



**PacificSource Central Oregon
Coordinated Care Organization**

TRANSFORMATION and QUALITY STRATEGY

March 2018

TQS Projects and Associated Components (PacificSource-Central Oregon)

Projects	Components
1. Identification and outreach to Special Health Care Needs members with Serious and Persistent Mental Illness through primary care clinics' use of Health Information Technology	Primary Component: Severe and Persistent Mental Illness Secondary Component: Special Health Care Needs Subcomponents: Health Information Technology: Health Information Exchange
2. Patient-Centered Primary Care Home enhancement focusing on high-value elements, behavioral health integration, and sustainable, aligned payment	Primary Component: Patient-Centered Primary Care Home Secondary Component: Integration of Care Additional Component: Value-based payment Models Subcomponents: Access: Availability of Services
3. Utilization Review and Second Opinions	Primary Component: Access: Second Opinions Secondary Component: Utilization Review
4. Analyzing Appeals & Grievances (A&G) data to support timely access to care	Primary Component: Grievances and Appeals Secondary Component: Access: Timely Access
5. Oral health care for adults with diabetes-Increasing preventative dental visits for adults with diabetes	Primary Component: Special Health Care Needs Secondary Component: Value-based payment Models Additional Component: Integration of Care Subcomponents: Health Information Technology: Analytics
6. Enhancing access to care with technical assistance and provider-directed education	Primary Component: Access Secondary Component: Health Information Technology: Patient Engagement Subcomponents: Access: Quality and Appropriateness of Care Furnished to all Members; Access: Availability of Services
7. Fraud, Waste, and Abuse-Effective lines of communication and well-publicized disciplinary standards	Primary Component: Fraud, Waste, and Abuse
8. Fraud, Waste, and Abuse-Claims audit process improvement	Primary Component: Fraud, Waste, and Abuse
9. Accountable Health Communities project	Primary Component: Social Determinants of Health Secondary Component: Health Information Technology: Health Information Exchange Subcomponents: Health Equity: Data
10. Supporting providers to deepen understanding of CLAS standards and enhance service delivery to meet the needs of a culturally diverse population	Primary Component: CLAS Standards & Provider Network Secondary Component: Access: Cultural Considerations Subcomponents: Health Equity: Cultural Competence

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:

Quality Program Structure:

The quality program of PacificSource Community Solutions, hereafter referred to as PacificSource, is designed to ensure that the members of the Coordinated Care Organization (CCO) have access to high quality health care that is safe, effective, provides a positive experience, and results in positive outcomes. The quality program is driven by our mission, values, strategic goals, and objectives. The quality program provides a comprehensive structure for organizing, monitoring, communicating, and improving the health and care of PacificSource members by addressing the requirements and recommendations from the following references:

- Quality Performance Outcomes and Accountability Requirements outlined in the CCO Health Plan Services Contract, Exhibit B - Statement of Work – Part 9
- 42 CFR 438.240 Quality Assessment and Performance Improvement Program
- OAR 410-141-0200 Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System
- OAR 410-141-3200 Outcome and Quality Measures
- CMS Quality Strategy 2016
- Key elements of Oregon's coordinated care model
 - Best practices to manage and coordinate care
 - Shared responsibility for health
 - Transparency in price and quality
 - Measuring performance
 - Paying for outcomes and health
 - Sustainable rate of growth

The Quality Program is integrated throughout the organization. The company values form the foundation:

- We are committed to doing the right thing. We are one team working toward a common goal.
- We are each responsible for our customers' experience.
- We practice open communication at all levels of the company to foster individual, team, and company growth.
- We actively participate in efforts to improve our many communities, internal and external.
- We encourage creativity, innovation, continuous improvement, and the pursuit of excellence.

PacificSource's Clinical Quality and Utilization Management Committee (CQUM) is the advisory body for quality, utilization management, and performance improvement activities under the direct authority of the Chief Medical Officer or a delegated Medical Director. The Chief Medical Officer collaborates with, and receives input and recommendations from the Committee regarding quality, utilization management, appeals and grievances, and performance improvement activities. Regular reports of the Committee's activities will be made to the internal Quality Improvement Committee. The CQUM Committee is responsible for the following functions:

- Selects and approves guidelines, criteria, and decision support resources related to clinical criteria and medical necessity.
- Identifies, researches, reviews, and makes recommendations on quality and performance improvement issues, topics and activities focusing on evidence-based outcomes, health system integration, health improvement, access to preventive services, and cost-effectiveness.
- Initiate and review quality and performance improvement projects, including the identification, development, promotion, evaluation, and monitoring of health plan projects.

- Serves as a technical advisory body for clinically relevant quality, utilization, and performance improvement issues.
- Receives and reviews feedback, and provides direction on quality improvement monitoring and evaluation.
- Determines and ensures applicable committee members are recused when valid and significant conflicts of interest exist among Committee members.

The CQUM Committee meets every other month and at least six times per year. Committee members are expected to attend two thirds of scheduled meetings. The CQUM Committee consists of primary care providers, behavioral health practitioners, and specialty care practitioners from the hospital-based practices, private practices, and community health centers in PacificSource's provider network.

PacificSource's Quality Improvement (QI) Committee consists of PacificSource staff who work together to provide consistency in the oversight of clinical and service quality for the Medicaid, Medicare, Commercial, and Exchange lines of business. The QI Committee's areas of oversight include new and changing medical, dental, and behavioral technology, clinical policies and programs, member and provider satisfaction, and quality initiatives. The QI Committee reviews clinical care events and other identified quality concerns, recommending finalized QI program content to the Executive Management Group (EMG) for approval. The QI Committee provides oversight and accountability for the QI Program across all lines of business. Strategic initiatives, as they pertain to QI programs, are reviewed and approved by this Committee. As such, the QI Committee oversees the development of the Transformation and Quality Strategy and makes recommendations to EMG for review and approval.

Additional committees within PacificSource that support health transformation and quality improvement within our CCOs include the TQS Steering Committee, the Community Advisory Council, the Provider Engagement Panel, the Quality Incentive Measures (QIMs) Steering Committee, the Behavioral Health Clinical Quality and Utilization Management Committee, the Government Operations Committee, and the Cross Departmental Medicaid Committee.

Utilization Management (UM):

PacificSource has a robust UM Program with the purpose to assure fair and consistent decision-making and to ensure the delivery of high quality, cost efficient health care for members, whether medical, dental, pharmacy, or behavioral health related. The UM Program detects both underutilization and overutilization by evaluating evidence-based criteria for the authorization of health care services to members, monitoring utilization practice patterns of participating practitioners, hospitals, and ancillary service providers, and by identifying and assessing the need for case management referrals through early identification of high or low utilization of services, high cost, chronic diseases and conditions. UM functions include referral management, prior authorization, and review of inpatient stays for members in facility care, retrospective review of claims or services delivered, and discharge planning. Auditing of decision-making, consistent application of criteria, and work processes is regularly performed. UM staff are audited on a quarterly basis and delegates are audited annually.

The goals of the UM Program are to:

- Ensure that services rendered are medically necessary, timely, provided in the most appropriate setting and are adherent to benefits.
- Ensure that available resources are utilized in an effective and efficient manner in the delivery of services.
- Develop, adopt, review, and evaluate evidence-based criteria for the authorization of health care services to members.
- Monitor utilization practice patterns of participating practitioners, hospitals, and ancillary service providers.
- Identify and assess the need for case management referrals through early identification of high or

low utilization of services, high cost, chronic diseases and conditions.

The objectives of the UM Program are to:

- Provide guidance, feedback, and education to providers in the efficient delivery and utilization of resources.
- Review utilization data identifying overutilization and underutilization practices, and to identify and implement program improvements that encourage appropriate utilization.
- Ensure consistent application of UM functions.

Appeal and Grievance System:

Appeal and grievance (A&G) processes are documented in policies and procedures. PacificSource policies and procedures reflect the requirement that Coordinated Care Organizations complete processing of member appeals within 16 days (with a possible additional 14 days under an approved extension), and grievances within 5 days (up to 30 calendar days if an extension is needed). When PacificSource grants a request to expedite a review, this is done within 72 hours of receipt. Resolution of complaints and grievances are provided in writing to the member. For quality of care, written follow-up is provided to the provider, if necessary. The Oregon Health Authority (OHA) requires that all appeals, with the exception of expedited requests, be filed in writing. Appeal forms and Administrative Hearing request forms are automatically included in the Notices of Adverse Benefit Decision sent to members. In addition, the member is mailed an appeal form upon request. Appeal rights are also included on Adverse Benefit Determinations for denials.

Reports are presented to the CQUM Committee on a quarterly basis. Complaints and grievances are reviewed by the CQUM Committee for activities and trends. Attention is called to complaints categorized as violations of consumer rights and protections. When monitored complaints show a trend, these concerns are elevated to Program Managers, the Medical Director, or the Quality Department, depending on the nature of the complaint. A root cause analysis is performed, and interventions are developed to resolve the issue.

Member rights are outlined in the Medicaid A&G Policy and Procedure, as well as in the member handbook. Consumer Rights is one of the categories of member grievances. Consumer Rights grievance types are described in the following table.

CONSUMER RIGHTS - "CR"
a) Provider's office has a physical barrier/not ADA compliant, prevents access to office, lavatory, examination room, etc.
b) Concern over confidentiality.
c) Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group, treatment options not discussed)
d) No choice of clinic or clinician choice not available
e) Fraud and financial abuse
f) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health, marital status, Medicare/Medicaid)
g) Complaint/appeal process not explained, lack of adequate or understandable NOA
h) Not informed of consumer (Member) rights
i) Member denied access to medical records (other than as restricted by law)
j) Did not respond to members request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)
k) Advanced or Mental Health Directive not discussed, offered or followed.
l) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. Restraint or seclusion used other than to assure members immediate safety.

Quality of care grievances are reviewed by medical directors to determine if harm occurred or potentially could have occurred to the member through the receipt of health care. If no potential for harm occurred, the event is considered a quality of service complaint. If harm occurred or potentially could have occurred, the event is counted in adverse event data. Complaints and Adverse Events are reported to credentialing organizations.

