and care coordination. | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity | |
| How activity will be monitored for improvement | Baseline or current state | Target or future state | Time (MM/YYYY) | Benchmark or future state | Time (MM/YYYY) |
| Monthly monitoring of ED data; updated dashboards. | TBD upon claims runout | | | 15% decrease from baseline | 12/31/2018 |
| Activity: Work with the DCOs to increase the number of members who complete a dental appointment within 30-days of the ED visit for non-traumatic dental issue. | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity | |
| How activity will be monitored for improvement | Baseline or current state | Target or future state | Time (MM/YYYY) | Benchmark or future state | Time (MM/YYYY) |
| Monthly PreManage reports cross-referenced to subsequent dental visits | TBD upon claims runout | | | 3% increase over baseline | 12/31/2018 |

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| A. TQS COMPONENT(S): 6b | | | |
| Primary Component: | Health information technology | Secondary Component: | Choose an item. |
| Additional Components: | | | |
| Subcomponents: | HIT: Analytics | Additional Subcomponent(s): | |
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | |
| <p>JCC, through CareOregon, is pursuing a data aggregation platform that would have the potential to integrate non-administration data with our existing claims data. The data aggregation platform could ingest EHR feeds and data from other HIE systems and integrate it with claims data. JCC will determine the extent to which it will develop this option during the 2018 program year, but there is potential for new avenues of analytics with this platform.</p> <p>Also in conjunction with CareOregon, JCC is developing an analytics tool that would allow the segmentation of the membership by risk. The tool would allow JCC to better identify high risk members who need complex care management. It also identifies “rising risk” members, or those who are at risk of high utilization in the coming months. Identifying these members will allow the CCO to intervene and potentially <i>avoid</i> harmful and costly health events for these members.</p> | | | |
| C. QUALITY ASSESSMENT | | | |
| Evaluation Analysis: | Data aggregation is a key capability for health plans and CCOs that manage member health. Effective care depends on having a comprehensive view of a patient’s overall health; data accuracy relies heavily on data aggregation and normalization. However, in today’s healthcare world, the bits and pieces that comprise a patient’s chart are spread out across entire communities and beyond. For example, a patient’s demographic information might be in the practice management system, whereas the information about the encounter is entered into an Electronic Health Record (EHR). To complicate matters, there is no | | |

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| | <p>guarantee the two pieces of software talk to each other, reference the same patient identifiers (IDs), use the same coding systems, or even come from the same vendor. Additionally, clinical quality measures are based on both administrative and clinical data.</p> <p>The combination of a data aggregator and a predictive analytics tool will equip JCC to nimbly progress towards outcome measures and reporting and enable meaningful care coordination and interventions to occur for our members.</p> |
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| D. PERFORMANCE IMPROVEMENT | | | | | |
|--|---|---|----------------|--|----------------|
| Activity: Develop risk segmentation analytics tool | | | | <input checked="" type="checkbox"/> Short Term Activity <u>or</u> <input type="checkbox"/> Long Term Activity | |
| Completion of the segmentation analytics tool | The analytics tool is in a beta testing phase | Fully functioning tool available to CCO for ongoing use | 1/31/2018 | Fully functioning tool available to CCO for ongoing use | 06/30/2018 |
| Activity: Data Aggregator | | | | <input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> 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) |
| Project Plan TBD | No aggregator | | Add text here. | Implementation Date TBD | Add text here. |

| A. TQS COMPONENT(S) 6c | | | |
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| Primary Component: | Health information technology | Secondary Component: | Choose an item. |
| Additional Components: | Click here to enter text. | | |
| Subcomponents: | HIT: Patient engagement | Additional Subcomponent(s) | Click here to enter text. |
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | |
| <p>In partnership with HealthTrio JCC will design and launch 1st phase of Member Portal in order to improve member satisfaction. This effort will provide a more comprehensive communication platform in conjunction with the existing Provider Portal. Through this, JCC will improve member satisfaction and member experience. The portal will reduce customer service call time and volume by providing self-service capabilities such as: ordering and printing ID cards, links to other sites such as Provider Directory, Pharmacy Formulary, and Medicare OTC Benefit portal.</p> | | | |
| C. QUALITY ASSESSMENT | | | |
| Evaluation Analysis (e.g. target population, root cause analysis): | <p>In 2017, JCC realigned its internal member engagement structure to create a new Member Engagement Coordination Committee (MECC) that is responsible for creating and implementing a member-centric context of review for all member specific projects and initiatives that prioritizes and provides recommendations to leadership across JCC (CO). The MECC seeks to align all member activities for physical health, oral health and behavioral health with the CO mission, vision and values and, most importantly, ensures that all leaders are considering member-centric business practices while using a member-centric viewpoint that is shared both inside and outside of their respective work areas across the CO business enterprise.</p> | | |

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| The MECC prioritized the development of a member portal as a core health plan business element, leveraging JCC's existing relationship with HealthTrio, an established vendor for health plan portals. | | | | | |
| D. PERFORMANCE IMPROVEMENT | | | | | |
| Activity: Implement Member Portal: provide and receive member information | | | | <input type="checkbox"/> Short Term Activity <u>or</u> <input checked="" type="checkbox"/> Long Term Activity | |
| Monitoring: | Baseline or current state | Benchmark or future state | Time (MM/YY) | Target or future state | Time (MM/YY) |
| Member Portal Steering Committee Progress Reports | Portal not implemented | Portal implemented: Desktop version | 7/2018 | Portal implemented: Desktop version | 7/2018 |
| Adoption Rate | 0% | 10% Adoption rate | 6 months post-launch | 15% Adoption rate | 12 months post-launch |

