OHA Transformation and Quality Strategy (TQS)

CCO: Jackson Care Connect
Contents

Section 1: Transformation and Quality Program Information ................................................................. 1
   A. CCO governance and program structure for quality and transformation: ........................................... 1
   B. Review and approval of TQS .............................................................................................................. 2
   C. OPTIONAL ........................................................................................................................................ 3

Section 2: Transformation and Quality Program Details ............................................................................ 4
   A. Project or program short title: 1a. Access: Availability of Services Project #1, MAT access .................. 4
   B. Primary component addressed: Access .............................................................................................. 4
   C. Primary subcomponent addressed: Choose an item .......................................................................... 4
   D. Background and rationale/justification: .............................................................................................. 4
   E. Project or program brief narrative description: .................................................................................. 4
   F. Activities and monitoring for performance improvement: ............................................................... 4

Section 2: Transformation and Quality Program Details ............................................................................ 6
   A. Project or program short title: 1b. Access, Cultural Considerations, Project #1, Improving Colorectal Cancer (CRC) screening rates ................................................................. 6
   B. Primary component addressed: Access .............................................................................................. 6
   C. Primary subcomponent addressed: Access: Cultural considerations .............................................. 6
   D. Background and rationale/justification: .............................................................................................. 6
   E. Project or program brief narrative description: .................................................................................. 6
   F. Activities and monitoring for performance improvement: ............................................................... 6

Section 2: Transformation and Quality Program Details ............................................................................ 8
   A. Project or program short title: 1c. Access: Quality and Appropriateness of Care Project, #1 Mercy Flights Transitions Model ................................................................. 8
   B. Primary component addressed: Access .............................................................................................. 8
   C. Primary subcomponent addressed: Access: Quality and appropriateness of care furnished to all members .................................................................................................................. 8
   D. Background and rationale/justification: .............................................................................................. 8
   E. Project or program brief narrative description: .................................................................................. 9
   F. Activities and monitoring for performance improvement: ............................................................... 9

Section 2: Transformation and Quality Program Details ............................................................................ 10
   A. Project or program short title: 1c. Quality and Appropriateness of care Project #2: Reducing Low Value Care ................................................................. 10
   B. Primary component addressed: Access .............................................................................................. 10
   C. Primary subcomponent addressed: Access: Quality and appropriateness of care furnished to all members .................................................................................................................. 10
   D. Background and rationale/justification: .............................................................................................. 10
   E. Project or program brief narrative description: .................................................................................. 10
F. Activities and monitoring for performance improvement: ................................................................. 10

Section 2: Transformation and Quality Program Details ........................................................................ 11

A. Project or program short title: 1d. Second Opinions, Project #1, Access to Second Opinions ......... 11
B. Primary component addressed: Access ............................................................................................. 11
C. Primary subcomponent addressed: Access: Second opinions ...................................................... 11
D. Background and rationale/justification: .......................................................................................... 11
E. Project or program brief narrative description: .............................................................................. 11
F. Activities and monitoring for performance improvement: ............................................................. 11

Section 2: Transformation and Quality Program Details ........................................................................ 12

A. Project or program short title: 1e. Access, Timely, Project #1, Access to Youth Behavioral Health (BH) Services ................................................................................................................................. 12
B. Primary component addressed: Access ............................................................................................ 12
C. Primary subcomponent addressed: Access: Timely access .......................................................... 12
D. Background and rationale/justification: ......................................................................................... 12
E. Project or program brief narrative description: .............................................................................. 12
F. Activities and monitoring for performance improvement: ............................................................. 12

Section 2: Transformation and Quality Program Details ........................................................................ 14

A. Project or program short title: 2. CLAS Standards and Network, Project 1: Health Equity Plan .... 14
B. Primary component addressed: CLAS standards and provider network ..................................... 14
C. Primary subcomponent addressed: Choose an item ...................................................................... 14
D. Background and rationale/justification: ......................................................................................... 14
E. Project or program brief narrative description: .............................................................................. 14
F. Activities and monitoring for performance improvement: ............................................................. 14

Section 2: Transformation and Quality Program Details ........................................................................ 16

A. Project or program short title: 3. Grievance and Appeal Project #1: Appeals Overturn Process Improvement ........................................................................................................................................ 16
B. Primary component addressed: Grievance and appeal system .................................................. 16
C. Primary subcomponent addressed: Choose an item ...................................................................... 16
D. Background and rationale/justification: ......................................................................................... 16
E. Project or program brief narrative description: .............................................................................. 16
F. Activities and monitoring for performance improvement: ............................................................. 16

Section 2: Transformation and Quality Program Details ........................................................................ 18

A. Project or program short title: 4a. Health Equity (Data) Project #1: Clinic Specific Disparity Data ... 18
B. Primary component addressed: Health equity ................................................................................ 18
C. Primary subcomponent addressed: Health Equity: Data ............................................................ 18
D. Background and rationale/justification: ......................................................................................... 18
E. Project or program brief narrative description: .............................................................................. 18
F. Activities and monitoring for performance improvement: ............................................................. 18
Section 2: Transformation and Quality Program Details

A. Project or program short title: 4b. Health Equity, Cultural Competency Project #1, Language Services
   B. Primary component addressed: Health equity
   C. Primary subcomponent addressed: Access: Cultural considerations
   D. Background and rationale/justification:
   E. Project or program brief narrative description:
   F. Activities and monitoring for performance improvement:

Section 2: Transformation and Quality Program Details

A. Project or program short title: 5a. HIT Health Information Exchange Project #1, ED Utilization for Non-Traumatic Dental Issues-PreManage
   B. Primary component addressed: Health information technology
   C. Primary subcomponent addressed: HIT: Health information exchange
   D. Background and rationale/justification:
   E. Project or program brief narrative description:
   F. Activities and monitoring for performance improvement:

Section 2: Transformation and Quality Program Details

A. Project or program short title: 5a. HIT, Health Information Exchange Project #2: PreManage
   B. Primary component addressed: Health information technology
   C. Primary subcomponent addressed: Choose an item
   D. Background and rationale/justification:
   E. Project or program brief narrative description:
   F. Activities and monitoring for performance improvement:

Section 2: Transformation and Quality Program Details

A. Project or program short title: 5b. HIT: Analytics, Oregon Pediatric Improvement Partnership Data
   B. Primary component addressed: Health information technology
   C. Primary subcomponent addressed: HIT: Analytics
   D. Background and rationale/justification:
   E. Project or program brief narrative description:
   F. Activities and monitoring for performance improvement:

Section 2: Transformation and Quality Program Details

A. Project or program short title: 5c. HIT Project #1, Member Portal
   B. Primary component addressed: Health information technology
   C. Primary subcomponent addressed: HIT: Patient engagement
   D. Background and rationale/justification:
   E. Project or program brief narrative description:
   F. Activities and monitoring for performance improvement:
Section 2: Transformation and Quality Program Details

A. Project or program short title: 6. Integration of Care Project #1, Dental Care Coordination Request Form

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

C. Primary subcomponent addressed: Choose an item

D. Background and rationale/justification:

E. Project or program brief narrative description:

F. Activities and monitoring for performance improvement:

---

Section 2: Transformation and Quality Program Details

A. Project or program short title: 6. Integration of Care, Behavioral, Project #2, SUD Penetration

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

C. Primary subcomponent addressed: Choose an item

D. Background and rationale/justification:

E. Project or program brief narrative description:

F. Activities and monitoring for performance improvement:

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Section 2: Transformation and Quality Program Details

A. Project or program short title: 7. PCPCH Project #1, Spreading the model

B. Primary component addressed: Patient-centered primary care home

C. Primary subcomponent addressed: Choose an item

D. Background and rationale/justification:

E. Project or program brief narrative description:

F. Activities and monitoring for performance improvement:

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Section 2: Transformation and Quality Program Details