As PacificSource moves further along the continuum of integrating dental, behavioral, and physical health, grievances are an important tool for monitoring access and member experience.

PacificSource has identified quality improvement opportunities in the monitoring and reporting of Dental Care Organization (DCO) grievances. A&G data will be stratified by special populations to determine if there are health care disparities, and to address these disparities appropriately. The accountability process for dental grievances is similar to the processing of physical and behavioral health grievances, as mentioned above.

- 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):

PacificSource has worked as part of a collaborative effort involving internal and external stakeholders and staff across multiple departments to develop the TQS. The TQS is part of PacificSource's 2018 Strategic Plan; PacificSource's Executive Management Group (EMG) and Medicaid Leadership Team (MLT) will have oversight over the TQS. As such, a charter, annual work plan, and multi-year work plan have been developed and refined through multiple iterations of review and feedback. The CCO's Community Advisory Council (CAC) and Provider Engagement Panel (PEP) provided feedback, and the EMG issued its final approval.

With the merger of the Transformation Plan and the QAPI reporting requirements, PacificSource departmental managers collaborated to form the TQS Steering Committee to guide the work for 2018. This Steering Committee includes representatives from the Medicaid Administrative team and the Clinical Quality team, representing both the Columbia Gorge and Central Oregon CCOs. This Steering Committee met on a biweekly basis to develop a work plan and to set goals, expectations, timelines, and strategies for developing the TQS. The Steering Committee will continue to meet throughout the course of the year to manage projects, collect feedback, and address any concerns with the reporting procedure. Steering Committee members will report regularly to the MLT on project status, resource needs, barriers, and successes. The MLT provides oversight of the Steering Committee, and, in turn, provides regular updates to the EMG.

PacificSource will track TQS projects and programs with support from PacificSource's Medicaid Contract Manager and through the use of auto-generated tasks, sent out to project/program leads 30 days, 15 days, and 2 days prior to reporting deadlines. The Clinical Quality Improvement Coordinator will provide support to any department leads who may be at risk of missing these deadlines. In addition, the Clinical Quality Improvement Coordinator will hold quarterly meetings with the project leads to share any successes, barriers, or updates to the project plan or outcomes.

The Steering Committee met with the staff from the Central Oregon Health Council to present the OHA's new reporting template and guidelines and to request information about community projects that align with the goals of the TQS. The Central Oregon Health Council provided input about community projects to the Steering Committee using the same selection process as mentioned above. PacificSource staff met with the CAC to engage and inform members of this new reporting process. CAC members provided feedback and input on the projects presented. The CAC members will continue to be involved in this work with regular updates provided by PacificSource staff. The PEP and the Central Oregon Health Council Board of Directors also reviewed the TQS projects. Both groups provided their feedback and will be briefed regularly as the TQS is implemented and executed. Representatives from the PEP, CAC, the EMG, and MLT are also a part of the Central Oregon Health Council (the CCO's community governing board). The board has been updated on the development and status of the TQS.

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

The Central Oregon CCO's Regional Health Assessment and Regional Health Improvement Plan (RHIP) use the clinical and community linkages in the region to gather community input and shape the improvement plan. Because of the high degree of community engagement throughout this process, efforts are made to tie elements in the RHIP to PacificSource's strategic plan. PacificSource's overall strategy in its 2018 Strategic Plan provides: *We achieve our vision by collaborating with our provider partners to deliver community-based systems of care and health plan products and services that emphasize our local presence and connections; a personal, high-touch approach in everything we do; member experience; and leading performance for service, quality, cost management and health promotion.*

Elements from the PacificSource strategic plan that are drawn from the RHIP include:

- Develop and implement enterprise-wide strategies to impact social determinants of health.

- Develop and implement breakthrough strategies to significantly improve experience for our existing and future members.
- Enable and leverage health information exchange, electronic medical record access, and clinical data assets in support of Quadruple Aim goals.

The RHIP has identified priority areas, actions, and progress that support the development of PacificSource's transformation and quality initiatives. Some of the priorities identified are:

- Access and availability of oral health services
- Access and availability of behavioral health services
- Adequate income
- Stable and affordable housing
- Food insecurity
- Transportation

- 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:

PacificSource will collaborate with key community partners, including contracted physical, mental, and dental health providers, the Community Advisory Council, the Central Oregon Health Council, and provider engagement groups, in order to advance the TQS. As displayed in more detail in Section ii of this report, above, success of the TQS will hinge on PacificSource's relationship and coordination with key community partners. For instance, PacificSource will engage with provider networks in improving member/patient experience through the use of culturally appropriate and linguistically sensitive communication material and campaigns. PacificSource will look to provider partners to engage on work related to health equity and in addressing social determinants of health as part of the collaborative work with Oregon Health and Science University on the Accountable Health Communities Grant. This work will also engage 211 and local social service agencies. To promote oral health integration within the primary care setting, the CCO collaborates closely with the Central Oregon Health Council's Regional Health Improvement Plan (RHIP) Oral Health work group. This work group is completing a RFP to provide funding to primary care clinics to support further integration of oral health services within primary care settings.

Subcommittees of the Central Oregon Health Council are actively involved in the work of the TQS, RHIP, Quality Incentive Measures, and other CCO deliverables. The Central Oregon Health Council Board and its subcommittees include representation from regional health systems, public health organizations, community mental health programs, early learning hubs, community-based organizations, and multiple clinics. Active engagement from these individuals and organizations is invaluable and creates multiple opportunities for transparency, collaboration, and successful outcomes.

B. Review and approval of TQS

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

The development of the 2018 TQS has been a collaborative effort involving multiple departments within PacificSource and with multiple inputs from community partners. In November, Medicaid department leads met with members of the TQS Steering Committee to share their efforts in transforming care, as well as their quality improvement initiatives that aligned with the TQS reporting requirements. The Steering Committee collected more than 70 quality improvement initiatives or compliance-related activities linked to 2018 work plans and key initiatives. From the original project list, the Steering Committee applied selection criteria to narrow the list down to a total of 20 projects with a clearly defined project lead that were found to be transformational, measurable, and supportive of PacificSource's strategic plan or other major initiatives. Projects included within the previous year's Transformation Plan and QAPI were cross-walked and selected if they met the above criteria and represented ongoing work.

After the initial projects were selected, members from the TQS Steering Committee met with the associated project lead(s) to perform a deep-dive of their proposed project or program. The project leads met with a member of the Steering Committee throughout the development phase, and once a close-to-final draft of each project was completed, the draft was submitted for review and approval by the department's Executive Manager. The Executive Manager reviewed the proposed project for its feasibility, transformational qualities, resource needs, and project scope as compared to the TQS Guidance Document. Once the Executive Manager approved the project selected for inclusion in the TQS, a lead Executive Manager responsible for reporting to the Medicaid Leadership Team reviewed the final reports. The Medicaid Leadership Team will have ongoing oversight of the TQS. The Clinical Quality Improvement Coordinator and Manager have the ultimate responsibility for timely reporting and tracking of the TQS projects.

The Clinical Quality Improvement Coordinator will present updates and findings to the Clinical Quality and Utilization Management Committee, as well as to the internal Quality Improvement Committee. Each committee is made up of provider and leadership staff, both external and internal to PacificSource, which provides for a unique offering of perspectives, areas of expertise, and community involvement.

The Central Oregon Health Council will continue to be involved in this work. PacificSource staff will regularly present on the status of the TQS throughout its lifecycle and as the 2018 TQS nears completion in order to answer questions, solicit feedback, and connect multiple work streams.

Section 2: Transformation and Quality Program Details

A. TQS COMPONENT(S)			
Primary Component:	Severe and persistent mental illness	Secondary Component:	Special health care needs
Additional Components:			
Subcomponents:	HIT: Health information exchange	Additional Subcomponent(s):	
B. NARRATIVE OF THE PROJECT OR PROGRAM			
<p>Identification and Outreach to Special Health Care Needs Members with Severe and Persistent Mental Illness through Primary Care Clinics’ Use of Health Information Technology</p> <p>Individuals with <u>Severe and Persistent Mental Illness</u> (SPMI), a subset of our members with <u>Special Health Care Needs</u> (SHCN), are at risk for significant health disparities. As a foundational strategy to improve health for these members, we seek to identify people with health care utilization patterns that may signal instability in their health conditions and/or inadequate engagement with primary care and specialty behavioral health.</p> <p>We will support our contracted provider clinics in using <u>Health Information Technology</u> (HIT) to identify targeted cohorts of members with SPMI who use emergency department services. Identification of these members will support workflows in integrated primary care settings that can reduce future emergency department utilization and help these members get care in more appropriate settings. Through timely identification of these specific members, providers can begin to outreach and engage them so that they are better able to access the medical and behavioral health services that can reduce harm and improve health outcomes in the right place and at the right time.</p>			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	<p>Problem Statement: Individuals diagnosed with Severe and Persistent Mental Illnesses (SPMI) have well-documented health disparities that contribute to Special Health Care Needs (SHCN).¹</p> <p>Root Cause: National data demonstrate that this population dies on average 20 years earlier than those without an SPMI diagnosis. The causes of these premature deaths are not primarily due to complications of primary psychiatric diagnoses; rather, early mortality is driven by co-morbid chronic medical conditions. This population is also disproportionately affected by social determinants of health; for example, members are more likely to live in social conditions such as inadequate housing that places them at risk of developing functional disabilities. As a result of these medical and social burdens, people with an SPMI diagnosis frequently seek care for chronic medical conditions in the ED.</p> <ul style="list-style-type: none"> • The SPMI population utilizes the emergency department at a rate 2.7 times higher than other CCO members without an SPMI diagnosis. • The SPMI population represents approximately 21% of CCO membership 19 years of age and older, but accounts for nearly half (46%) of emergency department utilization. <p>Furthermore, less than half of the members with SPMI who visit the emergency department are concurrently engaged in behavioral health services. Currently, providers are not able to efficiently track the utilization of this special needs population, and, as a result, efforts to outreach and engage the population are challenging and resource intensive. The use of HIT to</p>		

¹ Miller, B. J., Paschall III, C. B., & Svendsen, D. P. (2008). Mortality and medical comorbidity among patients with serious mental illness. *Focus*, 6(2), 239-245.

