



# **PacificSource** Community Solutions

**PacificSource Columbia Gorge  
Coordinated Care Organization**

## **TRANSFORMATION and QUALITY STRATEGY**

March 2019

## Section 1: Transformation and Quality Program Information

### A. CCO Governance and Program Structure for Quality and Transformation

- i. Briefly describe your CCO's quality program structure, including your grievance and appeal system and utilization management review. Be sure to include an explanation of CCO oversight, strategic planning, and accountability in addressing identified barriers or issues related to quality, grievances and appeals, and utilization.

#### **Quality Program Structure:**

The quality program of PacificSource Community Solutions (PacificSource) is designed to ensure members of the Columbia Gorge Coordinated Care Organization (CCO) have access to high-quality health care that is safe, is effective, provides a good member experience, and results in positive outcomes. The quality program is aligned with 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 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 with the company values as 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, appeals and grievances, and performance improvement activities under the direct authority of the chief medical officer or a designated medical director. Committee members are primary care, behavioral health, dental, and specialty care clinicians from the hospital-based practices, private practices, and community health centers in PacificSource's provider network. 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
- Initiates and reviews 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
- Reviews feedback and provides direction on quality improvement monitoring and evaluation
- Ensures committee members are recused from committee activities when conflicts of interest exist

CQUM meets every other month and at least six times per year. Committee members are expected to attend two-thirds of scheduled meetings.

PacificSource's Internal Quality Improvement (QI) Committee consists of PacificSource staff who work together to provide consistent oversight of clinical and service quality and accountability for implementing the Quality Improvement Program for the Medicaid, Medicare, Commercial, and Exchange lines of business. The QI Committee receives regular reports about CQUM activities. 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 also reviews clinical care events and other identified quality concerns. 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 the PacificSource Executive Management Group for review and approval.

Additional PacificSource committees that support health transformation and quality improvement within the CCO include the TQS Steering Committee, the Community Advisory Council (CAC), the Clinical Advisory Panel (CAP), the Behavioral Health Clinical Quality and Utilization Management Committee, the Government Operations Committee, and the Cross-Departmental Medicaid Committee.

#### **Appeals and Grievances:**

Processes for Appeals and Grievances are documented in PacificSource policies and procedures and outlined in the member handbook. 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 five days (up to 30 calendar days if an extension is needed). When PacificSource grants a request to expedite a review, the review is completed within 72 hours of receipt. The outcomes of the review of complaints and grievances are provided in writing to the member. For quality of care concerns, any necessary follow-up is communicated to the provider in writing. 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 (NOABD) sent to members. Additionally, PacificSource mails Appeal forms to members upon request.

Reports on Appeals and Grievances are presented to CQUM on a quarterly basis so the committee can review for activities and trends. The committee especially focuses on complaints categorized as violations of consumer rights and protections. When monitored complaints show a trend, these concerns are elevated to program managers, a 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 Appeals and Grievances policies and procedures as well as in the member handbook. Consumer Rights is one of the categories of member grievances, and its subtypes are described in the following table:

<b>CONSUMER RIGHTS — "CR"</b>
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 clinical 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 during 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. Events and situations that meet reporting criteria are forwarded to credentialing organizations.

By integrating the evaluation of grievance data related to dental, behavioral health, pharmacy, transportation, and physical health services, PacificSource is able to compare datasets when monitoring access and member experience. PacificSource has identified quality improvement opportunities in the monitoring and reporting of Dental Care Organization grievances. Appeals and grievance data will be stratified by special populations to determine if there are health care disparities and to address these disparities appropriately.

**Utilization Management:**

PacificSource operates Utilization Management (UM) services as an integrated and comprehensive system that evaluates the medical necessity, appropriateness, and efficacy of medical and behavioral health care services. The program operates in accord with documented policies and procedures, aligns coverage decisions with the member's health benefits, and complies with federal and state regulations and industry accrediting standards.

PacificSource operates UM services that specifically addresses the needs of the Medicaid line of business. The program functions include referral management, prior authorization review, and concurrent review that covers discharge planning and transitions of care.

The purpose of the UM program is to reduce variability in practice and ensure members receive quality, individualized care and appropriate, effective, and efficient services to meet their needs.

The goals of the UM program are as follows:

- Close gaps in care and improve health outcomes for members
- Collaborate with members and providers to improve members' health literacy and adherence to the members' plan of care
- Enhance the member and provider experience
- Ensure that services rendered are medically necessary, timely and provided in the most appropriate setting
- Optimize the quality of care and the efficacy with which care is provided

The UM program works to continuously improve and support the quality initiatives backed by the organization through:

- Ensuring consistent application of UM functions by maintaining and using a comprehensive library of up-to-date UM protocols, guidelines, and criteria
- Identifying a member's need for case management through early identification of service utilization, high cost, chronic or complex disease processes
- Providing guidance, feedback and training to practitioners and providers on efficient delivery and utilization of resources

The attending practitioners have the ultimate responsibility for the medical, behavioral, and dental health care of the patient. The utilization management process does not override this responsibility but, rather, seeks to advise the practitioners of benefits and coverage determinations and to provide information on evidence-based care options. The health plan determination is for coverage and payment purposes only, and it does not seek to influence clinical decisions or dictate treatment options, other than to clarify coverage options. The ultimate decision to proceed with treatment is between the practitioner and the patient. For non-coverage determinations, the member and practitioner are informed of their appeal rights.

- ii. Briefly describe your CCO's organizational structure for developing and managing its quality and transformation activities. Be sure to include how your CCO collaborates with your CCO's community advisory council (CAC) and CCO board to address quality and transformation, as well as how the CAC connects with the board.

The Columbia Gorge CCO is operated by PacificSource and the Columbia Gorge Health Council (CGHC) through a formal Joint Management Agreement. PacificSource has responsibility for managing OHP benefits and quality improvement activities, including the development and implementation of the Transformation Quality Strategy (TQS). While PacificSource staff take lead on the management of TQS projects, the design of the TQS and the project work is shared between PacificSource staff, CGHC staff and committees, and other community partners. These groups provide input on setting priorities and review the TQS during program development.