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| A. TQS COMPONENT(S): 7 | | | |
| Primary Component: | Integration of care (physical, behavioral and oral health) | Secondary Component: | Choose an item. |
| Additional Components: | | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s): | |

B. NARRATIVE OF THE PROJECT OR PROGRAM

C. QUALITY ASSESSMENT

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| Evaluation Analysis: | <p>Jackson Care Connect has taken significant steps toward the original vision of integration as a Coordinated Care Organization model. In 2017 we fully integrated the risk and benefit management of mental health resulting in physical health, substance use disorder treatment and mental health benefits managed in a true global budget. This allow us to manage quality, utilization, and costs with resulting improved access and decreased utilization. (Please see submission 9 and 12) We have implemented two alternative payment methods: Primary Care Payment Model (PCPM) and our Behavioral Health Integration Model that are now in their second iteration and aligned with CMS CPC+ model. This has moved our network of providers into the integrated model and uses Quality Pool funds and shared savings to fund it sustainably.</p> <p>Behavioral Health: We have had a year of significant change in 2017 within the mental health delivery system. Jackson Care Connect (through CareOregon) now manages a fully integrated benefit for medical, mental health and substance use disorder services. We terminated our risk delegation contract for mental health services with Jackson County Mental Health (JCMH), and stood up a new mental health network to absorb the members for outpatient services, respite, intensive case management and supportive housing. We continue to partner deeply with JCMH for crisis services and targeted intensive services such as ACT team.</p> <p>In our baseline year of 2017 for the integrated benefit and network transition, we saw a 10% reduction in ED utilization for a MH issue and psychiatric inpatient admissions. In addition, we increased our unique members served in MH treatment by 25%.</p> |
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| | <p>In 2018, we will build on the success of this new network and focus on improving quality, integration and cost. Please see sections 9 and 12 for Activities.</p> <p>Oral Health: Dental care should start at the time the first tooth erupts. Unfortunately, many children do not establish care with a dental provider until well after this time. Children, however do see their medical provider frequently during their first five years of life. Jackson Care Connect has adopted the First Tooth curriculum and will roll out the program to primary care provider groups, thereby increasing the number of children receiving oral health services and dental home referrals. Jackson Care Connect will measure:</p> <ul style="list-style-type: none"> • The number of primary care sites trained • The number of providers providing the service • The number/percentage of children receiving oral health services in primary care <p>Although much attention and effort has been put towards reducing the quantity and duration of opioid prescribing, less emphasis has been placed on reducing acute opioid prescribing. Dentists are the third most frequent prescriber of opioids, behind internal and family practice providers. Dentists generally, however, prescribe opioids for a shorter duration, and significantly lower MED than their medical counterparts. Yet, opioid prescribing practices should be examined and reduced for all provider types.</p> |
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D. PERFORMANCE IMPROVEMENT

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| <p>Activity: Jackson Care Connect is training primary care providers in First Tooth, a curriculum that includes an oral assessment, fluoride varnish application, anticipatory guidance and dental home referral. Technical assistance is provided in advance of and subsequent to the training. By providing basic oral health screenings and fluoride varnish in the medical office, children receive earlier and more frequent oral health care. The referral to a dental home allows for improved quality and appropriateness of care in the dental office.</p> | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity |
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| 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 plan; number of sites trained and successfully implemented | 3 sites trained | | | 5 sites trained | 12/31/2018 |

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| <p>Activity: Analyze claims data monthly to determine number and percentage of children receiving oral health services in primary care.</p> | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity |
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| How activity will be monitored for improvement | Baseline or current state | Target or future state | Time (MM/YYYY) | Benchmark or future state | Time (MM/YYYY) |
|--|----------------------------|------------------------|----------------|-----------------------------|----------------|
| Monthly data of services provided; integration dashboard developed | TBD pending claims run out | | | 5% increase over 2017 final | 12/31/2018 |

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| Add text here. |
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| <p>Activity:</p> | <input type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity |
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| Jackson Care Connect will develop a program to collect, analyze and reduce opioid prescribing by contracted dentists; Develop intervention toolkit to reduce opioid prescribing by contracted dentists | | | | | |
| 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) |
| Toolkit developed | Toolkit not available | | | Toolkit available | 6/30/2018 |
| Activity: Collect and analyze pharmacy data; provide necessary data to DCOs so that they can work with their contracted dentists and dental practices to reduce opioid prescribing | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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 report analyzed; providers identified for intervention | Not currently analyzed | | | Report analyzed and disseminated quarterly | 6/30/2018 |
| 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) |