	<p>simplify the identification of this population when they visit the emergency department closes the existing communication gap and will allow primary care providers to reach them in a timely and efficient manner.</p> <p>Desired Outcomes: Through the use of newly available HIT, we can support the providers in our community to efficiently identify members to target for outreach and engagement. As a result of this process, providers will be able to connect members with more appropriate and timely health care. Access to timely medical and behavioral health services will support improved health and health care utilization patterns in this population, including a reduction in avoidable use of the emergency department by this subset of the SHCN population.</p>
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D. PERFORMANCE IMPROVEMENT

<p>Activity: Utilize HIT to facilitate timely identification of members with an SPMI diagnosis, a subset of members with Special Health Care Needs, who have recently had an emergency department visit in order to connect the SPMI population to non-emergency medical and behavioral health services.</p>	<p><input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity</p>
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How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Quarterly tracking and report out of HIT utilization by primary care clinics to identify members with an SPMI diagnosis who have recently visited the emergency department.	0% of members are assigned to clinics that utilize HIT to identify members with an SPMI diagnosis who have recently visited the emergency department.	25% of members are assigned to clinics that utilize HIT to identify members with an SPMI diagnosis who have recently visited the emergency department.	12/2018	50% of members are assigned to clinics that utilize HIT to identify members with an SPMI diagnosis who have recently visited the emergency department.	12/2019

A. TQS COMPONENT(S)			
Primary Component:	Patient-centered primary care home	Secondary Component:	Integration of care (physical, behavioral and oral health)
Additional Components:	Value-based payment model		
Subcomponents:	Access: Availability of services	Additional Subcomponent(s):	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Patient Centered Primary Care Home Enhancement Focusing on High-Value Elements, Behavioral Health Integration, and Sustainable, Aligned Payment

PacificSource is dedicated to assisting our network of primary care providers in delivering increasingly robust medical home services as recognized by Patient Centered Primary Care Home (PCPCH) status as well as other process and outcome measures. Challenges with attaining top-tier recognition are well documented. These challenges are also reflected in the recent study *Implementation of Oregon’s PCPCH Program*.² In the study, one of the key findings of systems issues notes that “*Payment models and other financial arrangements do not currently incentivize clinics to operate in alignment with the PCPCH program aims. Clinic leaders struggle to financially support the changes necessary for top-tier recognition.*”

PacificSource’s current primary care agreements include support and funding for PCPCH. As part of this additional grant-funded project, PacificSource will design and implement financial and operational supports for clinics to maintain or improve PCPCH tier status. As priority areas within this work, PacificSource will refine a Value-Based Payment (VBP) Model to incentivize use of the PCPCH elements that have been found to deliver the most value, and PacificSource will focus on supporting and incentivizing clinics to establish integrated behavioral health (BH) programs with fidelity to statewide standards. Participants in this grant are incentivized to achieve higher levels of PCPCH tiers, fidelity BH integration, and availability of services. Annual payments will only be made when these clinics meet specific value-added targets.

Integrating BH in primary care is a lead strategy for the CCO to improve multiple aspects of CCO performance, including increasing integration of physical and behavioral health services, controlling costs, improving physical health outcomes, supporting provider well-being, and increasing patient-centeredness by providing behavioral health services in a venue that is preferred by many patients.

Access and availability to services is identified as a priority area by the Central Oregon Regional Health Assessment. Increasing the availability of BH services in primary care clinics is a priority strategy for the CCO to increase member choice among behavioral health providers and sites of service.

Project Plan:

The purpose of this project is two-fold. Using VBP, PacificSource will: 1) support clinics that wish to maintain or achieve a higher PCPCH tier status; 2) increase access to fidelity integrated BH services in primary care.

This project recognizes that the up-front cost in obtaining a higher tiered certification may be difficult to support. As of this writing, only one clinic in Central Oregon had obtained Tier 5 status. This project provides incentives for clinics to maintain or improve their PCPCH status.

Through this funding process, PacificSource will apply a new patient modifier to incentivize providers to accept auto assignment and new patients. Opening up additional providers to accepting new patients will increase access for additional members, providing greater choice, more timely access, and care that is located as close as possible to where

² <http://www.oregon.gov/OHA/HPA/CSI-PCPCH/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf>

the member resides. Increasing the access to services delivered by a clinic recognized as a PCPCH will provide patient-centered, high-quality care to members with diverse health and social needs.

In addition, the effective integration of BH services into primary care is a key component of best-practice primary care homes. This project will specifically identify those clinics that meet a fidelity level of BH integration based on the Integrated Behavioral Health Alliance of Oregon (IBHAO) minimum standards. The PCPCH program incorporates most of these IBHAO standards in the PCPCH 3.C.2 and 3.C.3 standards specifically. However, it is possible to become a Tier 5 PCPCH without meeting those standards. Therefore, full funding in this project will only be awarded if both of those PCPCH BH integration standards are met regardless of tier attestation level and whether the clinic meets additional IBHAO standards.

C. QUALITY ASSESSMENT

Evaluation Analysis:	<p>Root Cause: While PacificSource’s current primary care agreements include PCPCH requirements, clinics may lack additional reimbursement to sustain elevated PCPCH tier status and fidelity BH integration.</p> <p>As of December 2017, 75% of the CCO population was enrolled in a PCPCH, and the majority were enrolled in a Tier 4 medical home. Mosaic Medical, a Tier 4 FQHC, has the largest enrollment numbers of any PCP group, accounting for 30.5% of the CCO population.</p> <p>At the start of this project proposal, one clinic in Central Oregon had obtained Tier 5 status. Approximately 13 clinics are at Tier 4, and the remaining 11 of the participating clinics are at Tier 3.</p> <p>According to Central Oregon’s Regional Health Assessment, there are shortages of private mental health professionals in Central Oregon, and individuals with depression average twice as many visits to their PCP than do non-depressed patients. Increasing access to behavioral health services within the primary care setting will support the needs of patients with BH conditions within a setting preferred by many patients, while supporting provider well-being and controlling costs. The grant funds provided will allow for the enhancement of infrastructure and models of care. Participating clinics will be held accountable through specific, measurable deliverables detailed below.</p>
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D. PERFORMANCE IMPROVEMENT

<p>Activity: PacificSource will provide funds using a value-based payment strategy and technical assistance to clinics to achieve a higher PCPCH tier.</p>	<p><input type="checkbox"/> Short-Term Activity <u>or</u></p> <p><input checked="" type="checkbox"/> Long-Term Activity</p>
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How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
PacificSource will monitor and report changes in PCPCH tier certification among clinics in Central Oregon with assigned lives on a monthly basis.	1 clinic at Tier 5 certification.	2 clinics at Tier 5 certification.	12/2018	3 clinics at Tier 5 certification.	12/2019
PCPCH providers participating in the grant are eligible for additional funding if	0 regular monitoring processes in place to check the status of PCPCH provider’s	Develop and adopt policy and procedure for regular monitoring	12/2018	Process fully in place for regular monitoring of PCPCH provider	12/2019

>50% of providers are accepting new patients and open to auto-assignment.	status for accepting new patients and those who are open to auto-assignment.	of PCPCH provider status to promote access and availability of services.		status to promote access and availability of services.	
Activity: PacificSource will provide funding using a value-based payment strategy and technical assistance to clinics to achieve fidelity BH integration.				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Site Reviews by CCO SME consultant.	0 site reviews completed. 13 clinics self-attested to meeting IBHAO and 3.C.3 and 3.C.2 standards.	Site reviews of the 13 clinics confirm that at least 50% have met the standards.	12/2018	Site reviews of the 13 clinics confirm that at least 67% meet standards.	12/2019
Quarterly metric reporting for BH Integration: Penetration metric.	<5% penetration rate.	5% or greater penetration rate.	12/2018	10% or greater penetration rate.	12/2019

A. TQS COMPONENT(S)			
Primary Component:	Access	Secondary Component:	Utilization review
Additional Components:			
Subcomponents:	Access: Second opinions	Additional Subcomponent(s):	
B. NARRATIVE OF THE PROJECT OR PROGRAM			
<p>Utilization Review Overview: The <u>Utilization Management (UM)</u> Program is a component of the PacificSource Health Services Department. The UM Program is intended to assure that members receive the appropriate services, within regulatory guidelines, to attain and maintain their optimal health and wellness.</p> <p>UM functions include referral management, prior authorization and review of inpatient stays for members in facility care, retrospective review of claims or services delivered, and discharge planning.</p> <p>Data Findings, Collection, Analysis, and Reporting:</p> <p>In order to maintain state-mandated timelines, several processes are in place for monitoring and ensuring compliance. This includes delegate requests entered through our software system.</p> <p>Daily UM workflows are in place to avoid untimely decision-making, which include:</p> <ul style="list-style-type: none"> • Monitoring work queues • Daily UM team huddles to review volumes and timelines and address concerns/issues • Software enhancements to allow for easy identification of expedited and due dates of requested services. <p>Quarterly Notice of Adverse Benefit Determinations (NOABDs) are reported to the State which include those decisions not made within the State-mandated timelines. This includes data from delegates.</p> <p>Root-cause analysis is performed at a minimum on a monthly basis related to untimely decisions, if any. Re-education to staff is completed as applicable.</p> <p>Auditing of decision-making, consistent application of criteria, and work processes is regularly performed. UM staff: quarterly; delegates: annually.</p> <p>Data including volumes, timelines, and percentage of types of decisions (approvals, denials, and partials), reversals and overturns is collected and analyzed each month. Re-education to staff is completed as applicable.</p> <p>As part of the UM team’s referral management function, a mechanism has been developed to track a member’s referral to <u>Second Opinions</u> for physical and behavioral health needs. The referral rate for Second Opinions is unknown at this point in time, and PacificSource would like improved insight into how members are accessing this benefit.</p> <p>In year one of this project, the goal is to determine a baseline rate for the utilization of Second Opinions. Based on the trends from year one, strategies will be developed that represent an appropriate response to the baseline.</p> <p>Second Opinions:</p> <p>PacificSource Community Solutions covers Second Opinions. This information is captured in member and provider handbooks as well as the Member Access—Specialist Medicaid Policy, referenced below.</p> <p>As discussed above, PacificSource would like improved insight for monitoring Second Opinions for physical, behavioral, or dental health services. Work is underway to add software functionality and reporting enhancements to capture Second Opinions for physical and behavioral health services. When submitting preapproval and referral requests online, providers will be required (mandatory field) to select a “Yes” or “No” radio button if they are for Second Opinions. Similarly, within the UM team’s referral and preapproval software, there will be a mandatory field the UM</p>			

staff will select if the requested service is for a Second Opinion. These changes currently apply to all physical and behavioral health requests for a Second Opinion.