The CGHC board is the governing board of the CCO and charters the community advisory council (CAC) and a Clinical Advisory Panel (CAP). The CAC is composed of at least 51% Oregon Health Plan (OHP) members, as well as community partner representatives. The CAC provides a forum for OHP members to voice their experience and provide input and feedback to guide health care transformation and delivery. The CAC oversees the development and implementation of a Community Health Assessment and Community Health Improvement Plan, which are vital organizing structures for system-wide transformation. The CGHC board and subcommittees connect through interlaced membership, reporting at meetings, and decision-making structures that delegate decision-making and roles among the groups.

The TQS is part of the PacificSource 2019 Strategic Plan, demonstrating the commitment of the company's Executive Management Group to its success. The Medicaid Leadership Team (MLT) oversees a TQS Steering Committee and provides regular updates to senior leadership. The CGHC board, CAP, and CAC also receive updates on the status of the TQS.

- iii. Briefly describe how your CCO uses its community health improvement plan as part of its strategic planning process for transformation and quality, including how information is shared between bodies that have oversight for the community health improvement plan and TQS.

The Columbia Gorge Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are developed via a regional collaboration that includes health care and social service organizations from seven counties in Oregon and Washington as well as PacificSource. CGHC leads a planning and implementation process that includes explicit commitments from a cohort of community partners who contribute funding, personnel, and data to develop a comprehensive assessment of community health in the region. The CHA is used to inform the CHIP, which is organized around the [Robert Wood Johnson Culture of Health Action Framework](#). Because of the high level of CCO and community engagement throughout this process, the CHIP is used as a primary reference to identify priorities to address with the TQS.

Elements from the PacificSource strategic plan that connect with priorities identified in the CHIP include:

- Develop and implement enterprise-wide strategies to impact social determinants of health.
- Develop and implement breakthrough strategies to significantly improve the experience for our existing and future members.
- Enable and leverage HIE, EMR access, and clinical data assets in support of Quadruple Aim goals.

The CHP has identified the following priority areas that inform the development of our transformation and quality initiatives:

- Making Health a Shared Value: Sense of Community
- Fostering Cross-Sector Collaboration: Number and Quality of Partnerships
- Creating Healthier, More Equitable Communities: Built Environment
- Strengthening Integration of Health Services and Systems: Access to Care

Progress on both CHP and TQS initiatives is monitored and reported within PacificSource and at meetings of the Community Advisory Council and the CGHC board. When there is direct crossover between a CHP priority or CGHC program area and a TQS project, oversight of the project is shared.

- iv. Briefly describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, community mental health programs, local government, tribes, early learning hubs) to advance the CCO's quality program (including the goals or strategies used by the CCO quality program, or the CCO's quality improvement activities).

PacificSource is committed to collaboration with provider and community partners through a community-oriented approach in everything we do. The success of the 2019 Columbia Gorge CCO TQS depends on relationships and cooperation with diverse community partners. For example, PacificSource will coordinate closely with health care and social service partners to address social determinants of health through operation of the Bridges to Health Pathways Hub for care coordination. PacificSource acts as a primary funding source for the program and participates on the Systems Integration Team that governs implementation. CGHC operates the program, utilizing the nationally recognized Pathways model and contracting with health care and social service providers to support the work of community health workers in the region.

Another example of working closely with partners is the regional implementation of health information technology in the Gorge. The funding for the work comes from shared savings from CCO revenues, and the implementation has been led by CGHC staff. Both social service and health care organizations have joined the platform, with the result being improved communication among providers and a single data source for clinical information that supports health plan quality improvement activities.

**B. Review and Approval of TQS:**

Briefly describe your CCO's TQS development process, including review, development and adoption, and schedule. Be sure to include how your CCO collaborates with the CAC and CCO board on the TQS, including the process for developing the TQS, as well as the process for CCO review and approval of the final TQS, and how and on what schedule it is evaluated.

The development of the 2019 TQS has been a collaborative effort involving multiple departments within PacificSource and input from many external partners including the CCO's governing board and CAC. The PacificSource Executive Management Group and Medicaid Leadership Team (MLT) have ultimate oversight of the TQS and provide adequate resourcing through an annual strategic planning and information technology support process. A charter, annual work plan, and multi-year work plan have been developed and refined through multiple iterations of review and feedback by internal and external stakeholders. Through this process, a TQS Steering Committee was chartered to include a diverse group of people from multiple departments with specific expertise. Starting in 2019, each appointee to the steering committee holds a defined role, including project manager,

project development coordinator, state liaison, component manager, IT/analytics feasibility manager, and TQS report compliance manager. Each project within the TQS has an assigned project lead who is responsible for the planning, design and implementation of the project.

The TQS is composed of projects that are representative of the Columbia Gorge CCO's activities related to health care transformation and quality. The TQS Steering Committee utilized the following data sets to identify ongoing or new initiatives in the component areas specified by the Oregon Health Authority:

- Community Health Assessment
- Community Health Improvement Plan
- PacificSource Strategic Plan
- Delivery Service Review
- External Quality Review
- Information Systems Capability Assessment
- Office of Inspector General Audit
- 2018 TQS Progress Report

Utilizing these sources, the TQS Steering Committee identified a short list of potential projects for inclusion in the 2019 TQS. This list, with project descriptions, was proposed to internal stakeholders including the MLT and QI Committee for input, feedback, and approval. The list was also presented to the CGHC board, CAC, and CAP for input and guidance. The TQS Steering Committee incorporated the information from these internal and external stakeholders and began working with project leads to fully define projects. Once drafted, the projects underwent thorough review by the TQS Steering Committee, MLT, and PacificSource Executive Management Group to assess feasibility, transformational qualities, resource needs, and project scope. Once approved, the project descriptions were finalized for inclusion in the TQS. The final TQS was then reviewed in totality by the MLT, Executive Management Group, QI Committee, and CGHC board for final approval.

The TQS Steering Committee will continue to meet throughout the year to manage projects, collect feedback, and address any concerns with the reporting requirements. The MLT and QI Committee will continue to have oversight of the TQS, receiving regular status updates. Status updates will also be provided to the CGHC Board and CAC at regular intervals. The CAC will be consulted on all aspects of member experience as it relates to projects within the TQS.