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| A. TQS COMPONENT(S) 8 | | | |
| Primary Component: | Patient-Centered Primary Care Home | Secondary Component: | Choose an item. |
| Additional Components: | Click here to enter text. | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s) | Click here to enter text. |
| B. B1-NARRATIVE OF THE PROJECT OR PROGRAM-2017 | | | |
| <p>Jackson Care Connect is supporting the PCPCH model by offering alternative payment methodologies (APM) to our PCPCH clinics. Only clinics recognized as PCPCHs are eligible to participate in these APMs. The goal of the APMs is to sustain the elements required to offer patient-centered, team-based care that might not be adequately reimbursed through the fee-for-service model. In addition, our technical assistance team offers support through learning collaboratives and technical assistance to interested clinics. In 2017 we supported 4 new clinics in becoming PCPCH certified and had 3 new clinics begin participating in the APM as a result of their new PCPCH status in 2016. In addition, the Behavioral Health and Primary Care Innovation Specialists offered technical assistance and lead learning collaboratives focusing on key PCPCH initiatives throughout the year.</p> <p>Next, we will develop a preferential assignment process in order to link unassigned or unengaged JCC members into high quality PCPCH certified clinics, thus increasing our % of members in PCPCH clinics receiving high quality care.</p> | | | |
| C. QUALITY ASSESSMENT | | | |
| Evaluation Analysis (e.g. target population, | JCC will continue to provide technical assistance and learning collaboratives to increase the number and level of PCPCH clinics in Jackson County. In addition to members in non PCPCH clinics there are also clinics who have a significant number of unengaged JCC members who have not yet engaged with a PCP. We believe in the PCPCH model with integrated care as the best model for achieving triple aim for our population. To this end we will assess | | |

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| root cause analysis): | the data for assignment and engagement and determine a reassignment process that preserves member choice and increases engagement of these members in high performing PCPCH clinics. | | | | |
| D. PERFORMANCE IMPROVEMENT | | | | | |
| Activity: Assess network data for non PCPCH clinics unengaged JCC members. Determine data integrity, validity and volume of patients affected. Use this analysis to inform creation of a preferential assignment policy/process. | | | | | <input checked="" type="checkbox"/> Short Term Activity <u>or</u> <input type="checkbox"/> Long Term Activity |
| Monitoring: Creation of analysis | Baseline or current state: No analysis performed on unengaged JCC members in non PCPCH clinics | Benchmark or future state: Analysis performed | Time: 08/18 | Target or future state: Preferential assignment process developed | Time: 12/18 |

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| A. TQS COMPONENT(S) 9 | | | |
| Primary Component: | Severe and persistent mental illness | Secondary Component: | Integration of care (physical, behavioral and oral health) |
| Additional Components: | SUD – specifically high-risk users | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s) | Click here to enter text. |

B. B1-NARRATIVE OF THE PROJECT OR PROGRAM-2018

We have had a year of significant change in 2017 within the mental health delivery system. Jackson Care Connect (through CareOregon) now manages a fully integrated benefit for medical, mental health and substance use disorder services. We terminated our risk delegation contract for mental health services with Jackson County Mental Health (JCMH), and stood up a new mental health network to absorb the members for outpatient services, respite, intensive case management and supportive housing. We continue to partner deeply with JCMH for crisis services and targeted intensive services such as ACT team.

In our baseline year of 2017 for the integrated benefit and network transition, we saw a 10% reduction in ED utilization for a MH issue and psychiatric inpatient admissions. In addition, we increased our unique members served in MH treatment by 25%.

In 2018, we will build on the success of this new network and focus on improving quality, integration and cost.

1. Quality: Implement a wellness program in SPMI clinic to target smoking cessation and exercise. This will be in partnership with ColumbiaCare Services and targeted to the SPMI members they are serving in outpatient, ICM, respite, supported housing, and supported employment.
2. Integration: Increase capacity to provide integrated dual diagnosis treatment to SPMI members. During 2018 ColumbiaCare Services will be pursuing a Letter of Approval from

OHA to provide SUD treatment to existing SPMI member who have co-occurring substance use disorders.

3. Quality: Increase access to and engagement in SUD services for high risk users of meth and heroin. Currently Jackson County Public Health provides a needle exchange program 3 days per week, and is tracking to provide about 3000 services per year, which we know are for more than just the individuals seen in person. Jackson County Mental Health will begin providing on site engagement groups to those individuals, along with MAT services and SUD treatment, on site and targeting this specific population.

4. Cost, Quality & Integration: Increase access in a specialty primary care clinic (Birch Grove Clinic) targeting members with BH disorders, specifically targeting referrals from inpatient (medical and psych) and ED. During 2018 we will be working with the Birch Grove Collaborative partners to create workflows and referral pathways for members who present in the emergency departments and medical floors related to a substance use disorder or mental illness into specialized primary care. Birch Grove Clinic is a specialty primary care clinic with integrated MH and SUD treatment and close partnerships with SUD and MH providers. See table below: JCC Adults enrolled as of June 2017: 17% of the JCC adults = 38% of the total paid claims. Patients with dual diagnosis of MH and SUD have quadruple the inpatient cost.

| Comorbidity Groups | # mbrs | % mbrs | % Paid Cost, 12mos by Utilizer group |
|---|---------------|-------------|--------------------------------------|
| No Conds or MhltH or SubUse* | 8,426 | 55% | 19% |
| 1+ conds / no MhltH or SubUse** | 4,379 | 29% | 43% |
| SubUse ONLY/with or without conds † | 1,804 | 12% | 27% |
| Complex MhltH ONLY/with or without conds †† | 480 | 3% | 5% |
| SubUse AND MhltH/with or without conds †† | 252 | 2% | 6% |
| No ACG data | 1 | 0% | 0% |
| mean age = 40 yrs (min=19; max =105) | 15,342 | 100% | 100% |