In regard to reporting, Second Opinions will be added to a current report (SSRS/HPXR) so they can be tracked at any given point in time.

Because PacificSource delegates service decision-making to Dental Care Organizations (DCOs), PacificSource does not have an internal systems mechanism to view Second Opinion requests. PacificSource works with each DCO to ensure entities have policies and mechanisms in place to assure members have full access to Second Opinions, to monitor Second Opinion requests, and to ensure timely access to Second Opinions. PacificSource has begun working with DCOs to receive copies of each DCO's Second Opinion monitoring and tracking documents so PacificSource can have a full view of the Second Opinions systems to ensure members' needs are being met.

Second Opinion language:

Medicaid Policy Member Access - Specialist Medicaid:

All PacificSource Community Solution Members have access to contracted specialist(s) for **second** opinions. A **second** opinion is another specialist(s) opinion about treatment for a medical condition diagnosed by the primary specialist. PCP's must submit a referral request to another specialist for a **second** opinion.

Services, including **second** opinions, requested for an out-of-network provider or an out-of-state provider will require a preapproval and will be reviewed for medical necessity and in-network availability.

Provider Handbook:

- PacificSource Community Solutions covers **second** opinions. If a member wants a **second opinion** about their treatment options, they will consult with their PCP about a referral for another opinion. Their PCP will need to contact PacificSource Community Solutions to get approval of the referral (preapproval). If a member wants to see a noncontracted provider; the member or their PCP will need to get PacificSource Community Solutions approval first.
- The PCP may delegate care coordination to another provider if both the member and the other provider agree. This will be clearly documented in the PCP's clinical record. **Second opinions** for dental services are covered. Dental providers should coordinate with their dental care organization to arrange **second opinion** visits.

5.4 Out-of-Network Referrals

Requests to see an out-of-network provider, including for **second opinions**, must be submitted via the preapproval process and are not considered a referral. For referrals to a noncontracted provider, PacificSource Community Solutions must approve the service in advance. If the service is not approved, the plan will not pay for it. There are a few exceptions in which a member can see a noncontracted provider without getting an approval in advance. These are:

- Ambulance and Emergency Room Services (for emergencies);
- Family Planning; and
- Some Immunizations (shots).

Member handbook:

Second Opinions

If you want a **second opinion**, ask your PCP to refer you to another provider. **Second opinions** require a pre-approval from us. We cover one second opinion.

Physical Health Only

Second Opinions

We cover **second opinions**. If you want a second opinion, ask your PCD to refer you to another provider. You will need to get approval if you want to see someone outside of your dental plan's network.

Oral Health Only

C. QUALITY ASSESSMENT

Evaluation Analysis:

Root cause analysis: PacificSource is implementing automated reporting processes to track use of Second Opinions. This was identified as an opportunity in the 2017 QAPI Annual Evaluation. Through enhancing the current software utilized by both our providers when they enter online requests and our UM staff, we will have objective data to track the Second Opinions received by the CCO. PacificSource will be able to use this data to determine if Second Opinions are being requested and allow for a baseline to compare against in future years.

Monitoring and tracking of Second Opinions is a key function of the UM team. The processes discussed above will enable UM to better detect underutilization and overutilization of this benefit for medical and behavioral health services, with additional oversight in place to monitor access to dental referrals.

D. PERFORMANCE IMPROVEMENT

Activity: Work is underway to add software functionality and reporting enhancements to capture Second Opinions. When submitting preapproval and referral requests online, providers will be required (mandatory field) to select a "Yes" or "No" radio button if they are for second opinions. Similarly, within the UM team's referral and preapproval software, there will be a mandatory field the UM staff will select if the requested service is for a Second Opinion.

- Short-Term Activity or
- Long-Term Activity

With respect to reporting, Second Opinions will be added to a current report (SSRS/HPXR) so they can be tracked at any given point in time.					
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Determine baseline rate for utilization of second opinion.	Will establish a baseline in year one. 0 data points currently collected for a baseline.	Baseline determined based on year one monitoring results.	12/2018	Develop a strategy to increase utilization of second opinions, if indicated.	12/2019
Collaborate with DCOs to receive second opinion monitoring and tracking reports that demonstrate each DCO's full compliance with second opinion requirements and to see the extent to which members are requesting/receiving dental-specific second opinions.	0 second opinion monitoring and tracking reports regularly received from DCOs.	PacificSource receives second opinion monitoring and tracking reports from DCOs, on a quarterly basis.	12/2018	PacificSource receives second opinion monitoring and tracking reports from DCOs, on a quarterly basis.	12/2018

A. TQS COMPONENT(S)			
Primary Component:	Grievances and appeals	Secondary Component:	Access
Additional Components:			
Subcomponents:	Access: Timely access	Additional Subcomponent(s):	
B. NARRATIVE OF THE PROJECT OR PROGRAM			
Analyzing Appeals and Grievances Data to Support Timely Access to Care			
<p>The PacificSource <u>Appeals and Grievances</u> (A&G) Department ensures that CCO members have an avenue to request an appeal and/or grievance resolution. Pertinent information is gathered, reviewed, and completed in a confidential manner in accordance with applicable rules and regulations. A resolution is issued to the member or authorized representative by written notice. Reports are provided to the PacificSource Clinical Quality and Utilization Management Committee (CQUM) and to the OHA on a quarterly basis.</p> <p>PacificSource has developed a data solution to review and analyze claims on a monthly basis to identify trends in the types of A&G that have been received from members. PacificSource will develop a baseline measurement to track the number of A&G related to <u>Timely Access to Care</u>, as well as other access-related concerns. The data are reviewed for all provider types, including physical, behavioral, and dental. The A&G Department will then analyze the data and present identified trends or opportunities for improvement to the CQUM Committee. The CQUM Committee will develop strategies to address any identified trends or opportunities for improvement and track changes in data related to the number of A&G associated with access to care.</p> <p>The overarching goal of this project is to identify areas of opportunity for improving services, thereby reducing the number of grievances or areas of dissatisfaction among the CCO’s members. By analyzing appeal and grievance data to specifically look at timely access to care, PacificSource hopes to develop more strategic initiatives aimed at improving Timely Access to Care, increasing member access, understanding members’ specific barriers to care (language, location, hours, transportation, etc.), and collaborating internally with Provider Services, Case Management, and Customer Service Departments to increase knowledge of member needs and disparities in accessing care.</p>			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	<p>The CCO receives an average of 163 appeals and 176 grievances per quarter. The procedures that PacificSource has in place are fully compliant with state and federal rules and regulations, ensuring adequate resolution to each individual complaint. While these resolutions often address barriers to access at the clinic level, they may not provide insight into issues linked to a root cause. PacificSource currently provides a cumulative report on A&G to the CQUM Committee and to the OHA. PacificSource will develop a more sophisticated report that allows for internal identification of trends in member complaints. This report will be assessed and an internal team will utilize the data to develop solutions to address any trends that are identified.</p> <p>The following is an example of the type of grievances PacificSource has received related to access that demonstrates the need for more rigorous analysis:</p> <p>A&G received a grievance from a member who was dissatisfied that she had to wait 3 months for an appointment and then the appointment only took 5 minutes. A&G staff inquired with the provider regarding contacts with the member and by requesting medical records. From this inquiry, A&G staff identified the root cause of the appointment scheduling issue, which was related to the PCP’s delay in providing a referral to a specialist. Less than a week passed between the time the referral was received and when the appointment was scheduled. A&G staff provided written notification to the member and additional rights were afforded to this member. (Please note that this grievance will be part of aggregate data reported in March 2018 to the OHA as part of the Q4 review.)</p> <p>Strengths:</p>		

	<ul style="list-style-type: none"> • PacificSource adheres to the Oregon Administrative Rules regarding A&G. • PacificSource ensures that all A&G are addressed in a timely manner. • PacificSource also ensures that all A&G are addressed in a culturally and linguistically appropriate manner. • PacificSource collaborates with the OHA to conduct member hearings as applicable. • The A&G Department collects and reports data on A&G on a quarterly basis. • The A&G staff members at PacificSource provide high-touch customer service to members to ensure the best possible outcomes. • PacificSource identified the need to look at A&G data to identify opportunities to develop strategies that would improve member experience at the systems' level. <p>Challenges/Areas for Improvement:</p> <ul style="list-style-type: none"> • While PacificSource is compiling data for quarterly reports to the OHA and reviewing that data internally at the CQUM Committee, PacificSource has never established a baseline for the number of A&G received related to timely access. Without a baseline, it is difficult to measure overall improvement. • PacificSource has been very successful in researching individual member A&G to determine causal factors and develop strategies to address identified issues. However, PacificSource has not had a mechanism in place to track strategies and monitor improvements in service delivery based on aggregated A&G data. A&G data will be reviewed and analyzed in aggregate to develop strategies that are more systemic in nature. • The OHA is currently making changes to the Mid-Year Report Template. Due to these changes, the A&G Department may need to adjust current data collection and reporting methods. <p>Desired Outcome: By looking at complaints in a quantifiable way, PacificSource will be able to determine what types of issues related to access to care are occurring and develop strategies to address these issues by using specific or systemic action, as necessary.</p>
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D. PERFORMANCE IMPROVEMENT