A. Project or program short title: 8. SPMI Project #1, Improve Coordination of Care with CHOICE for members in OSH and residential levels care

B. Primary component addressed: Severe and persistent mental illness

C. Primary subcomponent addressed: Choose an item

D. Background and rationale/justification:

E. Project or program brief narrative description:

F. Activities and monitoring for performance improvement:

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Section 2: Transformation and Quality Program Details

A. Project or program short title: 9. SDOH Project #1, Rogue Retreat Housing, Case Management and Homeless Services

B. Primary component addressed: Social determinants of health

C. Primary subcomponent addressed: Choose an item

D. Background and rationale/justification:

E. Project or program brief narrative description:

F. Activities and monitoring for performance improvement: Develop post-graduate survey

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Project or program short title: 10. SHCN, Project #1: Developing and implementing Care Plans for members with Special Health Care Needs (SHCN) to address identified coordination needs ........................................... 35

A. Primary component addressed: Special health care needs ................................................................. 35
B. Primary subcomponent addressed: Choose an item ........................................................................... 35
C. Background and rationale/justification: .............................................................................................. 35
D. Project or program brief narrative description: .................................................................................. 35
E. Activities and monitoring for performance improvement: ................................................................. 35

Section 2: Transformation and Quality Program Details ........................................................................ 37

A. Project or program short title: 11. Utilization Review, Project #1, Mercy Flights Mobile Integrated Health Proactive Model ............................................................................................................. 37
B. Primary component addressed: Utilization review ........................................................................... 37
C. Primary subcomponent addressed: Choose an item ........................................................................ 37
D. Background and rationale/justification: .............................................................................................. 37
E. Project or program brief narrative description: .................................................................................. 37
F. Activities and monitoring for performance improvement: ................................................................. 37

Section 2: Transformation and Quality Program Details ........................................................................ 39

A. Project or program short title: 12. Value Based Payment Methods, Project #1, Cost of Care ......... 39
B. Primary component addressed: Value-based payment models .......................................................... 39
C. Primary subcomponent addressed: Health Equity: Data ................................................................. 39
D. Background and rationale/justification: .............................................................................................. 39
E. Project or program brief narrative description: .................................................................................. 39
F. Activities and monitoring for performance improvement: ................................................................. 40

Section 3: Required Transformation and Quality Program Attachments ............................................ 41

A. Attach your CCO's quality improvement committee meeting minutes from three meetings .......... 41
B. Jackson Care Connect Consumer Rights ......................................................................................... 68

Code of Conduct ................................................................................................................................ 69
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 a 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. The JCC Board of Directors oversees the development and implementation of the strategic plan for JCC and is accountable for setting performance expectations for the CCO, which include ensuring an accountable and effective structure for quality and transformation. The board has a Network and Quality Committee that has an annual review schedule of External Quality Review, Grievances, Appeals, and Delegation Oversight activities. It also reviews performance data on utilization, access, metrics, and cost.

   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. In the context of the Transformation and Quality Strategy (TQS), JCC is ultimately accountable for the submission of the TQS as a CCO contractual requirement, but responsibility for each of the twelve 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, 11), quality of care outcomes (TQS 1c), 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, and assessment of the effectiveness of the fraud, waste and abuse program. CareOregon also supports and administers the JCC IT infrastructure (TQS 5a, 5b, 5c), assures and monitors network adequacy (TQS 1a, 1e), administers value-based payment models (TQS 12), and supports the Equity and Diversity Department (TQS 4a, 4b). 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.

   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):

While health plan quality assurance functions occur as part of JCC’s administrative services agreement with CareOregon (see above), the quality and transformation work at Jackson Care Connect is embedded in the operations throughout every department and is overseen by the CCO’s Executive Director and Medical Director, with Board oversight through the Network & Quality Committee of the board. 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.
iii. **Describe how your CCO uses its community health improvement plan as part of its strategic planning process for transformation and quality:**

The Community Health Improvement Plan (CHIP) was created in 2014 and a new one is currently underway for 2019 completion. The CHIP is a reference point for the strategic planning conducted by JCC Board of Directors. The priority areas identified in the 2014 CHIP continue to be priorities through today: Healthy Beginnings (perinatal, early childhood, youth at-risk), Healthy Living (oral health, member engagement, healthy communities, tobacco use), and Health Equity (reducing health disparities, social determinants of health). Importantly, the JCC Board of Directors created a CHIP fund that is administered solely by the CAC. The CAC references the CHIP priorities when making funding decisions about projects. Any funded project presents progress and impact to the CAC as an accountability mechanism. Lastly, the CHIP is a reference point when planning our annual Innovation Conference that highlights different components of the local health care system. In 2019, for example, we are highlighting voices from our Youth Advisory Council, CAC, and other local experts on behavioral health and social determinants of health.

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.

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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:**

As a CCO, we rely heavily on our partnerships with others in the community to achieve the transformation goals outlined in the TQS. We have active participation on our Clinical Advisory Panel and Community Advisory Council from the following partners: Community mental health program, Public Health, primary care providers including pediatrics and FQHCs, hospitals, behavioral health providers, Housing Authority, dentists, Early Head Start, and the Veteran’s Administration. These individuals serve as advisors to the Board of Directors and to staff.

JCC staff hold monthly meetings with leadership from our largest primary care systems. During these meetings, we review progress on joint projects described in the TQS. We also hold regular cross-organizational care coordination staffings and lead a community-wide approach to adopting PreManage. This work requires full engagement of our clinical partners.

Our projects that are not clinically based require partnering with law enforcement, county leadership, housing providers, childcare providers, schools, social service agencies, and wellness programs. The partnership with these sectors depends on the programmatic requirements, but we have a regular cadence of meetings for each project.

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B. **Review and approval of TQS**

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

The 2019 TQS cycle began in late 2018. 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. The TQS is written by staff who are deeply involved with JCC’s operations and who staff the Board advisory committees. Since they are deeply embedded in JCC’s creation of annual goals, quarterly reporting, and daily work, they can guide TQS development and monitoring.
They are also able to ensure TQS projects are aligned with JCC work more broadly and therefore adequately resourced. The final report will be shared with the JCC board after completion. Throughout the year, the JCC Transformation Specialist will review the developed work plans and report on progress towards the stated goals in the September 2019 progress report.

C. OPTIONAL

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

JCC operates in the only region with multiple CCOs. 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. Duplication of administration when more than one CCO exists in a region happens at the CCO level but also at the provider level when the different programs and APMs from each CCO affect the providers. 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 next largest CCO in our county (AllCare 8.3%).

![CCO Estimate of Clients with Mental Illness](image)

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.
Section 2: Transformation and Quality Program Details

A. Project or program short title: 1a. Access: Availability of Services Project #1, MAT access
   Continued or slightly modified from prior TQS? □ Yes ☒ No, this is a new project or program

B. Primary component addressed: Access
   i. Secondary component addressed: Integration of care (physical, behavioral and oral health)
   ii. Additional component(s) addressed: Add text here
   iii. If Integration of Care component chosen, check all that apply:
       ☒ Behavioral health integration   ☐ Oral health integration

C. Primary subcomponent addressed: Choose an item.
   i. Additional subcomponent(s) addressed: Add text here

D. Background and rationale/justification:
   A longstanding concern in our community is around access to SUD treatment. Jackson Care Connect has been convening community partners for a monthly meeting, Pathways to SUD Treatment, to discuss what we can do, together, to build capacity and improve access, both short and long term. We have engaged both of our major SUD Treatment Service Providers, both of our local FQHCs, the addiction psychiatrist from Jackson County Mental Health who is piloting the Bridge Clinic, where individuals served at the Syringe Exchange can receive MAT while getting connected to ongoing medical and/or treatment services, ED physicians, Mobile Integrated Community Paramedics, local X waivered providers, and several other stakeholders. At this point in time, we have poor access to MAT in the primary care setting, and most recent research shows best practice for MAT in primary care results in lower morbidity, mortality, utilization and costs. Triple aim impact can be achieved when approached with the use of best practice research and community engagement to solve this crisis.