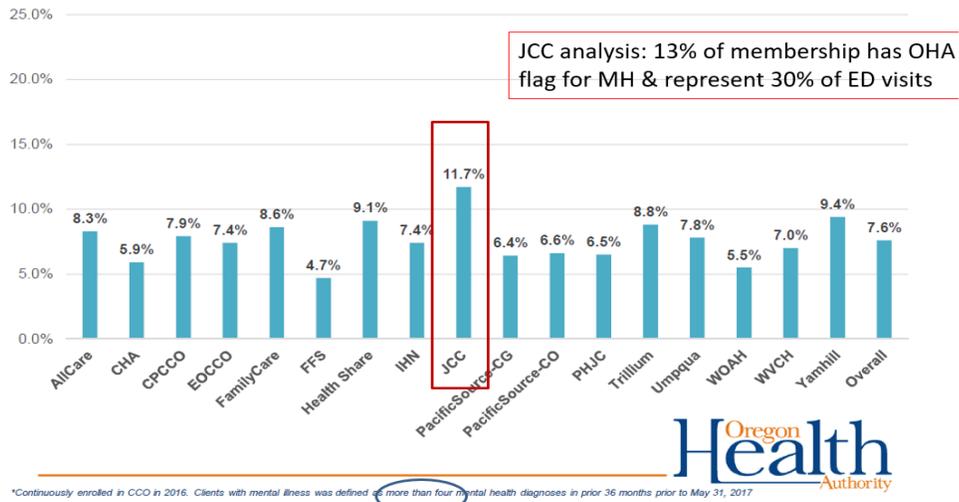
5. Cost, Quality, & Integration: Decrease ED admission for both medical and mental health issues by SPMI population.
 - a. This will be a primary evaluation focus for 2018. We will be working with ColumbiaCare Services, emergency departments, JCMH ACT and crisis services, PCP clinics and other stakeholders to develop and implement strategies.

C. QUALITY ASSESSMENT

| | |
|--|---|
| Evaluation Analysis (e.g. target population, root cause analysis): | <p>Our 2017 baseline for ED visits for medical concerns for the SPMI (OHA defined) population was 108 PTMPY. Our improvement target is 3%.</p> <p>OHA analysis shows Jackson Care Connect to have the highest prevalence of SPMI (OHA metrics definition) of any CCO in the state at 11.7%. Our internal analysis shows 13% of the JCC population has SPMI (OHA definition) and accounts for 1/3 of the ED visits. We</p> |
|--|---|

also have a top 20 dx list which shows our SPMI populaton has significant physical health ED visits, overlapping diagnoses of substance use disorder and likely much undiagnosed mental illness.

CCO Estimate of Clients with Mental Illness*



| In OHA SPMI Group (N=4,873) | | | Not in OHA SPMI Group (N=33,966) | | |
|--|-------------|------------|---|--------------|------------|
| Primary Diagnosis | # ED Visits | % of Total | Primary Diagnosis | # ED Visits | % of Total |
| CHEST PAIN UNSPECIFIED | 161 | 3% | ACUTE UPPER RESPIRATORY INFECTION UNSPECIFIED | 364 | 3% |
| UNSPECIFIED ABDOMINAL PAIN | 131 | 3% | CHEST PAIN UNSPECIFIED | 183 | 2% |
| HEADACHE | 119 | 2% | UNSPECIFIED ABDOMINAL PAIN | 167 | 2% |
| OTHER CHEST PAIN | 83 | 2% | FEVER UNSPECIFIED | 165 | 2% |
| ANXIETY DISORDER UNSPECIFIED | 83 | 2% | NAUSEA WITH VOMITING UNSPECIFIED | 148 | 1% |
| NAUSEA WITH VOMITING UNSPECIFIED | 78 | 2% | HEADACHE | 138 | 1% |
| PERS FEARED HEALTH COMPLAINT WHOM NO DX IS MADE | 73 | 1% | URINARY TRACT INFECTION SITE NOT SPECIFIED | 122 | 1% |
| URINARY TRACT INFECTION SITE NOT SPECIFIED | 71 | 1% | PERIAPICAL ABSCESS WITHOUT SINUS | 121 | 1% |
| MAJOR DEPRESSIVE DISORDER SINGLE EPISODE UNS | 68 | 1% | VOMITING UNSPECIFIED | 117 | 1% |
| ACUTE UPPER RESPIRATORY INFECTION UNSPECIFIED | 61 | 1% | S09.90X (Head injury) | 115 | 1% |
| EPIGASTRIC PAIN | 60 | 1% | PERS FEARED HEALTH COMPLAINT WHOM NO DX IS MADE | 111 | 1% |
| LOW BACK PAIN | 58 | 1% | ACUTE PHARYNGITIS UNSPECIFIED | 107 | 1% |
| SYNCOPE AND COLLAPSE | 55 | 1% | OTHER CHEST PAIN | 105 | 1% |
| OTHER SPECIFIED DISORDERS OF TEETH SUPPORT STRCT | 47 | 1% | ACUTE OBSTRUCTIVE LARYNGITIS CROUP | 103 | 1% |
| ALCOHOL ABUSE WITH INTOXICATION UNSPECIFIED | 47 | 1% | VIRAL INFECTION UNSPECIFIED | 98 | 1% |
| OTHER STIMULANT ABUSE UNCOMPLICATED | 46 | 1% | UNSPECIFIED ASTHMA WITH ACUTE EXACERBATION | 93 | 1% |
| GENERALIZED ABDOMINAL PAIN | 46 | 1% | EPIGASTRIC PAIN | 92 | 1% |
| MIGRAINE UNS NOT INTRACT W/O STATUS MIGRAINOSUS | 45 | 1% | SYNCOPE AND COLLAPSE | 89 | 1% |
| SUICIDAL IDEATIONS | 40 | 1% | PNEUMONIA UNSPECIFIED ORGANISM | 80 | 1% |
| PERIAPICAL ABSCESS WITHOUT SINUS | 39 | 1% | NONINFECTIVE GASTROENTERITIS & COLITIS UNS | 77 | 1% |
| Total Number of ED Visits | 5171 | | | 10414 | |