C. **Optional:**

This optional portion provides the space for your CCO to highlight to OHA the context of regional priorities, CCO strategic approach and connection to quality, CCO geographic regions and limitations, and/or enrollment demographics.

**A. Project or program short title:** [Access Project #1: Improving and Monitoring Access to Care](#)Continued or slightly modified from prior TQS?  Yes  No, this is a new project or program**B. Primary component addressed:** [Access](#)

- i. Secondary component addressed: [Choose an item.](#)
- ii. Additional component(s) addressed:
- iii. If *Integration of Care* component chosen, check all that apply:  
 Behavioral health integration  Oral health integration

**C. Primary subcomponent addressed:** [Access: Timely access](#)

- i. Additional subcomponent(s) addressed: [Access: Cultural considerations](#); [Access: Availability of services](#); [Access: Quality & appropriateness of care furnished to all members](#)

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

In 2018, staff from the PacificSource Provider Network Department developed a new procedure to educate providers on standards for member access to timely care. Additionally, provider service representatives implemented an enhanced data collection process to identify providers who fail to meet network standards. Data gathered through these new processes are cumbersome to analyze and do not yield actionable results. Creating documentation standards and utilizing a platform with capacity for data extraction will allow the Provider Service team to track progress toward goals, identify trends and gaps, and develop targeted education and training based on the results.

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

In 2019, the Provider Network Department, in collaboration with key stakeholders, will work to build a system that gathers and analyzes information from the established provider network and delivery system and triangulates that data with qualitative feedback from members to identify barriers to members' accessing care. The monitoring system will be comprehensive, incorporating all of the following components: [Access: Timely access](#); [Access: Cultural considerations](#); [Access: Availability of services](#); [Access: Quality & appropriateness of care furnished to all members](#)

There are currently several policies that articulate a requirement or monitoring practice. These policies are all owned by different departments, with minimal visibility to other stakeholders. Combining these policies into a single, comprehensive policy that has visibility to all involved departments will more clearly articulate how access to care should be established, monitored, and ensured within PacificSource. This new policy will address all service types within the delivery system and articulate standards for timely access and service availability, as well as cultural and language standards for the network. In support of this new policy, a systemic approach to reviewing and responding to this information will be developed.

One key component of the implementation of access to care standards and best practices within the delivery system are provider site visits. As provider service representatives conduct these site visits, they collect information about a provider's capacity and a member's ability to access services. They collect information about appointment availability, scheduling procedures, and whether or not a provider is accepting new patients. They gather information about the type of services offered and the degree to which a provider is prepared to serve populations with special needs, including compliance with ADA regulations. Provider service representatives also assess provider awareness and implementation of CLAS standards, staff resources, and education needs regarding cultural and linguistic services. The data collection system currently used by the Provider Service team to record and assess information collected at site visits has many free text data fields, making it challenging to extract data to better understand

trends and gaps in the services and education being delivered to providers. The Provider Service team will develop and implement a new platform to support more meaningful analysis of key data gathered at these provider site visits. The data gathered at site visits will then be triangulated with qualitative data gathered from members through a variety of sources including Access to Care surveys, Member Satisfaction surveys, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. In addition to survey data, PacificSource will assess appeal and grievance data, out-of-network requests, out-of-network utilization, and appointment availability analysis to formulate a comprehensive evaluation of access. Together this information will be used to identify gaps and remediate concerns.

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

**Activity 1 description:** Align policies and procedures addressing access to care across service types to improve effectiveness of monitoring activities.

Short term or  Long term

**Monitoring activity 1 for improvement:** An evaluation of policies and procedures regarding access to care across all service types is conducted. A policy comprehensive of all service types regarding access to care has been developed and submitted for approval.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
An evaluation of policies and procedures regarding access to care across all service types has not been conducted.	An evaluation of policies and procedures regarding access to care has been conducted across all service types.  A policy comprehensive of all service types regarding access to care has been drafted.	06/2019	A draft policy comprehensive of all service types regarding access to care is submitted for approval.	12/2019

**Activity 2 description:** Enhance internal workflows to support improved collection and analysis of data gathered from site visits to identify actionable improvements.

Short term or  Long term

**Monitoring activity 2 for improvement:** A new platform for site visit data is developed and implemented. A new process/workflow for review of data and identification of improvement opportunities is developed and implemented.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
The current platform for compiling site visit	Key data points for inclusion in new site	06/2019	A new platform for site visit data is	12/2019

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
data is inadequate for data analysis and reporting.	visit platform are identified.		developed and implemented.  A process to review site visit data and identify improvement opportunities is developed and implemented.	

**Activity 3 description:** Inventory and evaluate current data sources and monitoring processes, such as information collected at site visits, member surveys, appeal and grievance data, etc. Develop a cohesive system that allows for comprehensive data analysis, gap identification, and targeted intervention.

Short term or  Long term

**Monitoring activity 3 for improvement:** An inventory and evaluation of current access monitoring is conducted. A system for analyzing access to care data is developed and implemented.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
An inventory and evaluation of current monitoring processes has not yet been conducted.  A cohesive system for analyzing access to care data has not been clearly articulated.	An inventory and evaluation of current monitoring processes has been conducted.  A cohesive system for analyzing access to care data is articulated and proposed.	06/2019	A cohesive system for assessing access to care is developed and implemented and includes gap analysis and development of targeted interventions.	12/2019

**A. Project or program short title:** [Access Project #2: Primary Care Matching Strategy](#)

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

**B. Primary component addressed:** [Access](#)

- i. Secondary component addressed: [Choose an item.](#)
- ii. Additional component(s) addressed:
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [Access: Quality and appropriateness of care furnished to all members](#)

- i. Additional subcomponent(s) addressed: [Access: Cultural considerations](#)

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

PacificSource utilizes an automated method to assign Medicaid members to a primary care home. The auto-assignment method uses a data feed populated by the Oregon Health Authority 834 data file. This system was built early in the formation of the CCO and is in need of an update. With the recent augmentation of REAL+D data from the Oregon Health Authority, PacificSource will work to update the current auto-assignment process to pull additional data fields including race, ethnicity, and preferred language. This will improve [Access: Quality and appropriateness of care furnished to all members](#), [Access: Cultural considerations](#), and [Access: Timely](#) as members will be more likely to be assigned to a Primary Care Provider (PCP) who has the capacity to respond to their specific health care concerns as well as their cultural and linguistic needs.