   Jackson Care Connect will be supporting this work on multiple fronts. For instance, we are planning a Learning Collaborative for our community partners on Office-based Opioid Treatment (OBOT). We are identifying two clinics ready for TA to operationalize OBOT within their sites, and we will work with them on a targeted needs assessment. Once complete we will formalize a work plan with time frames based on identified needs. We are developing an alternative payment model for MAT practitioners. In an effort to mobilize community interest and reduce stigma, we are including a panel on Pain, Opioids, and Addiction at our annual Spring Innovation and Improvement Conference. And our Behavioral Health Innovation Specialist is participating on the HERC task force on compassionate opioid tapering.

E. Project or program brief narrative description:
   Increase access to OBOT.

F. Activities and monitoring for performance improvement:

Activity 1 description: Number of local X waivered providers
   ☒ Short term or ☐ Long term

Monitoring activity 1 for improvement:

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline number of X waivered providers and total</td>
<td>Complete environmental scan to learn the number</td>
<td>(06/2019)</td>
<td>A work plan is in place to increase the number of X</td>
<td>(12/2019)</td>
</tr>
<tr>
<td>capacity (number of patients per MAT provider) is unknown.</td>
<td>of X waivered providers and number of patients per MAT provider.</td>
<td>waivered providers and the number of patients that can access MAT in primary care settings.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. **Project or program short title**: 1b. Access, Cultural Considerations, Project #1, Improving Colorectal Cancer (CRC) screening rates

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

B. **Primary component addressed**: Access
   
i. Secondary component addressed: Health equity
   
ii. Additional component(s) addressed: [Add text here]
   
iii. If Integration of Care component chosen, check all that apply:
   
   ☐ Behavioral health integration  ☐ Oral health integration

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

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

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

Routine colorectal cancer screening can reduce deaths through early diagnosis and/or removal of precancerous polyps. Screening saves lives, but only if people get tested. However, one in three (36%) Oregonians ages 50-75 are not being screened as recommended, and only one in five Latinos were screened (21%) in 2015, the lowest among all racial/ethnic groups in Oregon. (Source: OHA Colorectal Cancer Screening Overview, 2015). We have been monitoring this disparity over the last 4 years, and have been encouraged to see the gap narrowing. We believe this is due, in part, to systematized mailings of FIT kits to members eligible for testing assigned to three of our largest clinic systems.

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

The BeneFIT program is one CRC screening activity that serves as a systematic, centralized approach with a directly mailed fecal immunochemical test (FIT) kits to Jackson Care Connect (JCC) members who are eligible for colorectal cancer (CRC) screening. CareOregon, on the clinic’s behalf, mails a letter introducing the importance of CRC screening, a FIT kit, and a reminder letter a few weeks after the kits are mailed. The goal is to minimize the impact on clinic operations by centralizing as much of the effort as possible, to increase the CRC screening rates across our membership, and to continue to narrow the disparity observed in White vs. Latino screenings, as previous data has demonstrated that Latinos are disproportionately likely to return to FIT kits.

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

**Activity 1 description**: BeneFIT program

☒ Short term or ☐ Long term

Three clinic systems serving a large percentage of JCC members participate in the BeneFIT program: Asante Physician Partners, La Clinica, and Rogue Community Health, and all three clinic systems have participated annually since 2016. Activities include:

- CareOregon identifies patients eligible for screening (active Jackson Care Connect members who are age appropriate) and sends the list to the clinic for scrubbing.
- Clinic scrubs the list to exclude patients who should not receive the mailing.
- After receiving the scrubbed list, CareOregon works with an outside print vendor to mail an introduction letter to targeted patients to demonstrate the importance of CRC screening and to give the member a head’s up that the kit is coming.
- CareOregon tracks letters that are returned because of an incorrect address.
• Approximately 4 weeks later, CareOregon works with an outside print vendor to mail the kits to all patients still on the list. Included with the kit is an incentive redemption form, such that if the patient does the CRC screening activity, he/she will receive a $25 gift card.
• Two weeks after the mailing of the kits, a reminder postcard is automatically mailed to all patients on the mailing list.
• This year, Panel Coordinators will outreach members who have not returned the kit and, through Motivational Interviewing, encourage their participation. We hypothesize this will increase the response rate.

**Monitoring activity 1 for improvement:** BeneFIT Mailing Response Rate

<table>
<thead>
<tr>
<th>Baseline or current state (2018 rates as of 2/13/2019)</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
</table>

**Activity 2 description:** Address a persistent health disparity with Latino CRC screening rates
☒ Short term or ☐ Long term

**Monitoring activity 2 for improvement:** Continue to monitor the CRC screening rates of Whites vs. Latinos

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 CRC screening White Rate: 38.4% Latino rate: 34.7%</td>
<td>Increase screening rates across the population by 3% and continue to narrow the ethnic disparity.</td>
<td>(12/2019) though data for 2019 will not be available until late February.</td>
<td>Increase screening rates across the population by 3% and continue to narrow the ethnic disparity.</td>
<td>(12/2019) though data for 2019 will not be available until late February.</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. **Project or program short title:** 1c. Access: Quality and Appropriateness of Care Project, #1 Mercy Flights Transitions Model

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

B. **Primary component addressed:** Access

   iv. Secondary component addressed: [Choose an item.](#)

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

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

   □ Behavioral health integration  □ Oral health integration

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

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

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

   We funded a pilot project with Mercy Flights in 2015, to engage specially trained Paramedics in connecting frequent ED utilizers to appropriate resources. The following year we implemented a Transitions Pilot with Mercy Flights for JCC members discharged from the hospitals. With learnings from both pilots, Paramedics improved engagement and outcomes for the JCC members served. The importance of engaging members face-to-face in the hospital, removing barriers to follow up care (sometimes that means empowering the member to select a PCP that will be a better fit for them), medication reviews with a pharmacist when the regimen is complex, and the great value of establishing a relationship of trust with a care team member, who supports members during and after discharge from an acute care facility, has shown cost reduction while improving patient experience and outcomes. At its foundation, this program is improving the quality and appropriateness of care for JCC members transitioning out of the hospital while preventing ED visits and, we hypothesize, readmissions.

   Starting in 2018 we transitioned to a case rate reimbursement for Mercy Flights paramedicine program for Transition Services.

Mercy Flights vs Control Group Per Member Cost

This preliminary data suggests a significant ROI and data tracking will continue as we increase the number of engaged members. More refined data tracking is needed to accurately evaluate ROI.

<table>
<thead>
<tr>
<th>Study Group</th>
<th>Total in each group</th>
<th>Avg Pre Cost</th>
<th>Avg Post Cost</th>
<th>Difference</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>MF</td>
<td>51</td>
<td>$14,382.63</td>
<td>$9,932.71</td>
<td>-$4,449.93</td>
<td>-30.9%</td>
</tr>
<tr>
<td>Control</td>
<td>103</td>
<td>$15,225.64</td>
<td>$13,695.07</td>
<td>-$1,530.57</td>
<td>-10.1%</td>
</tr>
</tbody>
</table>

Factors to consider:

- The N of both groups was small in the 6 months pre-post comparison so more time to analyze impact is needed.
- 6 months of data is too short to see longitudinal trends that include view of regression to the mean and beyond. Longer pre-post time frame yields more meaningful data re: ROI of the model.
• Of note, this program has had huge impact on our ED utilization rates and has contributed to JCC being on track to meet overall ED Metric and ED Disparity metric for the first time.

E. Project or program brief narrative description:
Mercy Flights Transition Model, target population: all Medicaid members who have an unscheduled inpatient admission. Our goal is to capture readmission rates for engaged members accurately to evaluate the impact of this program. We hypothesize a savings of $75,600 for 2019 if 60 members are engaged monthly, based on preliminary data.