27% of ED visits have a Top 20 Dx (1411/5171)
20% of Top 20 Dx Visits are MH or Chem Dep (284/1413)

25% of ED visits have a Top 20 Dx (2595/10452)
No Top 20 Dxs are MH or Chem Dep

13% of JCC members are in the SPMI group with 33% of the ED visits

D.

Activity: Identify three (3) primary care clinics with the largest JCC SPMI population (including Birch Grove Clinic).

- Short Term Activity or
- Long Term Activity

| | | | | | |
|---|---|---|----------------|--|----------------|
| Monitoring: monthly | Baseline or current state: 1 of 3 clinics identified | Benchmark or future state: 3 clinics identified | Time (Q2 2018) | Target or future state: 3 clinics engaged in decreasing ED utilization for SPMI | Time (Q3 2018) |
| E. | | | | | |
| Activity: Improve referral path (information exchange, work flows, communication) to specialty MH (Columbia Care, JCMH) and SUD services (ARC). | | | | <input checked="" type="checkbox"/> Short Term Activity <u>or</u> <input type="checkbox"/> Long Term Activity | |
| Monitoring: monthly | Baseline or current state: undocumented referral process | Benchmark or future state: clear and documented referral process | Time (Q3 2018) | Target or future state: define quality improvement process for improving referrals | Time (Q4 2018) |
| F. | | | | | |
| Activity: Match OHA SPMI cohort to CareOregon population segmentation cohorts for further analysis of appropriate interventions. | | | | <input checked="" type="checkbox"/> Short Term Activity <u>or</u> <input type="checkbox"/> Long Term Activity | |
| Monitoring: monthly | Baseline or current state: unknown intersection between OHA SPMI cohort and CO populations segmentation cohorts | Benchmark or future state: OHA SPMI population will be matched to the population segmentation cohorts | Time (Q3 2018) | Target or future state: use of OHA data matched to CO data will allow analysis of best interventions | Time (Q4 2018) |

| | | | |
|--|-------------------------------|------------------------------------|-----------------|
| A. TQS COMPONENT(S) 10 | | | |
| Primary Component: | Social determinants of health | Secondary Component: | Choose an item. |
| Additional Components: | Add text here. | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s): | Add text here. |
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | |
| Because dental care and oral health education are critical during pregnancy and early childhood, early childhood caries is the most common disease in children with more than 51 million school hours missed each year due to dental issues. It is concerning that our data consistently demonstrates low utilization of oral health services for pregnant members as well as members age 0-5. We also know that children from lower income households have higher decay rates and | | | |

twice the rampant decay rate. In response, a dental curriculum has been developed to offer to members through our Starting Strong Program, an incentive based program for members who are pregnant and/or have babies up to their 4th birthday. Eligible families earn “vouchers” for completing health-promoting activities. Once earned, the vouchers can be redeemed at the Starting Strong “store” for items to help support the family in caring for the baby or having safe and healthy practices within the home. As the voucher incentive program has proved an effective way to engage eligible members in these activities over the last 3 years, we are employing the voucher program to encourage participation in this newly developed oral health class (Two Bright Smiles).

C. QUALITY ASSESSMENT

Evaluation Analysis: Our goal is to increase utilization of dental services by 5% for pregnant members and for children 0-5. This will be achieved through offering and incentivizing a class that provides information on both oral health practices and system navigation. Through increasing knowledge of the critical importance of these services, as well as how to navigate and access services, we believe we can improve the oral health of these target populations. The goals below for 2018 are process measures, evaluation of oral health outcomes within this target population is targeted for 2019.

D. PERFORMANCE IMPROVEMENT

Activity: Oral health Education and Integration:
 “Two Bright Smiles” class will be held once per quarter in 2018, focusing on oral health during pregnancy, identifying, and preventing early childhood caries, and how to navigate the oral health benefits.