Activity: Develop Complaint Analysis Report to identify trends in member A&G. Develop process to address issues identified as trends.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Monitor trends in member grievance data related to timely access.	0 baseline exists for # of grievances related to timely access.	1 baseline exists for # of grievances related to timely access.	09/2018	1 baseline exists for # of grievances related to timely access. Number of grievances and appeals related to access to care is tracked over time.	12/2018
Develop and track at least one new strategy to address service-related grievances	0 strategies related to trends have been developed and tracked.	At least 1 strategy developed and tracked.	12/2018	At least 1 strategy developed and tracked.	12/2018

impacting access based on identified trends.					
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A. TQS COMPONENT(S)			
Primary Component:	Special health care needs	Secondary Component:	Value-based payment models
Additional Components:	Integration of Care (physical, behavioral, and oral health)		
Subcomponents:	HIT: Analytics	Additional Subcomponent(s):	
B. NARRATIVE OF THE PROJECT OR PROGRAM			
<p>Oral Health Care for Adults with Diabetes Project—Increasing Preventive Dental Visits for Adults with Diabetes</p> <p>The exacerbating relationship between co-occurring chronic diseases (such as diabetes) and poor oral health is well-documented. Poorly managed chronic diseases result in debilitating costs for members and extraordinary costs to the health care system. Optimal management of chronic diseases includes preventing or correcting oral diseases. Given that traditionally the dental team must first establish care with members in order to learn of their health status and coordinate care plans, members with chronic disease often go without specific and informed attention to their oral health. Further, the dental team is dependent on the member’s truthful disclosure of their <u>Special Health Care Needs</u>. Physical health providers may inconsistently integrate the oral health component in overall chronic disease management. When they do, they may not have the information necessary to connect with the member’s dental providers or have a view into oral health visit history.</p> <p>Unfortunately, for a variety of reasons, members with chronic disease may not get established with a dental team or may not disclose they have chronic disease; as a result, they may not receive the care they need. Dental service utilization rates for adults with chronic diseases, such as diabetes, is low. Proactive mechanisms, independent of whether the member has established care with the dentist, are needed to ensure dental care teams are equipped to outreach to members to deliver care and to assure physical health providers can access the information they need to more easily integrate the oral health component. PacificSource will deploy the following system-improvement strategies to target adult members diagnosed with diabetes:</p> <ul style="list-style-type: none"> • PacificSource will leverage <u>Health Information Technology (HIT) and Analytics</u> capabilities by extending the Member Insight Report to DCOs to facilitate an understanding of which assigned members have diabetes. In addition, PacificSource will create an analytics tool that provides the date of the member’s last dental visit. Doing so will better enable physical health providers in their <u>Integration of Care (physical, behavioral, and oral health)</u> efforts. Delivering the Member Insight Report to both provider types and communicating dental visit information to physical health providers facilitates inter-professional collaboration and whole-person care coordination tailored to specific health care needs. • PacificSource will leverage <u>Value-Based Payment</u> strategies to incentivize dental providers to prioritize the provision of diagnostic dental services to diabetic patients. Specifically, PacificSource will implement a performance payment withhold tied to rates of diabetic members receiving certain diagnostic dental services. • PacificSource will deploy analytics capabilities to build a visual performance management dashboard that displays baseline rates, YTD and rolling rates, and individualized improvement targets toward the desired benchmark. Analytics tools will be shared with DCOs on a monthly basis to track ongoing performance. 			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	<p>A 2017 OHA report highlighted CCO performance (as of mid-2016) with dental utilization rates for members with diabetes as very low, with a state average of 24.1%. Results revealed that only 18.6% of diabetic members had received dental care. Causal factors likely influencing this trend include:</p> <ul style="list-style-type: none"> • A potential lack of awareness by DCOs about which of their assigned members have diabetes. 		

	<ul style="list-style-type: none"> Information about diabetic member’s previous/recent dental visits is not readily available to physical health providers. Undeveloped analytics to understand and track trends and performance. No determination and/or shared understanding of regional goals concerning dental utilization specific to this population. Lack of contractual agreements and value-based payment strategies to support meaningful action. <p>PacificSource took a variety of immediate actions, including creating dental contracting priorities that included dental care for members with diabetes, building analytic tools, and working with DCOs to develop a dental utilization measure specific to members with diabetes. Because no national standard or benchmark existed for the optimal rate of diabetic members who receive dental care, PacificSource worked with DCOs to determine a desirable benchmark. PacificSource also assessed whether the Member Insight Report could serve as the notification vehicle regarding members diagnosed with diabetes. The Member Insight Report communicates risk status, chronic disease information, and other types of critical health data to inform and enable providers to prioritize outreach/care delivery and to coordinate/collaborate with other providers caring for that member.</p> <p>This particular report was introduced to DCOs beginning in late 2016. In early 2017, PacificSource worked with DCOs to address technical issues and data interpretation questions. The Member Insight Report leverages Truven analytics to provide an array of member data elements that are useful for care coordination and inter-professional collaboration—a critical aid for this very endeavor. As of January 1, 2018, contracts were executed with every DCO that include value-based payment strategies to encourage the increased provision of dental services to diabetic members. Building from the advancements with the Member Insight Report, PacificSource will create an analytics tool or report for physical health providers that includes dental visit information to better facilitate integration of oral health components into the physical health provider’s diabetes care management and to enable inter-professional collaboration for members with Special Health Care Needs.</p> <p>Desired outcome/objective: 50% or more of adults with diabetes receive at least one comprehensive, periodic, or periodontal oral evaluation service each year. This outcome measure was determined in collaboration with the DCOs as a suitable benchmark. Each DCO will also have individualized improvement targets based on their current performance.</p>
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D. PERFORMANCE IMPROVEMENT

<p>Activity: Develop an analytics tool or report that displays dental visit information to better facilitate integration of oral health components into the physical health provider’s diabetes care management and enable inter-professional collaboration for special health care needs.</p>				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
An analytics tool or report is developed to include the following:	0 dental visits (over last 12 months) are tracked or displayed on a report shared with physical health providers.	Dental visits (over last 12 months) are tracked or displayed on a report shared with physical health providers.	12/2018	Dental visits (over last 12 months) are tracked or displayed on a report shared with physical health providers.	12/2018

<ul style="list-style-type: none"> • # of Dental visits in last 12 months • # of Dental visits in last 6 months • Date of last dental visit • Dental Provider Name • Dental Provider Group Name 	<p>0 dental visits (over last 6 months) are tracked or displayed on a report shared with physical health providers.</p> <p>0 dental provider and provider group names are shared with physical health providers.</p>	<p>Dental visits (over last 6 months) are tracked or displayed on a report shared with physical health providers.</p> <p>Dental provider and provider group names are shared with physical health providers.</p>		<p>Dental visits (over last 6 months) are tracked or displayed on a report shared with physical health providers.</p> <p>Dental provider and provider group names are shared with physical health providers.</p>	
<p>Activity: Leverage value-based payment strategies to incentivize delivery of dental care to members with diabetes.</p>				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
<p>Apply and maintain a performance withhold to 2018 DCO capitation payments, tied to performance with provision of dental services to diabetic members. Administer these contract provisions throughout 2018.</p>	<p>Prior to 1/2018, 0 of 4 dental contracts include payment mechanisms to drive performance with dental visits for diabetic members.</p>	<p>A performance withhold, tied to dental visit(s) with diabetes members, is initiated and maintained throughout 2018 for 4 of 4 DCOs.</p>	<p>12/2018</p>	<p>A performance withhold, tied to dental visit(s) with diabetes members, is initiated and maintained throughout 2018 for 4 of 4 DCOs.</p>	<p>12/2018</p>
<p>By end of claims paid period of 1/1/18 – 12/31/18, improve rates of delivery of D0120, D0150, or D0180 to members with diabetes to either the CCO benchmark of 50% or to each of the DCO’s regional improvement targets (as adjusted for future performance).</p>	<p>Central Oregon <i>Regional Baseline:</i> 25.3% Advantage Baseline: 23.9% Capitol Baseline: 24.2% ODS Baseline: 37.3% Willamette Baseline: 26.0%</p>	<p>CCO benchmark of 50% or the below improvement targets: Central Oregon <i>Regional Improvement Target: 28.3%</i> Advantage Improvement target: 26.9% Capitol Improvement Target: 27.2%</p>	<p>12/2018</p>	<p>CCO benchmark of 50% or future adjusted improvement targets are achieved across both CCO regions and by at least 3 of 4 DCOs, individually.</p>	<p>12/2020</p>

		<p>ODS Improvement Target: 40.3%</p> <p>Willamette Improvement Target: 29.0%</p>			
<p>Activity: Deploy HIT analytics capabilities to build a visual performance management dashboard that displays baseline rates, YTD and rolling rates, and individualized improvement targets towards the desired benchmark. Analytics tools will be shared with DCOs monthly to track ongoing performance.</p>				<input checked="" type="checkbox"/> Short-Term Activity or <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
<p>Full production of an analytics dashboard capable of a monthly refresh to display the following data for each DCO, by region:</p> <ul style="list-style-type: none"> • YTD and 12 month rolling dental visit rates for specific codes of interest within the defined diabetic population. • CCO benchmark. • DCO-specific improvement targets. • # needed to meet target or benchmark. 	<p>0 analytics dashboards include dental visit rates for members with diabetes.</p> <p>Build of analytics tools to support measure specifications and performance tracking began mid-2017. Prototypes were introduced throughout Q4 of 2017. Peer review and production of analytics tools will continue through Q1 2018.</p>	<p>Analytics dashboards include dental visit rates for members with diabetes.</p> <p>Full production of dashboard.</p>	05/2018	Analytics dashboards include dental visit rates for members with diabetes.	05/2018