F. Activities and monitoring for performance improvement:

Activity 1 description: 2019 Data Evaluation to evaluate ROI of current model.
☒ Short term or ☐ Long term

<table>
<thead>
<tr>
<th>Monitoring activity 1 for improvement:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline or current state</strong></td>
</tr>
<tr>
<td>No monthly report that provides 30, 60, 90-day readmission rates for Medicaid members engaged in care.</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 1c. Quality and Appropriateness of care Project #2: Reducing Low Value Care

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

B. Primary component addressed: Access

- Secondary component addressed: Utilization review
- Additional component(s) addressed: Add text here
- If Integration of Care component chosen, check all that apply:
  ☐ Behavioral health integration   ☐ Oral health integration

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

- Additional subcomponent(s) addressed: Add text here

D. Background and rationale/justification:
As JCC progresses further into value-based care and providing clinically appropriate care to members while keeping the cost of care sustainable and maintaining patient experience, it is critical to consider the potential for health care waste in care processes. To truly measure and deliver “value”, we must know specifically where to target efforts.

E. Project or program brief narrative description:
JCC will adopt one or more of the Choosing Wisely Guidelines for reducing low-value care.

F. Activities and monitoring for performance improvement:

- Activity 1 description: Implement Choosing Wisely Guideline
  ☒ Short term or ☐ Long term

  Monitoring activity 1 for improvement:

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No baseline established.</td>
<td>Baseline and guideline identified</td>
<td>(06/2019)</td>
<td>Guideline implemented</td>
<td>(09/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 1d. Second Opinions, Project #1, Access to Second Opinions
Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

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

C. Primary subcomponent addressed: Access: Second opinions
   iv. Additional subcomponent(s) addressed: Add text here

D. Background and rationale/justification:
OHA requires that CCOs provide for a second opinion for members and monitor compliance with the second opinion policy. 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 and care coordination staff have the knowledge of this benefit to share with members as needed. It is highlighted in our member handbook as well. We find this area compliant through our external quality reviews.

E. Project or program brief narrative description:
Second Opinion Monitoring via grievance process

F. Activities and monitoring for performance improvement:
Ongoing monitoring of grievances related to second opinions

Activity 1 description Monitor performance and report to Quality Management Committee
☒ Short term or ☐ Long term

<table>
<thead>
<tr>
<th>Monitoring activity 1 for improvement:</th>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 1e. Access, Timely, Project #1, Access to Youth Behavioral Health (BH) Services

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

B. Primary component addressed: Access

xiii. Secondary component addressed: Integration of care (physical, behavioral and oral health)
xiv. Additional component(s) addressed: Add text here

xv. If Integration of Care component chosen, check all that apply:
☒Behavioral health integration ☐Oral health integration

C. Primary subcomponent addressed: Access: Timely access

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

D. Background and rationale/justification:

Providing timely access to youth specialty BH services is integral to our array of services and although our penetration rate for these services was relatively high at 22% in 2018, anecdotally we know that our youth specialty Mental Health (MH) preferred provider (Kairos) has had difficulty getting new members in within the preferred 14-day time frame. Highlighting the problem further, our data has shown that treatment engagement (follow up within 15 days of initial appointment) and retention (three follow-up visits within 45 days) rates have been consistently in need of improvement at 65% and 43% respectively through quarter 2 of 2018, which is the most recent data available.

To address these issues, Kairos has agreed to work with a national healthcare consultant provided by CareOregon, and focused on implementing an open access model for first time appointments, a process for reducing no show rates, and new methods toward improving productivity such as concurrent documentation. Using and implementing these new processes and procedures is now required through contract language holding Kairos accountable.

This project with Kairos, which includes implementing open access at the end of February 2019, will ensure that all members can be seen well within the 14-day requirement. A new no show policy will also be put in place at this time. It is expected that focus on these areas will help improve engagement and retention rates which we will be tracking more closely over the course of implementation. Claims data will be used to track engagement and retention.

E. Project or program brief narrative description:

Kairos Engagement and Retention rates.

F. Activities and monitoring for performance improvement:

Activity 1 description Measuring Kairos Engagement and Retention rates
☒ Short term or ☐ Long term

Monitoring activity 1 for improvement:

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement and Retention rates for most recent quarter available: 65% and 43% respectively (through quarter 2 of 2018)</td>
<td>Engagement Rate= &gt;70% Retention Rate= &gt;50%</td>
<td>(12/2019)</td>
<td>Engagement Rate= &gt;70% Retention Rate= &gt;50%</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 2. CLAS Standards and Network, Project 1: Health Equity Plan
Continued or slightly modified from prior TQS?  ☐ Yes  ☒ No, this is a new project or program

B. Primary component addressed: CLAS standards and provider network

xvi. Secondary component addressed: Health equity
xvii. Additional component(s) addressed: Add text here
xviii. If Integration of Care component chosen, check all that apply:
   ☐ Behavioral health integration  ☐ Oral health integration

C. Primary subcomponent addressed: Choose an item.

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

D. Background and rationale/ justification:
JCC’s work around Equity, Diversity and Inclusion (EDI) is led by a cross-departmental Equity Action Committee. This committee’s stated purpose is “To implement strategies aimed at reducing health inequities and healthcare disparities through shared learning and innovation, ongoing engagement, and diverse and inclusive leadership.”

The work being led by this committee includes:
- Reduce disparities in targeted metrics
- Improve language services and accessibility
- Maintain strategic and robust community-based organization partnerships related to health equity
- Embed EDI in our CAC, BOD, CAP
- Apply a “lens” of equity & diversity in our hiring practices and on-boarding
- Provide EDI support to our Provider Network/Community Partners
- Inform our organizational culture
- Uplift member voice, through the engagement of our CAC in this work

In 2019, the Equity Action Committee will expand to include representatives from our BOD, CAC, and CAP.

E. Project or program brief narrative description:
The Equity Action Committee is leading the development of the Health Equity Plan for JCC, which is our 2019 goal.

F. Activities and monitoring for performance improvement:
Development and adoption of Jackson Care Connect Health Equity Plan.

Activity 1 description
☒ Short term or ☐ Long term

Monitoring activity 1 for improvement:

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal Health Equity Plan has been adopted.</td>
<td>Jackson Care Connect has developed and adopted a system-</td>
<td>(12/2019)</td>
<td>Jackson Care Connect has developed and adopted a system-</td>
<td>(12/2019)</td>
</tr>
<tr>
<td>wide Health Equity Plan.</td>
<td>wide Health Equity Plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 3. Grievance and Appeal Project #1: Appeals Overturn Process Improvement

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

B. Primary component addressed: Grievance and appeal system

  xix. Secondary component addressed: Choose an item.
  xx. Additional component(s) addressed: Add text here
  xx. If Integration of Care component chosen, check all that apply:
      □ Behavioral health integration □ Oral health integration

C. Primary subcomponent addressed: Choose an item.

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

D. Background and rationale/justification:

CareOregon initiated a project to reduce overturned appeals during 2018. During that process, we found that overturned appeals occur for one of two reasons: 1) either inadequate information is submitted at the time of the request or 2) appeals staff find existing clinical information in the record upon review that supports the overturn. In a very small portion of cases, the requesting provider has sent appropriate documentation but it was missed by the prior authorization staff (this has since been remedied with a revised training process).

These findings suggest that we can reduce our rate of overturned appeals by improving the quality of documentation received at the time of the pre-service request, which would reduce the need for appeal and resulting overturn rate. In order to improve the quality of information received with appeals, CareOregon must accomplish two things: 1) better educate its provider network on the information required at the time of the pre-service request, and 2) ensure its internal processes for prior authorization are optimized. The Medical Management department convenes a monthly workgroup to identify trends related to prior authorizations, appeals, overturns and adequacy of clinical documentation.