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

PacificSource will assess member attribution to develop a baseline of discrepancies in member assignments and utilize that information to make system improvements. PacificSource will enhance the PCP auto-assignment process by integrating information from our claims data base and member demographic information to assign members in a way that is responsive to their language and cultural needs as well as their specific health care concerns.

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

**Activity 1 description:** PacificSource will use claims data to determine which providers a member is receiving services from, and we will then use this information to attribute the correct provider to the member in the event that there is a discrepancy.

Short term or  Long term

**Monitoring activity 1 for improvement:** Develop a report that establishes a baseline for discrepancies in member assignment, based on comparing assigned PCP with the PCP that the member is seeing based on claims data.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
A standardized report for evaluating discrepancies in	A standardized report for evaluating discrepancies in	06/2019	A process to regularly review the standardized report	12/2019

member assignment to PCP is unavailable.	member assignment to PCP has been developed.		and resolve discrepancies in member assignment to PCP has been implemented.	
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**Activity 2 description:** Enhance systems to auto-assign members to a PCP using REAL+D data in addition to the geographic criteria currently being used.

Short term or  Long term

**Monitoring activity 2 for improvement:** Status of enhancement to PacificSource member enrollment process.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Current enrollment system does not access REAL+D data in the PCP assignment process.	Enrollment system accesses REAL+D data in the PCP assignment process.	12/2019	Enrollment system accesses REAL+D data in the PCP assignment process.	12/2019

**A. Project or program short title:** [Access Project #3: Second Opinions](#)

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

**B. Primary component addressed:** [Access](#)

- i. Secondary component addressed: [Utilization review](#)
- ii. Additional component(s) addressed:
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [Access: Second opinions](#)

- i. Additional subcomponent(s) addressed: [Access: Quality and appropriateness of care furnished to all members](#)

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

In 2018, a quarterly monitoring process was implemented for second opinions. Second-opinion data includes physical health, behavioral health and dental care services. Software functionality and reporting enhancements were completed during the first quarter of 2018 to identify second-opinion requests. When Providers submit a prior authorization or referral request online for physical or behavioral health, they are prompted to select a mandatory “Yes” or “No” radio button to indicate if the request is for a second opinion. Additionally, within the PacificSource Utilization Management (UM) software, there is a mandatory field for staff to indicate if the requested service is for a second opinion. PacificSource also began receiving second-opinion monitoring and tracking reports from Dental Care Organizations (DCOs) on a quarterly basis in 2018.

There were no significant challenges identified in implementing these changes although, since this reporting was newly established in 2018, not all 2018 data has been received.

Currently, no standardized staff training is in place for PacificSource staff who perform prior authorizations related to second opinions. Additionally, a mechanism to track and monitor wait times for second opinions and compare them to OAR access standards does not exist.

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

PacificSource will establish a training process for CCO staff who perform prior authorizations related to second opinions as well as a mechanism to track and assess wait times. Standardizing staff training will ensure consistent knowledge across the organization and also create an awareness of both the importance of access to second opinions and the definition of these services.

By enhancing the reporting capability for requests processed through its referral and authorization platform, PacificSource will have reliable data to track and monitor second-opinion requests received and also allow for comparison of year-over-year trends and identification of concerns such as long wait times. Creating this tracking mechanism will enable PacificSource to detect over- and under-utilization of this benefit for medical and behavioral health services, with additional standardized oversight in place to monitor access for dental referrals. These results and trending will be reported quarterly to the PacificSource Clinical Quality and Utilization Management Committee for review and recommendations for improvement where needed. Reporting will include year-over-year trends once a data has been collected for long enough to establish a baseline.

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

**Activity 1 description:** Establish standard training for CCO staff who perform prior authorizations regarding second-opinion requests

Short term or  Long term

**Monitoring activity 1 for improvement:** The number/percentage of CCO staff trained will be tracked.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
A training plan for CCO staff is not currently in place.	A training plan for CCO staff has been developed.	06/2019.	A training plan for CCO staff has been implemented, and the number/percentage of staff trained is tracked.	12/2019

**Activity 2 description:** A mechanism to track and assess wait times for second opinions will be established.

Short term or  Long term

**Monitoring activity 2 for improvement:** Monitoring will take place through collection and analysis of standardized data. Results will be presented quarterly to the PacificSource Clinical Quality and Utilization Management Committee.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
A mechanism to track/monitor wait times for second opinions and compare them to OAR access standards does not exist.	A mechanism to track/monitor wait times for second opinions and compare them to OAR access standards has been developed.	10/2019	Tracking/monitoring wait times for second opinions and comparing them to OAR access standards has been implemented.	12/2019
Current DCO reports are not received in a standardized format.	A template for DCO quarterly reports has been created and distributed to DCOs.	10/2019	DCO quarterly reports provide standardized data that can be assessed.	12/2019

**A. Project or program short title:** [Patient-Centered Primary Care Home Project #1: Enhancement and Financial Support](#)Continued or slightly modified from prior TQS?  Yes  No, this is a new project or program**B. Primary component addressed:** [Patient-centered primary care home](#)

- i. Secondary component addressed: [Integration of care \(physical, behavioral and oral health\)](#)
- ii. Additional component(s) addressed: [Value-based payment models](#)
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [Access: Availability of services](#)

- i. Additional subcomponent (s) addressed:

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

Patient-Centered Primary Care Home (PCPCH) and Behavioral Health Integration of care (BHI) are linked functions that support each other in the primary care setting. Because primary care is available for direct access by any CCO member or community member, these care models have the potential to significantly improve health care outcomes across the population. Two of the major barriers to adoption of these models are the (1) lack of financial support for the non-encounterable elements of the work and (2) the need for technical assistance to assure that clinics are implementing unfamiliar care models effectively. This project continues prior years' work in which the contracts in 75% of CCO primary care clinics were amended to include payment for visits.