A. TQS COMPONENT(S)																												
Primary Component:	Access	Secondary Component:	Health information technology																									
Additional Components:																												
Subcomponents:	Access: Availability of services	Additional Subcomponent(s):	Access: Quality and appropriateness of care furnished to all members; HIT: Patient Engagement																									
B. NARRATIVE OF THE PROJECT OR PROGRAM																												
Enhancing Access to Care with Technical Assistance and Provider-Directed Education																												
<p>PacificSource is committed to using innovative strategies to ensure that members have access to high-quality care when they need it. We believe that high performance on both <u>Access: Availability of Services</u> and <u>Access: Quality and Appropriateness of Care</u> are crucial elements in meeting our overall goals as a CCO. In 2018, staff from the PacificSource Provider Network Department will work with providers specifically to address access issues related to the availability of services and quality and appropriateness of care provided to all members. In addition, we seek to leverage the use of mobile technology to promote <u>Health Information Technology (HIT): Patient Engagement</u> as a way to augment provider-directed strategies.</p> <p>Patients who have access to health care that’s appropriate for their needs and preferences have better health outcomes and higher satisfaction, as compared to patients who do not have that same access to care. PacificSource has in place several policies to ensure that members are able to get care when needed. To ensure adherence to these policies, PacificSource monitors network adequacy and provider compliance with access standards. However, current processes may not allow for optimal education and outreach to provider partners.</p> <p>PacificSource has Provider Service Representatives who are dedicated liaisons between the health plan and provider partners. The role of the Provider Service Representative is to develop relationships with providers that allow for open communication. The Provider Service Representative is available to assist the provider with navigating referral and billing systems while also offering education and training in regard to standards of care.</p> <p>Access to care has been identified as a concern among CCO members in the 2017 CAHPS survey. PacificSource will develop a procedure to utilize survey data to provide targeted technical assistance that more accurately addresses stress points in the system. In addition to this focused approach, PacificSource will create an Access to Care Team with the purpose of addressing access concerns for members more systemically. This committee will be comprised of team leads from numerous internal departments. The Access to Care Team will create member and provider facing material and education tools designed specifically to address identified issues. Provider Service Representatives will utilize these materials during site visits to reinforce messaging.</p> <p>In addition to our work with providers, engaging members will clearly augment our efforts to improve their health care experience and access to care. As part of this project, PacificSource will optimize and redeploy a mobile app, InTouch, that provides members with information and tools to know how and where to seek care when needed.</p>																												
C. QUALITY ASSESSMENT																												
Evaluation Analysis:	<p>Problem Statement: Access to care was identified as a concern among CCO members in the 2017 CAHPS survey. The below data represent our performance over the past three years’ surveys, as compared to the 2017 statewide OHP performance. The 2018 survey results, assessing care provided in 2017, are not available yet.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Central Oregon - Adult</th> <th style="width: 10%;">2015</th> <th style="width: 10%;">2016</th> <th style="width: 10%;">2017</th> <th style="width: 10%;">2017 OHP</th> </tr> </thead> <tbody> <tr> <td>Getting Needed Care</td> <td>79%</td> <td>69%</td> <td>80%</td> <td>79%</td> </tr> <tr> <td>Getting Care Quickly</td> <td>73%</td> <td>74%</td> <td>77%</td> <td>80%</td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Central Oregon - Child</th> <th style="width: 10%;">2015</th> <th style="width: 10%;">2016</th> <th style="width: 10%;">2017</th> <th style="width: 10%;">2017 OHP</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>			Central Oregon - Adult	2015	2016	2017	2017 OHP	Getting Needed Care	79%	69%	80%	79%	Getting Care Quickly	73%	74%	77%	80%	Central Oregon - Child	2015	2016	2017	2017 OHP					
Central Oregon - Adult	2015	2016	2017	2017 OHP																								
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Central Oregon - Child	2015	2016	2017	2017 OHP																								

Getting Needed Care	87%	79%	77%	84%
Getting Care Quickly	85%	84%	84%	89%
Access to Specialized Services	61%	69%	70%	73%

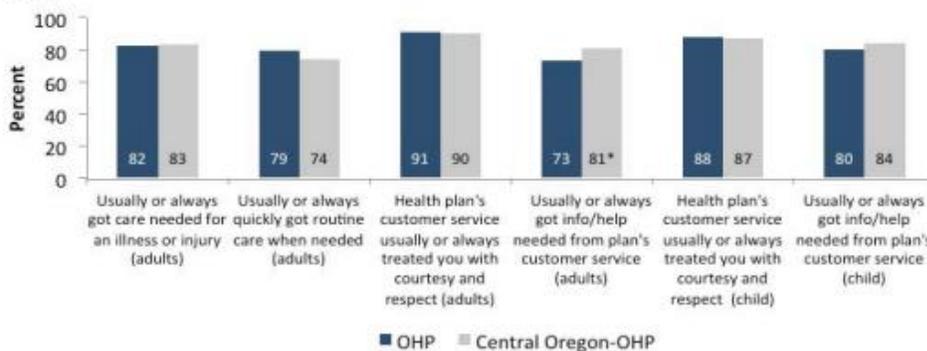
Further, access was identified as a concern in the Central Oregon Regional Health Assessment.

Central Oregon Community Health Assessment:

According to the CAHPS Survey in 2013, OHP members in Central Oregon reported they usually got care in a timely fashion. They also reported receiving support when needed from customer service (Figure 80). Most of these rates were no different than the state overall.

There were no significant differences by Hispanic ethnicity (data not shown).

Figure 80. Quality Measures for Oregon and Central Oregon OHP members, CAHPS Survey, 2013



In 2015, several systemic changes required that Provider Service Representatives spend a significant portion of their time working internally. Prioritizing this internal work meant that Provider Service Representatives were not available to conduct as many site visits. These activities may have diluted internal mechanisms to evaluate, monitor, and follow-up with noncompliant providers.

Strengths:

- Provider capacity reports are run on a regular basis to ensure that we have an adequate number of providers in our network to support the health care needs of members.
- PacificSource regularly administers an Access to Care Survey to a random sample of contracted providers.
- Provider Service Representatives periodically monitor the auto-assignment process and the number of providers who are open to new patients.
- Provider Service Representatives verify that providers who are open to new patients are actively accepting new patients.
- Customer Service Representatives and Member Support Specialists at PacificSource assist members with finding providers who meet their unique health care needs.
- PacificSource has participated in extensive training in health literacy, health equity, and culturally and linguistically appropriate services.
- PacificSource has updated several member-facing materials and the PacificSource Community Solutions website to improve readability and functionality for improved member engagement.

Challenges:

	<ul style="list-style-type: none"> Over the past year, Provider Service Representatives have routinely reviewed data from the provider Access to Care Survey. Throughout the year, the Department has recognized opportunities for improvement in provider education and development based on the survey data. Due to limited resources the Provider Services Department has not had the capacity to deliver the types of outreach necessary to meet identified needs. As the Provider Services Department has identified opportunities for enhanced education and outreach, the need for new provider education materials has also been identified. Multiple data sources track indicators related to Access to Care including CAHPS, the Regional Health Assessment, appeals and grievance data, and access to care surveys. No single department within PacificSource reviews all of these data sources. A cross-departmental committee is needed to analyze these data sources and develop strategies to improve access in a more systemic fashion. PacificSource has had a mobile app available to members for several years. However, the application has had limited functionality and minimal use by Medicaid members. <p>PacificSource plans to address these challenges by improving outreach to providers in our network with targeted technical assistance, enhancing internal capacity to review and act on data related to access and quality of care, and empowering members by enhancing the mobile app to ensure that members have the information they need right at their fingertips.</p>
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D. PERFORMANCE IMPROVEMENT

Activity: Enhance internal workflows to support improved site visits and allow for follow-up on identified access to care issues.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Develop a procedure to utilize data from the Access Survey to focus technical assistance resources on those clinics that need improvement.	0 procedures use access survey data for targeted technical assistance.	1 procedure developed.	09/2018	1 procedure developed and implemented.	12/2018
Increase the number of provider site visits conducted.	An average of 4 site visits per month were conducted in 2017.	Increase provider site visits by 25%.	09/2018	Increase provider site visits by 50%.	12/2018
Develop and deploy provider education materials for use during site visits regarding access standards.	0 documents related to access standards exist for use during site visits.	1 document related to access standards exists for use during site visits.	12/2018	1 document related to access standards exists for use during site visits.	12/2018
Charter an Access to Care Team.	0 Access to Care Teams established.	1 Access to Care Team established.	09/2018	1 Access to Care Team is meeting regularly.	12/2018

Activity: Add functionality to the PacificSource mobile app to better meet the needs of members				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Enhance Medicaid mobile app functionality to improve patient engagement.	Current functionality includes "Mobile ID card," "Find a Doctor," and "Contact us."	Add additional features to include "Your Health Benefits," "OHP Information," and "24-hour NurseLine."	06/2018	Add additional features to include "Your Health Benefits," "OHP Information," and "24-hour NurseLine."	06/2018

A. TQS COMPONENT(S)					
Primary Component:	Fraud, waste and abuse		Secondary Component:	Choose an item.	
Additional Components:					
Subcomponents:	Choose an item.		Additional Subcomponent(s):		
B. NARRATIVE OF THE PROJECT OR PROGRAM					
Fraud, Waste, and Abuse—Effective Lines of Communication and Well-Publicized Disciplinary Standards					
<p>PacificSource maintains a Compliance and <u>Fraud, Waste, and Abuse</u> (FWA) Program, which has all the elements required by state and federal regulations as well as the CCO contract with the OHA. Annually, the Compliance and FWA Program goes through a risk-assessment process, and the Program is approved by the PacificSource Board of Directors for the following calendar year. During the risk-assessment process, the Compliance team identified opportunities to improve the Compliance and FWA Program. Two elements selected by the team for monitoring after reviewing the results of the risk-assessment process include: (1) Lines of communication between employees and the Compliance team, and (2) Employee awareness of disciplinary standards.</p>					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	<p>The Compliance team launched a team email address, “Compliance Q&A,” in the summer of 2016. However, it wasn’t broadly publicized to employees as a method for reporting compliance or FWA concerns or for asking compliance-related questions. Therefore, use of Compliance Q&A was low; only 7 employees emailed the box from June 2016 through May 2017. The root cause for low utilization was determined to be lack of publicizing the creation and purpose of Compliance Q&A to employees. Compliance Q&A was tracked and inquiries were answered within Outlook, which didn’t allow for efficient management by Compliance.</p> <p>The Compliance team maintains the Compliance and FWA Program for employees at the time of hire and annually, which includes training on disciplinary standards. The 2017 Corporate Compliance and FWA Program policy document was also published on the PacificSource intranet (SharePoint) site locations, along with disciplinary standards. However, the Compliance team identified a lack of other methods for publicizing disciplinary standards. State, federal, and contractual requirements indicate that disciplinary standards should be well publicized. PacificSource would like to publicize the disciplinary standards using multiple methods to ensure employee awareness and understanding.</p>				
D. PERFORMANCE IMPROVEMENT					
Activity: In collaboration with the Information Technology Department, Compliance created a SharePoint site where Compliance Q&A emails are triaged, categorized, and answered by the Compliance team.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Compliance team will monitor site for emails and respond in a timely manner.	SharePoint site developed and functioning. 0 utilization tracking efforts in place.	SharePoint site shows increased utilization by employees by tracking number of email submissions.	07/2018	SharePoint site shows increased utilization by employees by tracking number of email submissions.	07/2018
Activity: In collaboration with the Marketing Department, Compliance created a Compliance team poster that is displayed in common areas in each of our office locations. The poster identifies our Compliance Officer, as well as all the other				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	