E. Project or program brief narrative description:

Prior Authorization Documentation Requirement Education

F. Activities and monitoring for performance improvement:

Activity 1 description: Update materials for provider network

□ Short term or □ Long term

Monitoring activity 1 for improvement: Develop materials for provider network that clearly outline prior authorization process and documentation requirements

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current materials are outdated</td>
<td>Assess and update materials</td>
<td>(02/2019)</td>
<td>New materials disseminated to network</td>
<td>(05/2019)</td>
</tr>
</tbody>
</table>
**Activity 2 description:** Monitor overturn rates
☐ Short term or ☒ Long term

**Monitoring activity 1 for improvement:** Develop materials for provider network that clearly outline prior authorization process and documentation requirements

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% of pre-service requests have adequate clinical documentation</td>
<td>85% of reviewed pre-service requests have adequate clinical documentation</td>
<td>(06/2019)</td>
<td>90% of reviewed pre-service requests have adequate clinical documentation</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 4a. Health Equity (Data) Project #1: Clinic Specific Disparity Data
   Continued or slightly modified from prior TQS? □Yes ☒No, this is a new project or program

B. Primary component addressed: Health equity
   xxii. Secondary component addressed: Choose an item.
   xxiii. Additional component(s) addressed: Add text here
   xxiv. If Integration of Care component chosen, check all that apply:
         □ Behavioral health integration    □ Oral health integration

C. Primary subcomponent addressed: Health Equity: Data
   viii. Additional subcomponent(s) addressed: Add text here

D. Background and rationale/justification:
   Jackson Care Connect has diligently tracked disparities across our membership related to race, ethnicity, geography, etc. with ongoing efforts to reduce identified disparities. In the coming year, we will be identifying clinic-specific disparities to share with our network partners to afford them the opportunity to consider possible contributing factors.

   For example, in one specific clinic within an FQHC system, white males in their early 50’s have a significantly lower rate of CRC screening. Providing this data can generate a conversation: how is CRC screening (or, more broadly preventative care) being flagged in this setting? Is it different than the procedure at other sites? What improvement opportunities can be learned from this data, and spread for wider impact?

E. Project or program brief narrative description:
   Providing clinic-specific disparity data

F. Activities and monitoring for performance improvement:

   Activity 1 description Identify and share clinic-specific disparities
   ☒ Short term or ☐ Long term

   Monitoring activity 1 for improvement:

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic-specific disparities have not been shared with network partners.</td>
<td>Clinic-specific disparities have been shared with at least 2 clinic systems.</td>
<td>(06/2019)</td>
<td>At least 1 clinic-system has developed a plan to address the identified disparity.</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. **Project or program short title:** 4b. Health Equity, Cultural Competency Project #1, Language Services

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

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

   xxv. Secondary component addressed: Access

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

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

       ☐ Behavioral health integration  ☐ Oral health integration

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

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

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

JCC membership data shows that over 8% of members have limited English proficiency. Interpretation is being offered at a variety of levels across the provider network and there is room for improvement in following best practices. It is common for bilingual staff who have other duties and are not qualified or certified interpreters to get pulled in to interpret. It is also not uncommon for members to rely on family members for interpretation. Even in cases where providers are using qualified interpreters there is a need to train providers on best practices for meaningful interpretation to improve health outcomes as well as member experience.

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

As a central objective of the JCC Equity Action workplan, JCC will be working with language service vendors to increase awareness among providers on the importance of interpretation, resources available, and the best practices. In collaboration with vendors, trainings will be provided to clinic staff at a variety of levels to increase meaningful and effective use of interpretation. This will extend to our provider network including physical, behavioral, and oral health. Once providers have been trained and interpretation capacity has started to increase, JCC's Community Engagement Team will work with partners to outreach our members to ensure they are aware of their rights to an interpreter, and that there is support in the provider network for making this a part of their experience of care. We have a strong partnership in place with a Spanish language magazine, Caminos, that is widely read by our Latino community, and we will run at least one article on patients' rights to have quality interpretation services available at no cost.

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

**Activity 1 description:** Providers using language vendors

☒ Short term or ☐ Long term

**Monitoring activity 1 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 providers using language vendors</td>
<td>30 providers using language vendors</td>
<td>(12/2019)</td>
<td>30 providers using language vendors</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>

**Activity 2 description:** Members using interpretation
☒ Short term or ☐ Long term

**Monitoring activity 2 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of requested visits interpreted (coverage rate)</td>
<td>85%</td>
<td>(06/2019)</td>
<td>Increase interpretation appointments by 5% (90% of requested visits are interpreted)</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. **Project or program short title:** 5a. HIT Health Information Exchange Project #1, ED Utilization for Non-Traumatic Dental Issues-PreManage

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

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

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

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

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

  □ Behavioral health integration

  ☒ Oral health integration

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

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

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

JCC delegated dental plan partners have all implemented PreManage and receive notifications for their members going to the ED for non-traumatic dental issues. They have also implemented a care coordination process whereby each member who goes to ED for dental issues receives outreach, care coordination and support in scheduling a visit.

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

JCC is working with dental care partners to increase the percentage of members completing a dental visit within 30 days of an ED visit for non-traumatic dental issues.

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

  **Activity 1 description:** Increasing percentage of members who complete a dental visit within 30 days of ED visit.

  ☒ Short term or ☐ Long term

  **Monitoring activity 1 for improvement:** Members completing a dental visit within 30 days of an ED visit for non-traumatic dental issues

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>38.6%</td>
<td>3% increase from baseline</td>
<td>(12/2019)</td>
<td>3% increase from baseline</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 5a. HIT, Health Information Exchange Project #2: PreManage

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

B. Primary component addressed: Health information technology

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

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

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

           ☒ Behavioral health integration  ☐ Oral health integration

C. Primary subcomponent addressed: Choose an item.

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

D. Background and rationale/justification:

Care coordination and integration is foundational to the work JCC has undertaken to achieve triple aim goals. Since 2017, JCC has been convening community partners regularly to advance implementation of the PreManage platform in support of this work. For the last several months, leadership from 13 network partners (including both local hospitals and AllCare) has been engaged and is committed to meeting quarterly as part of a Cross-system Care Coordination Steering Committee.

Though these efforts, we have developed best practices for care recommendations and mapped the roles and responsibilities of all participating partners before, during, and after an ED visit. The population of focus for this collaborative work is members identified in the OHA MH disparity group. This has provided an opportunity to enhance behavioral health integration efforts across our network, and stimulated innovative workflows to better serve the population.

E. Project or program brief narrative description:

Using PreManage, and the best-practice, community-driven, shared care plans documented through this platform, JCC is working with our community to inform more effective care while members are in the ED, and direct members to care more appropriate to their needs.

F. Activities and monitoring for performance improvement:

Activity 1 description: Network partners operationalize PreManage

☒ Short term or ☐ Long term

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified 4 clinics have not yet met implementation targets.</td>
<td>Primary Care Innovation Specialist has engaged staff from 4 target clinics and staff are actively using the PreManage platform.</td>
<td>(09/2019)</td>
<td>Active users from each targeted clinic average 5-10 log in's per month, author or update care history, care guidelines or security events and</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
**Activity 2 description:** Decrease in ED utilization through Care Recommendations

☑️ Short term or ☐ Long term

**Monitoring activity 2 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 baseline MH Disparity ED utilization not yet available.</td>
<td>Decrease ED utilization by 5% among Medicaid members with 2 or more diagnosis of mental illness (as defined by the OHA ED Disparity metric) who utilize the emergency department for physical health concerns not related to these diagnoses.</td>
<td>(12/2019)</td>
<td>Decrease ED utilization by 5% among Medicaid members with 2 or more diagnosis of mental illness (as defined by the OHA ED Disparity metric) who utilize the emergency department for physical health concerns not related to these diagnoses.</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>

**Activity 3 description:** Embedding Mental Health Specialty Navigator in primary care home that serves members with high acuity chemical dependence and/or SPMI.