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) |
|--|------------------------------------|---|----------------|--|----------------|
| 1) Number of families that complete this course in 2018 | 0 | 15 families attend and complete class | 6/30/18 | 40 families attend and complete class | 12/31/18 |
| 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) |
| 2) Curriculum adjusted based on evaluation by participants | Participant survey to be developed | Survey developed and administered to participants | 6/60/18 | Curriculum has been modified and/or adjusted based on participant feedback | 12/31/18 |

A. TQS COMPONENT(S) 10

| | | | |
|-------------------------------|-------------------------------|------------------------------------|-----------------|
| Primary Component: | Social determinants of health | Secondary Component: | Choose an item. |
| Additional Components: | Add text here. | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s): | Add text here. |

B. NARRATIVE OF THE PROJECT OR PROGRAM

Lack of adequate housing and homelessness has been shown in multiple studies to impact health outcomes and cost. Jackson County has experienced significant lack of affordable housing with vacancy rates in the 1-2% range. We have had a program with a regional housing partner Rogue Retreat, grant funded, to expand their services in recent years. In the last year Rogue Retreat has developed increased housing capacity with different levels of housing while adding

| | | | | | |
|---|----------------------------------|--|-----------------------|--|-----------------------|
| Case Management services for the people they serve. This has created a successful model increasing permanent housing for many. In 2018 we have contracted with Rogue Retreat to pay for case management while tracking best practice process measures (Self Sufficiency scores) and utilization (ED and inpatient) outcomes. | | | | | |
| C. QUALITY ASSESSMENT | | | | | |
| Evaluation Analysis: | | Our goal is to increase housing for JCC members and to track impact on best practice measures (Self Sufficiency scores) and utilization outcomes for ED and inpatient stays. | | | |
| D. PERFORMANCE IMPROVEMENT | | | | | |
| Activity: 1) Rogue Retreat will be doing a Self Sufficiency Outcome Assessment Score for each person in any level of housing services. This score is averaged and uses 15 assessment domains. Rogue Retreat will report the most recent average assessment score for each JCC participant each month. 2) JCC will set baseline ED and Inpatient utilization measurements and will track utilization while in the Rogue Retreat programs. Because of claims lag this will happen at the earliest mid year 2018 and Jan 2019 to evaluate the impact on utilization for this SDOH program | | | | <input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> 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) |
| 1) Rogue Retreat tracking average Self Sufficiency Outcome Assessments | TBD | Baseline established | July 2018 | TBD | July 2018 |
| 2) ED and Inpt Utilization | TBD | Baseline established | Jan 2019 | TBD | TBD |

| | | | |
|---|---------------------------|------------------------------------|--|
| A. TQS COMPONENT(S) 11 | | | |
| Primary Component: | Special health care needs | Secondary Component: | Integration of care (physical, behavioral and oral health) |
| Additional Components: | Add text here. | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s): | Add text here. |
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | |
| JCC's Health Resilience Specialist (HRS) is a Qualified Mental Health Professional (QMHP) and Certified Alcohol/Drug Counselor (CADC) with decades of experience working directly in the community with vulnerable populations. The role of the HRS is to reduce ED and inpatient stays by connecting some of our most vulnerable members to appropriate community support services to improve their health. Ultimately, the goal is for members to learn long term coping skills to manage their health. Currently, referrals for this | | | |

program are generated internally. The average length of engagement time is 3-9 months with weekly face to face contact in member’s home or wherever is convenient for them. One of the tools JCC employs to support this work is bi-monthly Complex Care Coordination Team meetings that serve as an opportunity to bring our network partners together to staff members with a multi-disciplinary team, share resources and best practices, and make successful hand-offs. While our HRS has made valuable connections through in this space, we believe we could increase his penetration by establishing deeper partnerships with integrated behavioral consultants working within clinic systems. In addition, we know from our data analysis that much acute care utilization is generated by unmet behavioral health needs. By offering support that exceeds what can be offered through the patients’ medical homes, we believe we can impact this utilization and better support our most vulnerable members.

C. QUALITY ASSESSMENT

| | |
|-----------------------------|---|
| Evaluation Analysis: | In 2018, our HRS will be receiving direct referrals from our external partners, thereby engaging individuals identified in the primary care medical home that would not otherwise have come to his attention. We have identified process measures for the coming year, hoping to review data in support of the effectiveness of this model in 2019. |
|-----------------------------|---|

D. PERFORMANCE IMPROVEMENT

| | |
|--|--|
| Activity: The HRS will pilot the opportunity for direct referrals to his caseload with two clinic systems. Once working smoothly, he will spread to our other two major clinic systems. | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity |
|--|--|

| How activity will be monitored for improvement | Baseline or current state | Target or future state | Time (MM/YYYY) | Benchmark or future state | Time (MM/YYYY) |
|---|---|---|----------------|---|----------------|
| Network partners will directly refer high risk members in need of support to JCC’s HRS. | No direct referrals are received from network partners. | 2 clinic systems are referring high risk members directly to JCC’s HRS. | 4/30/18 | 4 clinic systems are referring high risk members directly to JCC’s HRS. | 12/31/18 |
| % of HRS caseload engaged through external partner referrals. | None of HRS caseload is engaged through external partner referrals. | 5% of HRS caseload is engaged through external partner referrals. | 12/31/18 | 5% of HRS caseload is engaged through external partner referrals. | 12/31/18 |