Currently, 61.8% of our members are served by clinics designated as PCPCH Tier 4 or above (per our internal PCPCH report). These clinics include Rural Health Clinics and an FQHC. Several clinics are interested in increasing their Tier status. By offering meaningful support, PacificSource seeks an outcome of increased PCPCH enrollment in Tier 4 or higher, with the ultimate goal of improved health care outcomes across the population. Patient acceptance of integrated models has resulted in this work being a priority for our region to further improve [Access: Availability of services](#).

The existing Value-based Payment (VBP) model for non-encounterable visit functions (PCPCH and BHI) is intended to support enrolled providers and all assigned members. This model is layered on top of financial models that include modest downside and significant upside risk-sharing as well as partial capitation. The quality component of the program requires clinics to report on population metrics to assess progress toward outcomes.

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

PacificSource will be providing financial support, on-site assessments, and technical assistance to implement high-value PCPCH and behavioral health integration elements in primary care clinics that serve our members. Progress will be accomplished through financial support through a Per Member Per Month (PMPM) VBP model and monitored through site visits and program reporting requirements.

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

**Activity 1 description:** Support fidelity implementation of PCPCH and BHI in primary care using a Value-Based Payment strategy and technical assistance (TA) for clinics. The PCPCH TA will include gap analyses and assessments of the clinics' abilities to achieve the more challenging aspects of program

participation, with the goal of increasing the CCO membership cared for by Tier 4 or 5 clinics. BHI TA will include a variety of approaches that support BHI programs, including collaborative meetings, individual clinic support, and facilitation of community of practice meetings.

Short term or  Long term

**Monitoring activity 1 for improvement:** We will monitor progress in advancing PCPCH clinic status through monthly PacificSource PCPCH reports; tracking of technical assistance; and fidelity to program models through clinic attestations and quarterly data reporting.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
PCPCH Quality Incentive Metric baseline (Q4 2018): 61.8% of members are represented by clinics with Tier 4 or 5 status.	At least 75% of members represented by clinics with Tier 4 or 5 status.	12/2019	At least 75% of members represented by clinics with Tier 4 or 5 status.	12/2019
Baseline for BHI activities in 2018: Community of Practice meetings - 2 Learning collaborative meetings - 2 Site visits - 6	Increase technical assistance activities by 25%.	12/2019	Increase technical assistance activities by 25%.	12/2019
No baseline exists for BHI population reach metric in participating clinics. Clinics have not yet started collecting and reporting this data.	Baseline determined for BHI population reach in participating clinics.	12/2019	Baseline determined for BHI population reach in participating clinics.	12/2019

**A. Project or program short title:** [Social Determinants of Health Project #1: Addressing Social Needs Through Clinic and Community Linkage: Bridges to Health Pathways HUB](#)

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

**B. Primary component addressed:** [Social determinants of health](#)

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

**C. Primary subcomponent addressed:** [Health Equity: Data](#)

- i. Additional subcomponent(s) addressed: [HIT: Health information exchange](#); [Health Equity: Cultural competence](#); [Access: Cultural considerations](#).

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

The Bridges to Health (B2H) Pathways program, the Columbia Gorge's regional implementation of the Pathways HUB model, is a cross-sector collaborative approach to providing community care coordination. The Pathways model creates a centralized HUB that coordinates, tracks, and measures both the process and the resources that enable distributed community care coordination. Community Care Coordinators (Community Health Workers or equivalent) are employed by Community Care Agencies, such as clinics, schools, social service, and housing agencies, to help coordinate and navigate needed services for clients and members of their households. Agencies contract with the HUB to receive pay when evidence-based outcomes are met. The program is a data-informed intervention with three primary overall goals:

1. Empower community members most in need to improve their overall health and well-being.
2. Improve access to services and resources by addressing disparities.
3. Increase coordination of services through linking health care and community services.

The Gorge Regional Community Health Assessment highlighted housing, transportation, and food, as well as access to care, as priority needs. In particular, one in four individuals had to go without a basic need, went without a health care need being met, or worried about their housing situation. Additionally, one in three were worried about running out of food, and these rates were higher among the Hispanic/Latino populations in our region. The B2H program works with the highest utilizers of our systems to address all of these priorities using an evidence-based model rooted in equity. Community Health Workers, by profession, help to bridge the gaps in services through culturally and linguistically appropriate relationship-building, data-sharing, advocacy, and navigation across both health care and social services.

In 2018, the B2H program more than doubled its enrollment and is serving clients who reflect the ethnicity of our region's OHP members. Over the past year, staff found that operating with mostly part-time Community Care Coordinators was limiting the HUB's ability to reach outcomes and collect good, quality data. As a result, agency contracts were amended to support full-time Community Care Coordinators dedicated specifically to the program, resulting in an increase in enrollments and outcomes. As of December 2018, there were seven agencies contracted and 14 Community Care Coordinators working in the program for a total of 12.5 FTE with 295 unique clients enrolled.

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

The Bridges to Health Program will continue its collaborative approach, designed to address disparities by providing clients with screening for identified health and social determinants of health (SDOH) needs and providing closed loop referrals for available services and resources. The program does this through relationships with linguistically and culturally appropriate Community Health Workers (CHW), employed in multiple organizations throughout the region, centering the program on principles related to Health Equity.

During 2019, the B2H program will continue to expand the number of clients screened for SDOH and health needs, maintain the number of Community Care Coordinators, and measure Pathways outcomes to assess overall impact.

The program will refine its care coordination and data collection software, CLARA, to better collect, aggregate, and report on Health Equity: Data: to influence larger systemic change. The program will report on REAL+D data and improve the tracking of unmet needs to assess for systemic patterns and their relationship to REAL+D data. Streamlining the data collection process will include collaborating with other Pathways programs throughout the state. In order to facilitate HIT: Health Information Exchange between a larger number of health care entities and agencies utilizing CLARA, including the regional Early Learning HUB, the program will create interconnectivity between CLARA and Reliance, the regional Health Information Technology platform.

Finally, the program will support Health Equity: Cultural Competency and Access: Cultural Considerations through workforce development activities for Community Care Coordinators working in the program. Activities include ensuring CHW training and certification, facilitating a monthly community of practice, and offering ongoing training including cultural humility training.