☑️ Short term or ☐ Long term

**Monitoring activity 3 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Navigator currently measuring performance by patient touches.</td>
<td>In collaboration with the primary care team, the Mental Health Navigator co-authors 5 Care Recommendations/month.</td>
<td>(12/2019)</td>
<td>In collaboration with the primary care team, the Mental Health Navigator co-authors 5 Care Recommendations/month.</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. **Project or program short title:** 5b. HIT: Analytics, Oregon Pediatric Improvement Partnership Data

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

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

   xxxiv. Secondary component addressed: Special health care needs
   xxxv. Additional component(s) addressed: Add text here
   xxxvi. If Integration of Care component chosen, check all that apply:
      □ Behavioral health integration □ Oral health integration

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

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

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

   In 2017, Oregon Health Authority (OHA) and Oregon Pediatric Improvement Partnership (OPIP) developed data from more than thirty data sources to identify pediatric health complexities among OHP members. Q4 of 2018 total pediatric health complexity data was received from OHA. On November 28th, a full-day training was provided by OPIP and OHA to provide CCO’s with initial information on appropriate use of the data.

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

   JCC will work with CareOregon CCO regions to align frameworks around interpreting the OPIP data. This will include how to best apply information within the network and how to develop strategies related to pediatric complexity data provided by OHA/OPIP and CareOregon’s internal data sources (e.g. population segmentation). Strategies will drive regional workgroups to develop tactics around how to best address health complexity, medical complexity, and social complexity among pediatric populations through internal and external activities with the Jackson Care Connect equity lens.

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

**Activity 1 description:** Develop a data-informed Strategic Framework to identify population risk, needs, and disparities

☒ Short term or ☐ Long term

<table>
<thead>
<tr>
<th>Monitoring activity 1 for improvement:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline or current state</strong></td>
<td><strong>Target / future state</strong></td>
</tr>
<tr>
<td>Develop strategic framework based on analysis of OPIP data.</td>
<td>Strategic framework established.</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 5c. HIT Project #1, Member Portal

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

B. Primary component addressed: Health information technology

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

C. Primary subcomponent addressed: HIT: Patient engagement

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

D. Background and rationale/justification:

The member portal was originally planned for launch in July 2018; however, during the functional testing period, several items were identified as improvement opportunities. These opportunities were given more development resources to consider what the best end results can and should be for our member portal. We used the 4th quarter of 2018 for more member portal discovery and are targeting the 2nd quarter of 2019 for “Full “member portal launch.

E. Project or program brief narrative description:

A Portal Support Model was developed comprised of a Steering Group and combined Provider and Member Portal Workgroup Committee. This operating structure will support completion of remaining work to the full portal “go-live” date and will remain in place for ongoing development.

F. Activities and monitoring for performance improvement:

Activity 1 description  Implement Member Portal with appropriate functionality.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement:

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portal not launched</td>
<td>Portal launched</td>
<td>(07/2019)</td>
<td>5% Adoption rate</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 6. Integration of Care Project #1, Dental Care Coordination Request Form

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

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

xl. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration  ☑ Oral health integration

C. Primary subcomponent addressed: Choose an item.

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

D. Background and rationale/justification:

Navigating dental care has been a struggle for primary care providers and patients. Chief among the challenges is knowing what clinics accept what dental plan. To mitigate this struggle, a dental portal was created that allows primary care providers to submit a request for dental navigation and coordination by dental plan coordinators.

E. Project or program brief narrative description:

On the CareOregon provider portal, Primary Care Clinics have access to an online form where they can input basic patient information (name, member ID, DOB, phone, clinic referring, provider name, phone number of clinic) and the dental care team will send the information to each respective dental plan for outreach and care coordination.

F. Activities and monitoring for performance improvement:

Activity 1 description: # of patients sent through portal

☐ Short term or  ☑ Long term

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>48 patient requests sent in 2018</td>
<td>100 patient requests sent through portal</td>
<td>(12/2019)</td>
<td>150 patient requests sent through portal</td>
<td>(12/2020)</td>
</tr>
</tbody>
</table>

Activity 2 description: % of patients that receive services after portal request.

☐ Short term or  ☑ Long term

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a – no data yet to identify</td>
<td>Create data report to capture patients who got outreach</td>
<td>(12/2019)</td>
<td>30% of patients receive services</td>
<td>(12/2020)</td>
</tr>
</tbody>
</table>
and received services
Section 2: Transformation and Quality Program Details

A. Project or program short title: 6. Integration of Care, Behavioral, Project #2, SUD Penetration

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

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

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

C. Primary subcomponent addressed: Choose an item.

- Additional subcomponent(s) addressed: Add text here

D. Background and rationale/justification:

JCC is a fully integrated health plan with a global budget that encompasses not only physical health, but also behavioral health. We know that low barrier access and properly matched treatment is key to improving the health of our entire membership, decreasing cost, and reducing provider burnout.

To achieve this, we are focusing on innovative programs that meet our members where they present for care which, for this population, is often in primary care settings. At our 2019 monthly Leadership Meetings with our four primary network partners, we are establishing shared accountability for supporting MAT in primary care settings. Care Oregon also recently created a new position for a Behavioral Health Primary Care Innovation Specialist, who can provide the primary care clinics with tools and offer TA on workflows to integrate MAT services.

Because penetration rates will only go up with improved access, in the coming year we will also be working with our contracted SUD providers to improve access. We are connecting our contracted Paramedics who provide support to JCC members with our SUD treatment providers to establish a pathway to treatment. In addition, we are working with our SUD services providers on a redesigned intake process, which we believe will provide same day access, help reduce documentation burden, implement strategies for reducing now shows, and facilitate more effective cross-system care coordination.

E. Project or program brief narrative description:

To measure the impact of our interventions, we have set a goal to increase the SUD penetration rate from 6% to 8%.

F. Activities and monitoring for performance improvement:

- Activity 1 description: Increase SUD treatment penetration from 6% to 8%
  - ☒ Short term or ☐ Long term

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Penetration Rate is 6%.</td>
<td>SUD Penetration Rate is 8%.</td>
<td>(12/2019)</td>
<td>SUD Penetration Rate is 8%.</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 7. PCPCH Project #1, Spreading the model

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

B. Primary component addressed: Patient-centered primary care home

xlii. Secondary component addressed: Choose an item.

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

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

☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Choose an item.

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

D. Background and rationale/justification:

The PCPCH Program is a key strategy in achieving the “Triple Aim.” Research suggests that by following the PCPCH guidelines, healthier patients, improved patient experience, and decreased cost can be achieved. PCPCH set the standard for patient-centered and evidence-based care. Currently Jackson Care Connect has 26,095 members assigned to PCPCH certified clinics ranging from tier 2 to tier 5, which is 86.4% of our members.

E. Project or program brief narrative description:

Jackson Care Connect is supporting the PCPCH model by providing a Practice Transformation Learning Series which focuses on the Building Blocks of Primary Care Transformation. Through this Learning Collaborative, many of the elements of the PCPCH will be presented. In advance of scheduling the meetings, our Primary Care Innovation Specialist (PCIS) surveyed our network partners’ Practice Managers to as part of an environmental analysis to understand where their clinics are terms of operationalizing the model. Based on the responses, the curriculum has been developed to ensure training can be as impactful as possible. The series will occur in ten two-hour sessions concluding on December 17th, 2019. We will have attendees from Rogue Community Health, Asante Physician Partners, Providence Medical Group and La Clinica, Jackson Care Connect’s four largest network partners. Jackson Care Connect also offers an Alternative Payment Model (APM) to our PCPCH clinics, and clinics recognized as tier four receive a higher level of payment.