<p>members of the Compliance team and their titles. It also explains the multiple methods by which employees can report compliance or FWA issues, concerns, or violations anonymously or directly. The Compliance team also published an article to the PacificSource intranet site to let employees know about the information on posters and to look for the posters in their offices.</p>					
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Posters are displayed in each PacificSource office location.	0 posters displayed in each of our 9 office locations.	At least 1 poster displayed at each of our 9 office locations.	05/2018	At least 1 poster displayed at each of our 9 office locations.	05/2018
<p>Activity: In 2018, the Compliance team plans to continue to build on the improvements implemented in 2017. Specifically, the Compliance team is working on table tents to be displayed in common areas (lunchrooms and meeting rooms). The table tents will identify the Compliance Officer by name and picture on one side. The second side will remind employees to do the right thing by reporting compliance or FWA concerns and the consequences of not reporting, including our disciplinary standards. Compliance also plans to launch a "Compliance Newsletter," which will be disseminated to all employees via email and cover topics across the compliance and FWA spectrum.</p>				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Completion of table tents and dissemination of Compliance Newsletter.	0 table tents displayed and 0 newsletters sent.	Table tents and Compliance newsletter in development.	03/2018	Table tents displayed at each of our 9 office locations and inaugural Compliance newsletter sent to all PacificSource employees.	12/2018
<p>Activity: Conduct a telephonic "Compliance Program" employee survey of at least 30 employees, asking a specific list of questions about the Compliance Officer and Program, and document correct and incorrect answers. The Compliance team will evaluate the results to determine if the efforts to better publicize the Compliance and FWA Program, including methods for communicating with Compliance and publicizing disciplinary standards, were successful.</p>				<input type="checkbox"/> Short-Term Activity <u>or</u> <input checked="" type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Telephonic "Compliance Program" survey of employees.	0 employee surveys administered.	Survey in development.	03/2018	Survey administered to at least 30 employees.	03/2019

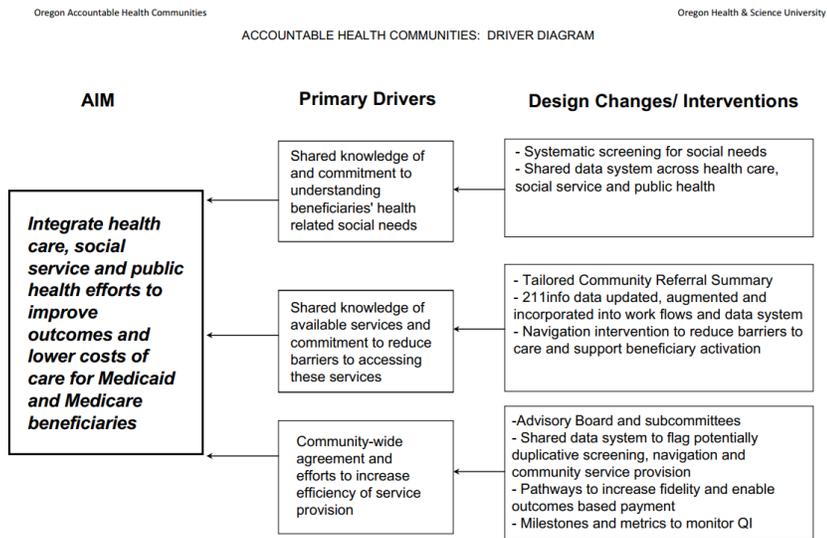
A. TQS COMPONENT(S)					
Primary Component:	Fraud, waste and abuse	Secondary Component:	Choose an item.		
Additional Components:					
Subcomponents:	Choose an item.	Additional Subcomponent(s):			
B. NARRATIVE OF THE PROJECT OR PROGRAM					
Claims Audit Process Improvement					
<p>As part of PacificSource’s <u>Fraud, Waste, and Abuse</u> (FWA) program, PacificSource Compliance staff performed a Medicaid Claims Audit to evaluate claims processes against CCO contract requirements. This work is in addition to the recurring weekly audit of 1% of claims by the Operations Department. Results are reported to the Corporate Compliance Committee. The initial audit cycle identified one issue requiring internal corrective action, which is now ready for reassessment as an additional element of the recurring Compliance audit of claims.</p>					
C. QUALITY ASSESSMENT					
Evaluation Analysis:	<p>In 2017, as part of its comprehensive work plan, the Compliance Department assumed responsibility for work previously performed by an Internal Audit Department. During the first claims audit, one error was found in payment for which a corrective action plan was opened.</p> <p>A root cause analysis was performed, and staff identified human error and a failure in the quality check process as the underlying factors. Since the time of the claims processing error but before the audit, PacificSource had implemented a revised quality check process, which should prevent recurrence. The impacted claims were identified, and all were reprocessed at the correct payment rate. The provider’s record was updated to ensure future claims process correctly.</p> <p>This project will support completion of a repeat second-level claims audit as well as validate the corrections made after the 2017 finding to ensure that additional, similar issues haven’t occurred.</p>				
D. PERFORMANCE IMPROVEMENT					
Activity: A formal corrective action plan (CAP) was initiated to resolve the incorrect payment to providers identified in the 2017 Medicaid claims audit. Compliance will conduct another Medicaid claims audit beginning in April 2018.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Corrective Action Plans required as a result of 2018 audit.	1 CAP in 2017 for incorrect provider rate assignment.	0 CAPs needed post-2018 audit for incorrect provider rate assignment.	12/2018	0 CAPs needed post-2018 audit for incorrect provider rate assignment.	12/2018
Compliance team on-going annual audit process.	1 Medicaid claims audit performed in 2017 with findings for incorrect provider fee schedule configuration.	1 Medicaid claims audit performed in 2018 showing no repeat findings related to Medicaid claims payment.	12/2018	1 Medicaid claims audit performed in 2018 showing no repeat findings related to Medicaid claims payment.	12/2018

A. TQS COMPONENT(S)			
Primary Component:	Social determinants of health	Secondary Component:	Health information technology
Additional Components:			
Subcomponents:	HIT: Health information exchange	Additional Subcomponent(s):	Health Equity: Data
B. NARRATIVE OF THE PROJECT OR PROGRAM			
Central Oregon Accountable Health Communities			
<p>The Oregon Accountable Health Communities project will help to better understand and address the impact of <u>Social Determinants of Health</u> on the needs of Medicare and Medicaid patients in the CCO. Under principal investigator Dr. Bruce Goldberg at the Oregon Rural Practice-Based Research Network (ORPRN), a consortium of health and social service organizations in four regions of the state was recently awarded a five-year, \$4.5M, Accountable Health Communities (AHC) grant by the Centers for Medicare and Medicaid Services (CMS). Central Oregon and the Columbia Gorge are two of the four CCO regions involved in the project. The purpose of the grant is to understand social needs within participating communities and create community-wide support for the highest need residents by:</p> <ul style="list-style-type: none"> • Implementing screening of Medicaid and Medicare patients to identify health-related social needs, such as housing, food, utilities, transportation and violence; • Connecting patients to community services; and • Developing a tailored referral and care plan for a subset of high-risk patients. <p>The study primarily seeks to determine if screening for social needs plus tailored navigation to health and social services lead to improved outcomes and reduced costs of care.</p> <p>In addition to participating in AHC, the region is also at the forefront in adopting <u>Health Information Technology (HIT): Health Information Exchange</u> that enables electronic referrals between health care, public health, oral health, behavioral health, and social service agencies. The screening process and the electronic tracking of results will create a repository of information about met and unmet needs, allowing community-based organizations to use <u>Health Equity: Data</u> to understand and address resource needs. This TQS project is focused on successful completion of the work listed above as well as alignment between the AHC and HIT/Health Equity initiatives.</p>			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	<p>Problem Statement:</p> <p>Many clinicians are aware that social needs can be barriers to the health of their patients, but these social needs often remain undetected or unaddressed. A growing number of health centers, hospital emergency departments, and health plans are beginning to screen for social determinants of health, and models are emerging to support community-based referral and navigation to help meet social needs. In the absence of shared parameters for this work, however, there is broad variation in how questions are asked at the point-of-care level, how data are administered, and how communities and clinics communicate to ensure people are getting access to the resources they need.</p> <p>Root Causes that Create Challenges:</p> <ul style="list-style-type: none"> • While health systems and other providers in the CCO are increasingly being held accountable for health outcomes and cost of care, the system does not yet provide incentives or standardized infrastructure to address community and social factors. • Tools and infrastructure that are needed to support a shared framework include screening tools, best-practice methods for stratifying social risk, and information-sharing between clinical and social service agencies who often serve the same populations. 		

This data-informed TQS project is focused on the following AHC components:

- At participating clinics, screening Medicaid beneficiaries (CCO and fee-for-service) annually using a standardized CMS screening tool;
- Connecting patients with social risk factors to a community resource tool such as 211;
- Providing navigation for persons with one or more social needs and two or more emergency department visits in the prior year;
- Implementing a community resource tool and electronic referral functionality; and
- Tracking and reporting screening and referral data.

While this TQS is short term, there is a longer-term vision for the work that will be captured in future TQS projects:



D. PERFORMANCE IMPROVEMENT

Activity: Screening. Initiate screening for social needs in Medicare and Medicaid patients, including tracking of the population who screen positive. Train community-based screeners to use culturally and linguistically responsive practices as well as to respond to clients who screen positive for interpersonal violence. Aggregation of the screening data will map social needs and gaps in services by patient demographics, informing future health equity work.