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

**Activity 1 description:** Continue to expand the number of clients in the program, all of whom will be screened for social determinants of health and health needs, maintain the number of Community Care Coordinators, and measure outcomes to assess overall impact.

Short term or  Long term

**Monitoring activity 1 for improvement:** B2H will measure the number of unique community members enrolled in the program, the number of members who are connected to services and resources once their needs are assessed, the number of Community Care Coordinators trained in the program, and the number of Pathways “closed complete”, meaning the client’s need has been met.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
295 unique members have been enrolled and their SDOH and medical related needs assessed.	450 unique members will be enrolled and their SDOH and medical related needs assessed.	12/2019	450 unique members will be enrolled and their SDOH and medical-related needs assessed.	12/2019
Currently 14 Community Care Coordinators in seven different agencies are	Maintain at least 10 Community Care	12/2019	Maintain at least 10 Community Care	12/2019

contracted to work under B2H for a total of 12.5 FTE.	Coordinators working in the B2H Program		Coordinators working in the B2H Program	
Members' needs are being met at a rate of 42% of Pathways closed complete.	Increase the rate of Pathways closed complete to 45%	12/2019	Increase the rate of Pathways closed complete to 45%	12/2019

**Activity 2 description:** Refine the B2H technology platform (CLARA) to better collect, aggregate, and share data to learn about and address systemic disparities. The program is already tracking and reporting demographic data for race, ethnicity, and language, but not disability status. The demographic data collected in CLARA will be changed to include all REAL+D data, including disability. B2H staff will also begin to analyze pathway outcome data and its relationship to the REAL+D data collected.

Short term or  Long term

**Monitoring activity 2 for improvement:** Demographic and outcome data will be reported and analyzed using all REAL+D data components. The percentage of pathways open longer than six months will be tracked.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Of the Pathways opened, 27% have been active longer than 6 months. This is likely not reflective of current work but rather of poor data quality.	Decrease by 15% the number of Pathways active longer than six months.	12/2019	Decrease by 15% the number of Pathways active longer than six months.	12/2019
CLARA database currently tracks race, ethnicity, and preferred language. It does not track disability status. Outcomes are not currently analyzed using REAL+D data.	The CLARA database tracks all REAL+D data components. Aggregated reports are reviewed quarterly by the advisory team to identify trends and disparities.	12/2019	The CLARA database tracks all REAL+D data components. Aggregated reports are reviewed quarterly by the advisory team to identify trends and disparities.	12/2019

**Activity 3 description:** Establish interconnectivity between CLARA and the regional Health Information Exchange platform (Reliance) to allow referrals entered into CLARA to be tracked in the Reliance eReferral system.

Short term or  Long term

**Monitoring activity 3 for improvement:** B2H staff will track progress toward achieving a single sign-on process for users of the CLARA and Reliance HIE systems.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
The two systems, CLARA and Reliance, are not currently connected.	CLARA and Reliance are accessed via a single sign on and operate with interconnectivity.	12/2019	CLARA and Reliance are accessed via a single sign on and operate with interconnectivity.	12/2019

**Activity 4 description:** Track the percentage of Community Care Coordinators (CCC) who are certified as Community Health Workers (CHW). Provide ongoing training for CCCs and track participation at regular Community of Practice meetings.

Short term or  Long term

**Monitoring activity 4 for improvement:** B2H staff will monitor the percentage of CCCs who are certified as CHWs and the percentage of CCCs attending Community of Practice meetings.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
43% of the current CCCs working in the program have completed CHW training and become certified.	80% of the CCCs working in the program have completed CHW training and become certified.	12/2019	80% of the CCCs working in the program have completed CHW training and become certified.	12/2019
Monthly CHW Community of Practice meeting was financially supported for six of the previous 12 months and was attended by 50% of the B2H-contracted CCCs.	Financially support at least 75% of CHW Community of Practice meetings and maintain a 75% attendance record for B2H-contracted CCCs	12/2019	Financially support at least 75% of CHW Community of Practice meetings and maintain a 75% attendance record for B2H-contracted Community Care Coordinators	12/2019

**A. Project or program short title:** [Health Equity Project #1: Health Equity Strategy and CLAS Standards](#)

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

**B. Primary component addressed:** [Health equity](#)

- i. Secondary component addressed: [CLAS standards and provider network](#)
- ii. Additional component(s) addressed: [Social determinants of health](#)
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [Health Equity: Cultural competence](#)

- i. Additional subcomponent(s) addressed: [Health Equity: Data](#)

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

Previous PacificSource assessments indicated that the majority of provider and community partners had little or no knowledge of the Culturally and Linguistically Appropriate Services (CLAS) Standards, designed by the Office of Minority Health to address [Health Equity: Cultural Competence](#) and [Access: Cultural Considerations](#). As a result, PacificSource's 2018 TQS initiative sought to 1) improve PacificSource's internal and external-facing operations to promote CLAS and 2) deepen understanding of CLAS standards within the broader provider network. As such, a number of improvements and stakeholder engagement activities were carried out:

- Updating the PacificSource interpreter services FAQ document
- Adding a CLAS Standards update within the Provider Bulletin, our internal newsletter
- Updating the CCO website to include an online CLAS resource and toolkit link for providers
- Developing a CLAS "one pager" for providers
- Updating the provider network site visit assessment form to include four questions related to CLAS Standards
- Planning and developing a webinar on CLAS standards (scheduled for February 20th, 2019)
- Introducing CLAS language in 2019 provider contracts: "Providers shall meet the National Standards for Culturally and Linguistically Appropriate Services (CLAS) by providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs."
- In addition, CLAS Standards are now included in the workshops that PacificSource's Provider Network offers on a routine basis and, to date, a total of 142 people from 50 provider groups have attended the workshops.

In addition to internal improvements, a series of in-person presentations were conducted by PacificSource's Health Equity and Diversity Strategist to educate stakeholders about CLAS standards, help build a shared understanding of cultural competency and raise awareness about equity issues in health care delivery.

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

Building on the 2018 CLAS TQS, PacificSource will promote [Health equity](#) through the continued advancement of the National Standards for Culturally and Linguistically Appropriate Services (CLAS). This project outlines improvements to be made within the CCO provider network, analytics, community engagement, and case management departments to support key CLAS Standards and other priorities to advance Health equity, that were identified during the 2018 Multi-Stakeholder TQS initiative on CLAS.