Through these APMS our goal is to sustain the elements required to offer patient-centered, team-based care that might not be adequately reimbursed through a fee-for-service model. In addition, the Primary Care Innovation Specialist will offer technical assistance to clinics that are interested in becoming PCPCH certified or would like to increase their tier. This technical assistance is tailored to the individual needs of the clinics. Recently, the Primary Care Innovation Specialist assisted a large pediatric clinic in applying for tier four status, through weekly site visits over 8 weeks. Her assistance was found invaluable to the Medical Director, so we plan to replicate that model for other clinics.

F. Activities and monitoring for performance improvement:

Activity 1 description: Practice Transformation Learning Series

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement:
Activity 2 description: Primary Care Innovation Specialist (PCIS) will provide technical assistance (TA) to in network clinics that wish to become PCPCH certified or advance tiers.
☒ Short term or ☐ Long term

Monitoring activity 2 for improvement:

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Sessions Completed</td>
<td>10 Practice Transformation Learning Series (10 2-hour sessions) are scheduled, and 3 have been held.</td>
<td>(06/2019)</td>
<td>Practice Transformation Learning Series (10 2-hour sessions) have been completed.</td>
<td>(12/2019)</td>
</tr>
<tr>
<td>PCIS has provided TA to one clinic.</td>
<td>Provide TA to three additional clinics.</td>
<td>(12/2019)</td>
<td>Provide TA to three additional clinics.</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 8. SPMI Project #1, Improve Coordination of Care with CHOICE for members in OSH and residential levels care

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

B. Primary component addressed: Severe and persistent mental illness

   xlix. Secondary component addressed: Integration of care (physical, behavioral and oral health)
   l. Additional component(s) addressed: Add text here
   li. If Integration of Care component chosen, check all that apply:
      X Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Choose an item.

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

D. Background and rationale/justification:

The Jackson Care Connect region has a high prevalence of SPMI when compared to other CCO’s around the state (11% according to the most recent OHA data). This subgroup requires a high level of care coordination due to its inherent complexity. The goal of such coordination is to improve the health and functioning of people with SPMI, particularly because they are at high risk for “falling through the cracks” as they are often involved with multiple agencies and individuals helping to address their care needs. Further, the coordination is necessary to reduce duplication of services and over utilization of EDs, acute psychiatric hospitals, residential treatment facilities, and the Oregon State Hospital (OSH).

JCC has been collaborating with the local CHOICE contractor, Jackson County Mental Health (JCMH), for several years. We have a weekly meeting with JCMH representatives of CHOICE, ACT and crisis services, as well as our main treatment provider for adults, Columbia Care Services. Depending on the circumstances, this meeting can also include ad hoc representation from the local acute care system, private practice network, and other social services agencies who may be involved. This has been a functional cross system meeting to review members who are currently in or have the potential for needing the Oregon State Hospital or other residential levels of care, and is intended to ensure that the community services are in place to keep members in the least restrictive setting possible, as well as helping with successful transition to and from these higher levels. However, scoping and defining roles and processes will afford an opportunity to improve quality, support better outcomes, reduce duplicative efforts and overutilization, and provide a structure to track system barriers over time.

E. Project or program brief narrative description:

The plan to improve the coordination involves developing a charter collaboratively with all stakeholders which will further define the scope of this group, the various roles within it, and standardize decision making processes to include a standardized case presentation form for collecting data and tracking progress or common barriers on those cases discussed.

The meeting charter will align with the Oregon DOJ Performance plan by tracking data such as length of stays for members in EDs, Acute psychiatric hospitals, RTF/SRTFs, and the Oregon State Hospital (OSH) including the specific goal of increasing the number of people who discharge within the desired 30-day time frame after being deemed ready to transition, which will be the target success indicator for this project’s first year.
F. Activities and monitoring for performance improvement:

With the initial goal of completing the charter by the end of June 2019, we will then have a defined system of tracking key several process measures that will help us monitor progress towards the overall goals of the improved coordination which is to reduce length of stays in higher levels of care. For this project, we will specifically be working on increasing the number of people who discharge from the state hospital within the desired 30-day time frame after being deemed ready to transition.

Process measures to be tracked this year include:

- # of members at OSH staffed at meeting
- # of collaborative individualized care plans developed at the meeting and entered our care coordination platform

**Activity 1 description** Develop and implement meeting charter

☒ Short term or ☐ Long term

**Monitoring activity 1 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/ YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charter exists.</td>
<td>Meeting charter developed which identifies clear roles, scope, and processes needed to manage this complex population across several systems.</td>
<td>(06/2019)</td>
<td>Charter has been implemented and serves to solidify an integrated and shared systematic cross-system process that is not person dependent.</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>

**Activity 2 description:** Increase number of members discharged within 30 days of deemed ready to transition.

☐ Short term or ☒ Long term

**Monitoring activity 2 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We currently do not have updated data on the number of people who discharge within 30 days of being deemed ready to transition from OSH.</td>
<td>Data will be tracked and 70% of all discharging members from OSH will do so within 30 days of being deemed ready to transition.</td>
<td>12/2019</td>
<td>90% of all discharging members from OSH will do so within 30 days of being deemed ready to transition.</td>
<td>12/2020</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. **Project or program short title:** 9. SDOH Project #1, Rogue Retreat Housing, Case Management and Homeless Services

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

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

   li. Secondary component addressed: Health equity
   lii. Additional component(s) addressed: Add text here
   liii. If Integration of Care component chosen, check all that apply:
       ☐ Behavioral health integration  ☐ Oral health integration

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

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

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

   The adverse impact of homeless on the health of individuals, families, and communities has been widely documented. Housing insecurity contributes substantially to health disparities, including increased vulnerability to illness and trauma, and rates of mortality are found to be three to four times higher among the homeless than in the general population. Since 2015 Jackson Care Connect has contracted with Rogue Retreat to provide a wide range of housing support and case management. The continuum of housing opportunities supported by JCC include:
   - Kelly’s Shelter – emergency shelter
   - Hope Village – shelter and case management
   - Recovery Housing – for men and women
   - Housing Retreat – subsidized rent
   - Restart Retreat – rebuilding rental history

   And most recently we added a pilot housing unit to specifically serve individuals (and their families) who are being prescribed medication assisted treatment in their recovery.

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

   Since 2018 JCC has expanded our contract with Rogue Retreat to support JCC members in all levels of their housing programs and case management. The levels of programing will support members in moving along a continuum of housing and self-sufficient stability. In this expanded contract, we are working together to evaluate health-related outcomes and the impact on cost and utilization. Metrics we are tracking include utilization (physical and behavioral health care), preventative care, and increasing stability tracked through self-sufficiency case management matrix. We have a 2019 goal to add an evaluation of maintained stability post program graduation.

F. **Activities and monitoring for performance improvement:** Develop post-graduate survey

   **Activity 1 description:** Survey has been developed with incentives to increase response rates.
   ☒ Short term or ☐ Long term

   **Monitoring activity 1 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
</table>

33
No long-term data is available to evaluate impact of housing programs over time.  

| Follow up evaluation process and survey questions are developed. | (09/2019) | The first survey has gone out to graduates of the program. | (12/2019) |
Section 2: Transformation and Quality Program Details

Project or program short title: 10. SHCN, Project #1: Developing and implementing Care Plans for members with Special Health Care Needs (SHCN) to address identified coordination needs

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

A. Primary component addressed: Special health care needs
   lv. Secondary component addressed: Integration of care (physical, behavioral and oral health)
   lvii. Additional component(s) addressed: Add text here
   lvii. If Integration of Care component chosen, check all that apply:
      ☒ Behavioral health integration  ☐ Oral health integration

B. Primary subcomponent addressed: Choose an item
   xix. Additional subcomponent(s) addressed: Add text here

C. Background and rationale/justification:
Jackson Care Connect offers care coordination through a Regional Care Team model. This care team offers and provides appropriate care coordination services and supports to meet member and provider needs. The regional care team is comprised of integrated multidisciplinary staff including both clinical (nursing and behavioral health staff) and non-clinical care coordinators, who can provide both telephonic and community based supports. As many members will have additional needs, the regional care team is also supported by several other departments and disciplines such as pharmacists, medical directors, dental coordinators, and the benefit review team.
Developing Care Plans for individuals with special health care needs (SHCN) is a high priority for 2019. The individualized care plan is developed and implemented during the care coordination process. Care plans are developed by the assigned care coordinator and/or care team.