Short-Term Activity or
 Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Number of unique community members screening positive for health related social needs, disaggregated by factors, such as gender, age, race, ethnicity, language, education level attained, and income level.	Baseline 0 until project start in mid-2018.	Year 1 data will be used to establish baseline and inform future screening protocols.	12/2018	Year 1 data will be used to establish baseline and inform future screening protocols.	12/2018

Percentage of screeners who are trained in culturally responsive protocol and responding to positive interpersonal violence screens.	0% of screeners have been trained.	75% of participating screeners have received training.	12/2018	75% of participating screeners have received training.	12/2018
Activity: Resource Referral. For patients who screen positive for social needs through AHC, offer a resource summary and track acceptance rate. Health Equity data collected on race, ethnicity, language, and gender will guide the referral process to ensure that referrals are made to culturally and linguistically appropriate services.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Number of unique community members who screened positive for 1 or more social needs and were offered and accepted a community resource summary, by risk strata.	Baseline 0 until project start in mid-2018.	Establish baseline from first 6 months of screening.	12/2018	Establish baseline from first 6 months of screening.	12/2018
Activity: Health Information Technology/Health Information Exchange. Leverage health information technology to create a shared electronic referral system across health care, social service, and public health to support patients with health-related social needs.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Number of health care organizations using HIT to send and receive e-referrals.	0 mental health, dental health, or physical health providers.	At least 2 additional participating organizations.	12/2018	At least 2 additional participating organizations.	12/2018
Number of social service agencies using HIT to send and receive e-referrals.	0 social service providers.	At least 1 social service agency sending and receiving referrals with health care organizations.	12/2018	At least 1 social service agency sending and receiving referrals with health care organizations.	12/2018
A. TQS COMPONENT(S)					
Primary Component:	CLAS standards and provider network		Secondary Component:	Access	
Additional Components:					

Subcomponents:	Health Equity: Cultural competence	Additional Subcomponent(s):	Access: Cultural Considerations
B. NARRATIVE OF THE PROJECT OR PROGRAM			
<p>Supporting Providers to Deepen Understanding of CLAS Standards and Enhance Service Delivery to Meet the Needs of a Culturally Diverse Population</p> <p>PacificSource is committed to advancing the National Standards for <u>Culturally and Linguistically Appropriate Services</u> in Health and Health Care (CLAS) in the execution of our role as a health plan and to supporting implementation of CLAS Standards among our network of providers.</p> <p>In this project, PacificSource will educate, assess, and engage our provider network regarding the CLAS Standards. The Provider Network team will utilize a multimodal approach to build awareness and engage providers in implementing these practices to advance <u>Health Equity and Cultural Competence</u>, which will also function as the lead strategy to strengthen <u>Access: Cultural Considerations</u> on behalf of CCO members. The Provider Network team will also review and revise site visit materials to include assessment of <u>CLAS Standards</u>. This assessment information will provide a reference point for a collaborative process with CCO providers and staff to develop a contracting strategy that aims to improve member access to culturally appropriate services.</p> <p>CLAS standards and provider network: CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a set of principles designed to guide providers in the care of members who may be faced with racial, ethnic, literacy and/or cultural barriers in their pursuit of quality health care. PacificSource is invested in advancing CLAS Standards throughout the entire organization and within our provider network. PacificSource hired a Health Equity and Diversity Strategist and has engaged in technical assistance from the Oregon Health Authority to assess health disparities within Central Oregon. PacificSource has also invested in staff participation in the Developing Equity Leadership through Training and Action (DELTA) program through the Oregon Health Authority Office of Equity and Inclusion. These staff have been leading efforts to develop a culture of health equity at PacificSource while also conducting outreach to community partners and provider groups. This project will provide additional education, support, and monitoring of CLAS among providers in PacificSource’s networks.</p> <p>Health Equity: Cultural Competence: PacificSource has prioritized improvements in cultural competence. PacificSource has made changes in staffing, recruiting, and employee training, most importantly in outreach and recruiting of local bilingual and bicultural employees from regional educational institutions. In addition, the CCO-led work in 2017 significantly increased the number of qualified/certified health care language interpreters in the region. PacificSource has also expanded efforts to address health literacy, partnering to co-sponsor the Legacy Health Literacy Conference for the past two years and making significant changes to member-facing materials. This project will support continued integration of these efforts as part of a cohesive set of culturally attuned practices.</p> <p>Access: Cultural Considerations: The PacificSource CCO governance model empowers the community to drive system improvements. Improving Access for minority populations has been a focus for improvement throughout the health system transformation process. The CCO, together with community partners, has developed sophisticated systems to support community health workers and has put special emphasis on recruitment and training of bi-lingual, bi-cultural staff to provide care coordination and management in a culturally appropriate way. This project will enhance accountability of providers in our network by assessing our monitoring processes to ensure that providers adequately address CLAS Standards and Cultural Considerations.</p>			
C. QUALITY ASSESSMENT			
Evaluation Analysis:	<p>Promoting CLAS Standards in Provider Network, increasing Cultural Competence, and improving Access through addressing Cultural Considerations have been part of the health system transformation process since the formation of the CCO. While this work is well under way, there is still much to be done.</p> <p>Strengths:</p>		

	<ul style="list-style-type: none"> • Community Health Workers and Care Coordinators are employed throughout the region. This diverse workforce includes many bi-lingual, bi-cultural health professionals. • PacificSource has adapted its hiring practices to develop a more diverse workforce, including moving the customer service functions, which were previously contracted, in-house. Our many bi-lingual, bi-cultural Customer Service staff have enhanced member experience. • PacificSource has internal staff with health equity expertise, creating capacity to provide education and support for our provider network. PacificSource has successfully mentored one provider group to fully adopt the CLAS Standards. • The PacificSource Provider Network team has developed a multimedia approach to provider education and is committed to enhancing monitoring and compliance procedures to incorporate CLAS Standards and Cultural Competency. • PacificSource has developed analytics tools to monitor health disparities and utilization by race/ethnicity. • PacificSource has experience in creating and operating payment models that align performance goals across our provider network. <p>Challenges:</p> <ul style="list-style-type: none"> • Clinic-based and community work with providers has been ongoing but without objective tracking of current status and improvement efforts. • Provider groups express a variable level of commitment to adopt CLAS Standards. • While our interactions with clinics indicate that many clinics have made efforts to address health-related social, cultural, and linguistic needs, there is a great deal of variation in implementation. <p>This project will improve the ability of our network of contracted providers to provide high-quality services for all CCO members through education and skill building, on-site assessment, and creation of contract language and other collaborative strategies to support accountability and progress.</p>
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D. PERFORMANCE IMPROVEMENT

<p>Activity: Provider awareness, skills, and capabilities. Increase educational and technical assistance “touches” around CLAS standards and cultural competency with providers so that they can better provide members access to culturally appropriate services.</p>	<p><input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity</p>
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How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
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Track materials and interactions with contracted providers related to CLAS Standards.	<ol style="list-style-type: none"> 1. PacificSource FAQ about interpreter services exists. 2. Provider bulletin annual schedule does not include CLAS. 3. PacificSource provider website includes 0 CLAS resources. 4. 0 provider webinars have been developed specific to CLAS. 5. 0 CLAS implementation toolkits are available to the PacificSource provider network. 6. 0 provider update calls address CLAS. 	<ol style="list-style-type: none"> 1. PacificSource FAQ about interpreter services has been updated. 2. Provider Bulletin includes CLAS at least 1 time. 3. PacificSource provider website includes 1 CLAS resource. 4. At least 1 webinar on CLAS offered per year. 5. 1 tool kit is included on the PacificSource website for providers. 6. At least 2 provider update calls address CLAS annually. 	12/2018	<ol style="list-style-type: none"> 1. PacificSource FAQ about interpreter services has been updated. 2. Provider Bulletin includes CLAS at least 1 time. 3. PacificSource provider website includes 1 CLAS resource. 4. At least 1 webinar on CLAS offered per year. 5. 1 tool kit is included on the PacificSource website for providers. 6. At least 2 provider update calls address CLAS annually. 	12/2018
Activity: Provider Assessment. Integrate CLAS assessment with existing periodic on-site evaluations and technical assistance to improve clinic performance.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	
How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Integration of CLAS in provider pre-visit and site-visit material contents related to CLAS (e.g. checklist, site-visit reports).	Provider pre-visit checklist 0 activities to assess CLAS capabilities of providers. Site visit reporting forms currently include questions related to 2 CLAS standards.	Provider pre-visit checklist contains 2 activities to assess CLAS capabilities of providers. Site visit reporting forms continue to include questions related to 2 CLAS standards.	12/2018	Provider pre-visit checklist contains 2 activities to assess CLAS capabilities of providers. Site visit reporting forms continue to include questions related to 2 CLAS standards.	12/2018
Activity: Provider Engagement. In collaboration with our Community Advisory Council, provider groups, and other contracted entities, develop a shared agenda for advancing CLAS. Strategic elements may include template contract language supporting augmented CLAS performance, financial incentives to support clinic costs, and audits or surveys over time to assess progress. The elements of this activity will be informed by the baseline material obtained through the Provider Assessment activity, as described above.				<input checked="" type="checkbox"/> Short-Term Activity <u>or</u> <input type="checkbox"/> Long-Term Activity	

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time	Benchmark or future state	Time
Develop and track strategy for advancing CLAS as documented by CCO.	0 documented multi-stakeholder strategies for advancing CLAS.	1 documented multi-stakeholder strategy for advancing CLAS.	12/2018	1 documented multi-stakeholder strategy for advancing CLAS.	12/2018
Develop contract language to consolidate written expectations regarding implementation of CLAS standards.	0 examples of consolidated language addressing CLAS for use in contracting.	1 example of consolidated language addressing CLAS for use in contracting.	12/2018	1 example of consolidated language addressing CLAS for use in contracting.	12/2018

Section 3: Required Transformation and Quality Program Attachments

- A. Attach your CCO’s quality improvement committee meeting minutes from three meetings
- B. Attach your CCO’s consumer rights policy
- C. OPTIONAL: Attach other documents relevant to the above TQS components, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.