A. TQS COMPONENT(S) 12

| | | | |
|-------------------------------|---------------------|------------------------------------|--------------------------------------|
| Primary Component: | Utilization review | Secondary Component: | Severe and persistent mental illness |
| Additional Components: | Integration of care | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s): | Add text here. |

| | | | | | |
|---|--|------------------------------------|-----------------------------|--|-----------------------|
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | | | |
| <p>Over utilization in the acute settings (ED and Inpatient) reflect poor health outcomes, poor patient experience and increased cost for JCC members with MH, SUD or both. We propose that appropriate engagement in primary settings (PCP, MH and/or SUD treatment) with care coordination will decrease acute setting utilization. We are in the early stages of developing network wide goals for engagement and care coordination of this cohort. To begin we will define the cohort (MH, SUD, or both with high acute utilization) and define this cohort’s current engagement rates with PCP, MH, and/or SUD. Later we will define clinic system (PCP, MH, SUD) level goals for engagement of this cohort and use the PreManage Steering Committee to develop the cross-system care coordination pathways and standard practices needed for this cohort.</p> | | | | | |
| C. QUALITY ASSESSMENT | | | | | |
| Evaluation Analysis: | <p>Our overall goal is to decrease ED and Inpatient over-utilization while increasing primary under- utilization (PCP, MH, SUD treatment) for people with behavioral health diagnosis. Our current goal is to define the BH cohort with high acute utilization and this cohort’s current baseline acute and primary utilization rates.</p> | | | | |
| D. PERFORMANCE IMPROVEMENT | | | | | |
| <p>Activity:</p> <ol style="list-style-type: none"> 1) Define BH cohort with High acute utilization 2) Define this cohort’s current (baseline) acute (ED, Inpatient) utilization rate 3) Define this cohort’s current (baseline) primary (PCP, MH, SUD) engagement rate | | | | <input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> 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) |
| 1) Create cohort | TBD | Cohort defined | Q2 2018 | TBD | TBD |
| 2) Define cohort’s baseline acute utilization rate | TBD | Baseline defined | July 2018 | TBD | TBD |
| 3) Define cohort’s baseline primary engagement rate | TBD | Baseline defined | July 2018 | TBD | TBD |
| | | | | | |
| A. TQS COMPONENT(S) 12 | | | | | |
| Primary Component: | Utilization review | | Secondary Component: | | |
| Additional Components: | | | | | |
| Subcomponents: | Choose an item. | Additional Subcomponent(s): | Add text here. | | |
| B. NARRATIVE OF THE PROJECT OR PROGRAM | | | | | |
| <p>JCC monitors over-utilization and under-utilization through its Cost & Utilization Steering Committee. The committee is responsible for monitoring cost and over/under utilization trends and for strategic decision-making related to cost and over/under utilization including:</p> <ul style="list-style-type: none"> • Prioritizing cost and over/under utilization problem areas for focused attention • Approving strategies to address cost, under/over utilization, and problem areas | | | | | |

- Designing, developing, and implementing the analytic approach and tools needed to perform work
- Monitoring the execution of strategies using process and outcome metrics
- Removing barriers by making high level decisions (or getting them made), ensuring sufficient resources and time to implement strategies
- Evaluating the efficacy of strategies (including contract changes) and redirecting when necessary
- Communicating effectively to C&U Steering Committee stakeholders
- Ensuring cross-CCO communication and learning
- Ensuring that CCO Leadership Teams have the knowledge and tools to monitor cost and utilization trends to be accountable

C. QUALITY ASSESSMENT

Evaluation Analysis:

This steering committee was officially chartered as the UM Oversight Committee in mid-2017 and since that time has engaged in appropriate oversight of Utilization Management activities. While monitoring of over and under-utilization is one of its core functions, the steering committee has developed a framework for using data to sponsor interventions that encompass six pillars of cost and utilization:

- Benefit Management
- Field-Based Care
- Preventable Hospitalizations
- Transitions
- Managing the Cost of Care
- Value-Based Network Assignments

Each of these pillars have associated interventions and programs that provide members with combinations of community, home, and clinic-based interventions that can keep them out of the hospital, address their needs, and reduce the total cost of care. The interventions are detailed in individual TQS components.

The JCC Network & Quality Committee reviews the effectiveness of UM monitoring against the CCO contractual obligations quarterly and finds that UM monitoring meets the required elements:

| Required Elements | Assessment |
|--|------------|
| Mechanism(s) to detect over- and under-utilization of services | Meets |
| Documentation of findings | Meets |
| Regular reporting of aggregate data | Meets |
| Follow-Up Actions | Meets |

Throughout 2017, JCC expanded its analytic capabilities that will allow for deeper exploration of utilization trends by population segment, member attributes such as race, language, ethnicity, and by level of risk for future high utilization. In 2018, this population segmentation approach will be used to identify “rising risk” cohorts most at risk for unnecessary utilization and amenable to advanced care coordination (see TQS 11).