This project will address CLAS standards and provider network by introducing a new system to track active provider policies, with an emphasis on continuing education for clinical staff and access to certified or qualified medical interpreters. In addition, we will improve Health Equity: Cultural competence by introducing online training for CCO staff on cultural responsiveness topics. In addition, PacificSource will advance CLAS standards in its provider network through promoting CLAS as an eligible effort for Community Health Excellence (CHE) funding and developing an incentive model to use with Medicaid provider agreements.

Finally, PacificSource analytics staff will implement processes to address Health Equity: Data and Social Determinants of Health through integrating data to inform case management and quality interventions for target populations. Current data available includes Race, Ethnicity, and Language plus Disability (REAL+D) data from the Oregon Health Authority, and future sources include the data on social, medical, and health complexity in children (“child complexity data”) being developed through the Oregon Pediatric Improvement Partnership, a process in which CCO staff have been involved.

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

**Activity 1 description:** Establish a method to track the number of providers who have policies related to CLAS standards. Provide cultural responsiveness training for CCO staff.

Short term or  Long term

**Monitoring activity 1 for improvement:** Provider Network will track the number of contracted providers who have documented CLAS policies related to continuing education on cultural competency and access to interpreter services. A baseline percentage of contracted providers with existing policies will be established. PacificSource will contract with a cultural responsiveness training vendor. We will measure the number of CCO staff and leaders who participate in the training modules.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
PacificSource does not currently track the number of contracted providers who have policies related to continuing education on cultural responsivity or interpreter access.	One standard method is established to track the number of CCO provider organizations that have policies related to continuing education on cultural responsiveness and that have policies around access to interpreter services. Baseline established.	12/2019	One standard method is established to track the number of CCO provider organizations that have policies related to continuing education on cultural responsiveness and who have policies around access to interpreter services. Baseline established.	12/2019
PacificSource does not have a contract for online training related to cultural responsiveness.	PacificSource executes a contract for online training on cultural responsiveness.	06/2019	PacificSource offers cultural responsivity training module to at least 60% of CCO staff.	12/2019

**Activity 2 description:** Enhance infrastructure to advance CLAS standards in the PacificSource provider network, including promoting CLAS as an eligible program for Community Health Excellence (CHE) funding and developing an incentive model for Medicaid provider agreements.

Short term or  Long term

**Monitoring activity 2 for improvement:** Monitoring will include the number of communication strategies implemented to promote CLAS as an eligible CHE grant, number of grants awarded for CLAS initiatives, and documentation of contract language for a CLAS incentive model.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
No Community Health Excellence grants have been awarded for CLAS work.	Implement at least one communication strategy to promote the addition of CLAS to the priority funding categories of CHE grant program.	07/2019	CCO awards at least one CHE grant (if competitive applications are received) to support CLAS-related improvements among CCO providers.	12/2019
Incentives to advance CLAS Standards are not currently included in provider contracts.	CCO develops and proposes an incentive model within existing Medicaid agreements with providers to advance CLAS beginning 2020.	12/2019	CCO develops and proposes an incentive model within existing Medicaid agreements with providers to advance CLAS, beginning 2020.	12/2019

**Activity 3 description:** Incorporate external data sources into member records and case management/quality workflows to inform the development of internal quality and case management services for members with cultural, linguistic, or health-related social needs.

Short term or  Long term

**Monitoring activity 3 for improvement:** Monitoring will occur through process measures that indicate improved workflows and capabilities, including tracking the number of member records that have been updated with REAL+D or Oregon Pediatric Improvement Partnership (OPIP) data.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
REAL+D data and OPIP data have not been integrated into quality or case management algorithms to inform interventions.	REAL+D and OPIP data are incorporated into member records to inform quality and case management algorithms.	12/2019	REAL+D and OPIP data are incorporated into member records to inform quality and case management algorithms.	12/2019

**A. Project or program short title:** [Health Information Technology Project #1: Strategies to Engage Patients](#)Continued or slightly modified from prior TQS?  Yes  No, this is a new project or program**B. Primary component addressed:** [Health information technology](#)

- i. Secondary component addressed: Choose an item.
- ii. Additional component(s) addressed:
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [HIT: Patient engagement](#)

- i. Additional subcomponent(s) addressed:

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

Successful engagement enables patients to see themselves as influential in their own health outcomes, to actively exchange information with their care providers, and to be knowledgeable and empowered to make health-related decisions. Patients who proactively engage in their health tend to have less utilization of the health care system as well as improved experiences. Health Information Technology (HIT) supports making such data sharing and engagement activities a reality.

While PacificSource is relatively knowledgeable about the technological capability of the largest providers in the network, a broader and more formal assessment of [HIT: Patient engagement](#) capabilities has not been conducted.

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

In 2019, PacificSource will focus on collecting, aggregating, and analyzing data related to provider partners' health information technology strategies for patient engagement. An evaluation of the solutions used, including discontinued, active, and planned activities, will be captured and reviewed to help create a representative sample of the HIT found at the clinic level within the CCO.

The scope of the project will include engaging a sample of Medicaid provider partners, representing a cross section of organizational size, to collect information about the HIT in use. Outreach will include physical health, behavioral health, and dental care partners. The content in the assessment will include questions about patient access to the following: a patient portal, personal health information, education materials, alerts, appointment scheduling, bill payment, secure messaging, patient communities, and telemedicine. Also, we will ask about provider use of patient-generated data.

The last questions will relate to whether the clinic is meeting its current strategic vision for HIT adoption, a review of any barriers to achieving HIT goals, and eliciting technical assistance needs.

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

**Activity 1 description** Develop and conduct an HIT patient engagement survey to targeted physical health, behavioral health, and dental care providers.