D. Project or program brief narrative description:
Members with SHCN receive special outreach via a letter that informs them of their right to care coordination. They may also be engaged in care by the Regional Care Team's High-Risk Triage Coordinator who pulls monthly reports on these members. Care plans are then developed by the assigned care coordinator and/or care team, and completion of a Health Risk Assessment is a critical source of information for this care plan. And proactively reaching out to members with SHCN who are part of the Rising Risk cohort is a 2019 strategy to increase our support for this vulnerable population.

E. Activities and monitoring for performance improvement:

Activity 1 description: Health Risk Assessment Completion for adult members engaged in care coordination through the regional care team.
☐ Short term or ☒ Long term

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40% completion rate</td>
<td>65% completion rate</td>
<td>(12/2019)</td>
<td>65% completion rate</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
**Activity 2 description:** Engage Rising Risk cohort in care coordination  
☑️ Short term or ☐ Long term

**Monitoring activity 2 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No proactive process in place to engage SHCN members in care coordination with the regional care team.</td>
<td>Identify members monthly to engage in care coordination, and successfully engage 50 members</td>
<td>(12/2019)</td>
<td>Identify members monthly to engage in care coordination, and successfully engage 50 members</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
## Section 2: Transformation and Quality Program Details

### A. Project or program short title: 11. Utilization Review, Project #1, Mercy Flights Mobile Integrated Health Proactive Model

<table>
<thead>
<tr>
<th>Continued or slightly modified from prior TQS?</th>
<th>Yes</th>
<th>☒ No, this is a new project or program</th>
</tr>
</thead>
</table>

### B. Primary component addressed: Utilization review

- Secondary component addressed: Integration of care (physical, behavioral and oral health)
- Additional component(s) addressed: Add text here
- If Integration of Care component chosen, check all that apply:
  - ☐ Behavioral health integration
  - ☐ Oral health integration

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

- Additional subcomponent(s) addressed: Add text here

### D. Background and rationale/justification:

Over utilization in acute care settings, Emergency Department (ED) and Inpatient, may reflect poor health outcomes, poor patient experience, and/or increased costs. We hypothesize that mobile paramedics who are trained to provide care coordination, disease education and facilitation of engagement in needed services will increase Patient Centered Primary Care (PCPC) engagement rate, prevent inpatient hospitalization, and reduce health care costs. Care Oregon has developed a population segmentation algorithm that identifies a cohort of members we believe to be most likely to require acute care in the future (“Rising Risk”), and this is the target population to be served by this project.

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

PreManage real-time auto notifications are being sent to Mercy Flights (our contracted local mobile paramedics) when a JCC member included in the PreManage “Rising Risk” Proactive Cohort admits to the ED. Mercy Flights is outreaching the member in the ED, and providing support for the member for up to 60 days. The supports include:

- Completing an intake, which includes SDoH barriers, ensuring appropriate follow up for the precipitating problem, and referring and/or connecting to needed services and resources.
- Initiating a medication review by pharmacist.
- Using standardized Chronic Disease Protocols for conditions such as CHF, COPD, Diabetes, Wound Care, and SUD to increase member engagement and self-management skills, and to ensure member has access to appropriate supplies and services.
- Co-authoring ED Care Recommendations with assigned primary care teams as appropriate.
- Supporting member in achieving identified self-goals.

Based on preliminary data, we project a cost saving through decreased acute care utilization of $120,000. While our initial partnership with Mercy Flights was grant-funded, we are developing a contract to support a case rate for the above services.

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

**Activity 1 description** Contract in place between JCC and Mercy Flights.

<table>
<thead>
<tr>
<th>Short term or Long term</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Short term or ☐ Long term</td>
</tr>
</tbody>
</table>

**Monitoring activity 1 for improvement:**
**Activity 2 description:** By Q2, 2019 Mercy Flights will engage 10 Rising Risk Members

☑ Short term or ☐ Long term

**Monitoring activity 2 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Rising Risk members served by this program.</td>
<td>Mercy Flights will engage 90 Rising Risk members.</td>
<td>(12/2019)</td>
<td>Mercy Flights will engage 90 Rising Risk members.</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>
Section 2: Transformation and Quality Program Details

A. Project or program short title: 12. Value Based Payment Methods, Project #1, Cost of Care

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

B. Primary component addressed: Value-based payment models

lx. Secondary component addressed: Health equity
lxii. Additional component(s) addressed: Utilization Review
lxiii. If Integration of Care component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Health Equity: Data

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

D. Background and rationale/justification:

In 2018 Jackson Care Connect (JCC) added a Cost of Care Incentive Payment to the primary care APM program. The Cost of Care components measure emergency department and inpatient visits for Ambulatory Care Sensitive Conditions (ACSC). The measure is adapted from the Agency for Healthcare Research and Quality (AHRQ)’s PQI 90 and is one of the measures that OHA monitors as part of the CCO waiver. ACSCs are conditions in which an acute event (ED or inpatient) could have been prevented with timely, high quality intervention in primary care. As such, they focus specifically on domains that are impactable by primary care clinics. In addition, the measure is aligned with work we have been doing with network partners by reinforcing concepts of population health management, care coordination and use of PreManage.

E. Project or program brief narrative description:

The Cost of Care Incentive Payment was added to the primary care APM program on July 1, 2018. The program has two reporting events per contract, one every six months. Baseline data for Cost of Care has been provided to each participating organization. At the first reporting event, data on the measurement period will be provided to the participating clinics, but achievement of the payment is not contingent on the achievement of a target or benchmark. Starting on August 31, 2019, participating clinics will be required to demonstrate a 1.5% reduction in their ACSC rate in order to receive the payment. JCC has coordinated with CMT in order to produce PreManage cohorts around the ACSC grouping and the cohorts are now available to clinic partners. In addition, technical assistance has been offered to clinics around panel management, team-based care, self-management support and primary care access in support of this work.

<table>
<thead>
<tr>
<th>Program Description:</th>
<th>Cost of Care Incentive Payment</th>
</tr>
</thead>
</table>
| Eligibility Requirements: | • Track 2 PCPM  
• Tier Four (4) Patient Centered Primary Care Home recognized  
• 500 or more JCC members |
| Payment Model: | • Tiered per member per month  
• Payment based on performance of selected clinical Quality Measure Set |
| Included Measures: | • Emergency Department & Inpatient Admissions for ACSC |
| Clinic Requirements: | • Report data on selected Clinical Quality Measure Set twice annually |
F. Activities and monitoring for performance improvement:

**Activity 1 description:** Implement and hold clinics accountable for Cost of Care Ambulatory Care Sensitive Conditions  
☒ Short term or ☒ Long term

**Monitoring activity 1 for improvement:**

<table>
<thead>
<tr>
<th>Baseline or current state</th>
<th>Target / future state</th>
<th>Target met by (MM/YYYY)</th>
<th>Benchmark / future state</th>
<th>Benchmark met by (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No network partners are being measured on cost of care.</td>
<td>All Track 2 clinics are measured on Cost of Care</td>
<td>(07/2019)</td>
<td>All Track 2 participating clinics will be required to demonstrate a 1.5% reduction in their ACSC rate.</td>
<td>(12/2019)</td>
</tr>
</tbody>
</table>