D. PERFORMANCE IMPROVEMENT

| | | | | | |
|---|----------------------------------|-------------------------------|-----------------------|--|-----------------------|
| Activity: Quarterly UM Monitoring | | | | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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) |

| | | | | | |
|---|------------|-------------|---------|-------------|---------|
| UM Monitoring occurs quarterly and is reported at QMC | 2x in 2017 | 4 x in 2018 | 12/2018 | 4 x in 2018 | 12/2018 |
|---|------------|-------------|---------|-------------|---------|

A. TQS COMPONENT(S) 13

| | | | |
|------------------------|----------------------------------|----------------------------|---|
| Primary Component: | Value-based payment models | Secondary Component: | Access |
| Additional Components: | Utilization Management | | |
| Subcomponents: | Access: Availability of services | Additional Subcomponent(s) | Click here to enter text. |

B. B1-NARRATIVE OF THE PROJECT OR PROGRAM

JCC has supported innovative partnerships to develop patient-centered primary care medical homes, used alternative payment methods to align provider pay with outcomes, and expanded access through new and more efficient pathways for care. JCC offers a spectrum of Value-Based Payment methodologies:

| | Primary Care Payment Model (PCPM) | Comprehensive Primary Care Plus (CPC+) | Behavioral Health Integration (BHI) | Enhanced Fee Schedule (EFS) |
|----------------------------------|--|--|--|---|
| Program Description | CareOregon program designed to align pc payment with CO quality priorities and build clinic pop health and data reporting capacity | CMS multi-payer and practice program designed to create national alignment, and build clinic/health plan capabilities and care processes | CareOregon program designed to support the integration of behavioral health services in primary care and promote adoption of minimum PCPCH standards | CareOregon program to increase reimbursement for services that will increase primary care access (e.g. RN visits, telemedicine visits) |
| Eligibility Requirements | 1. PCPCH recognition 2. 150 or more CO members | 1. CPC+ designated clinic (no FQHCs) 2. PCPH recognition 3. 150 members at clinic or 2000 at system | 1. PCPCH recognition 2. Membership threshold: 1. Metro: 1,000 2. CPCCO: 250 3. JCC: 150 | 1. PCPH recognition |
| Payment Model | Tiered per member per month payment based on performance on quality metrics | Tiered per member per month payment based on performance on quality metrics | Tiered per member per month payment based on level of integration | Increased rate of fee for service payments for selected CPT codes |
| Included Measures | CCO metrics, Medicare STARS measures, miscellaneous (primary care engagement) | CCO metrics, Medicare STARS measures, miscellaneous (primary care engagement) | Productivity, same-day access, reporting on a target population | N/A |
| Frequency | Twice a year | Twice a year | Twice a year | Continuous – payment occurs upon delivery of service |
| What does the clinic have to do? | Track 1 Report whole clinic population performance on selected metrics | Track 2 Report member level performance on all CO members for required metrics | Track 1 Report whole clinic population performance on selected metrics Track 2 Report member level performance on all CO members for required metrics | 1. Maintain employment of at least 0.5 FTE of a behavioral health clinician 2. Participate in a learning collaborative 3. Report on measures Provide selected services to CareOregon members Ex. Telephone & telehealth Nurse visits Care management Tobacco & substance use Nutrition assessment |

C. QUALITY ASSESSMENT

| | |
|---------------------|--|
| Evaluation Analysis | As a result of these partnerships with providers, JCC has already surpassed the 2018 federal target of 50% for payments already in alternative payment models/ population-based payments. JCC will focus on implementation and spread of alternative payment methodologies to ensure that an increasing amount of JCC’s membership is impacted by these arrangements, and will focus on spreading models to community partners that serve a large number of JCC members. We are particularly |
|---------------------|--|

| | |
|--|--|
| | committed to supporting integration of physical, mental and dental health, through payment methodologies that support new clinical models of care. |
|--|--|

D. PERFORMANCE IMPROVEMENT

| | |
|---|--|
| JCC funds a robust Primary Care Behavioral Health program through an alternative payment methodology. Clinics are required to identify and target a specific subpopulation such as children with ADHD, adults with depression, etc. and report on identified interventions. | <input type="checkbox"/> Short Term Activity <u>or</u> <input checked="" type="checkbox"/> Long Term Activity |
|---|--|

| How activity will be monitored for improvement | Baseline or current state | Benchmark or future state | Time (MM/YY) | Target or future state | Time (MM/YY) |
|---|---------------------------|---------------------------|--------------|------------------------|--------------|
| Clinics are evaluated on population reach, and adherence to the model through analysis of the encounter data and annual site visit. Clinics are provided ongoing technical assistance and coaching based on analysis. | 5% (Tier 1)/12% (Tier 2) | 20% | 12/2019 | 20% | 12/2019 |

| | |
|---|--|
| Activity: Jackson Care Connect introduced a performance accountability measure with financial implications in its 2018 contractual agreements with its delegated dental plan partners. The measure specifically addresses increasing the percentage of adult and child members who receive a dental service during the year. Tying performance accountability to payment allows Jackson Care Connect to work with its dental plan partners to improve access to both preventive and restorative dental services. | <input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> 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) |
|--|--|------------------------|----------------|--|----------------|
| Analyze claims data monthly to determine number and percentage of individual members assigned and seen by dental plan partners. Work with DCOs on strategies to improve access, outreach and strategies to increase utilization. | 2017 utilization rate pending claims run-out | | | 3 percentage point increase over 2017 final; segregated by child and adult | 12/31/2018 |