Short term or  Long term

**Monitoring activity 1 for improvement:** A survey will be developed and distributed to provider partners.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
A formal assessment of provider capacity has not been conducted.	An assessment tool or survey is developed.	6/2019	Distribute assessment tool to physical health, behavioral health, and dental care providers.	9/2019

**Activity 2 description:** Determine a baseline for use of HIT for patient engagement among targeted providers.

Short term or  Long term

**Monitoring activity 2 for improvement:** Returned assessments will be shared with analytics department for initial baseline creation.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Baseline not yet established.	Baseline for use of HIT for patient engagement has been determined.	11/2019	Baseline for use of HIT for patient engagement has been determined.	11/2019

**Activity 3 description:** Engage stakeholders in creating an action plan for technical assistance for clinics.

Short term or  Long term

**Monitoring activity 3 for improvement:** CCO staff leading HIT work will engage internal and external stakeholders to review baseline data from Activity 2 and define strategy and options for future technical support.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
A plan for providing technical assistance information and supports is not established.	A tentative plan has been created to provide technical assistance to clinical care sites on patient engagement using HIT.	12/2019	A final plan has been documented for technical assistance on patient engagement using HIT, including collateral to be shared with clinical care site.	06/2020

**A. Project or program short title:** [Special Health Care Needs Project #1: Oral Health Care for Adults with Diabetes](#)Continued or slightly modified from prior TQS?  Yes  No, this is a new project or program**B. Primary component addressed:** [Special health care needs](#)

- i. Secondary component addressed: [Value-based payment models](#)
- ii. Additional component(s) addressed: [Integration of care](#)
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [HIT: Health information exchange](#)

- i. Additional subcomponent(s) addressed: [HIT: Analytics](#)

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

Optimal management of chronic physical health conditions includes preventing or correcting oral diseases. In addition, poorly controlled physical health conditions can worsen a patient's oral health. Barriers to optimal dental care for people with chronic disease have included dental teams' not knowing about a member's needs prior to the member seeking care and having no sources of health status information beyond the patient's report. In addition, physical health providers frequently do not address oral health with their patients and, when they do, typically do not have the information that they need to know the member's oral health visit history or dental care provider. For these reasons, many members with special health care needs like diabetes do not establish care with a dental home or do not disclose they have a chronic condition. As a result, they do not receive the coordinated and specialized care they need.

Dental service utilization rates for adults with diabetes remain low. Encouraging yet insufficient progress was made in 2018 with the initiation of a payment arrangement tied to dental visits with diabetic members. In addition, over the course of 2018, PacificSource developed the Dental Care for Diabetics report to provide information about dental visits by PCP and by clinic. Physical health providers and clinics are the intended recipient of this information so that the provider can more effectively integrate oral health into overall care. However, it hasn't yet been determined how best to introduce and routinely deliver this report to providers. Finally, dental and physical health providers continue to need mechanisms to effectively communicate with each other to coordinate or arrange care, collaborate on care plans, and ensure needed care is received. The persistent lack of a viable information technology solution that enables inter-professional collaboration is arguably the biggest barrier to achieving coordination, collaboration, and integration.

The Reliance eReferrals platform was released to the Columbia Gorge area last year and has been adopted by public health, four behavioral health clinics, and about 41 physical health providers in the region. Two dental clinics have adopted the eReferrals platform. Adoption of the community health record component has been more limited. At present, the Reliance community health record has been adopted by public health, five physical health clinics, two dental clinics, and one behavioral health program. The release of a new version of the community health record software is planned for 2019 and is expected to increase the number of clinics using this component of the Health Information Exchange.

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

PacificSource will continue using [Value-based Payment models](#) (VBP) to incentivize delivery of dental care to members with diabetes, a population with [Special health care needs](#). This work complements

the new Quality Incentive Measure addressing oral evaluations for diabetic members and builds on the 2018 long-term TQS strategy to use VBP to incentivize each Dental Care Organization (DCO) to achieve performance improvement targets and, ultimately, the region’s performance benchmark on this measure. A financial performance withhold tied to reaching target or benchmark will facilitate continued DCO engagement.

PacificSource will disseminate the Dental Care for Diabetics report to primary care providers to advance Integration of care and coordination. This activity builds on 2018 HIT: Analytics work, which developed a report that provides physical health providers with dental visit information for their patients. Now that report development is complete, PacificSource must determine how to efficiently deliver the report to provider clinics and create an ongoing dissemination process in partnership with key stakeholders.

Finally, PacificSource will promote the adoption of HIT: Health information exchange (HIE) via the use of electronic referrals platform and community health record functions of the Reliance HIE. Adoption of an eReferrals platform will enable inter-professional collaboration and care coordination between physical and dental providers. Adoption of the community health record will facilitate access to important clinical patient information such as problem lists, medication lists, and visit history.

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

**Activity 1 description:** Leverage VBP strategies to increase the percentage of diabetic members who receive a comprehensive or periodontal exam during the measurement period.

Short term or  Long term

**Monitoring activity 1 for improvement:** Monitoring will occur via a dashboard that displays rolling 12-month and year-to-date performance on diabetic members with dental visits. This dashboard is refreshed monthly and shared with each DCO.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Columbia Gorge CCO baseline for the region overall and each contracted DCO:  Regional: 30.40% Advantage: 26.10% Capital: 24.60% ODS: 40.50%	Baseline and improvement target for each DCO is determined.  Each DCO meets the CCO benchmark of 50% or its DCO-specific improvement target.  Regional: 33.40% Advantage: 29.10% Capital: 27.60% ODS: 43.50%	06/2019  12/2019	CCO benchmark remains at 50%, and all DCOs perform at or above this level.	12/2020

**Activity 2 description:** Configure and implement an analytics process to deliver the Dental Care for Diabetics report to physical health provider groups that also receive the Member Insight report. Meet with provider groups to introduce the process.

Short term or  Long term

**Monitoring activity 2 for improvement:** CCO will track the number of clinics that receive the Member Insight report and also receive the Dental Care for Diabetics report.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
0 clinics that receive the Member Insight report also receive the Dental Care for Diabetics report.	4 clinics that receive the Member Insight report also receive the Dental Care for Diabetics report.	12/2019	4 clinics that receive the Member Insight report also receive the Dental Care for Diabetics report.	12/019

**Activity 3 description:** Work with various internal and external stakeholders to encourage adoption of the Reliance HIE eReferrals platform and community health record to enable care coordination and inter-professional collaboration. Facilitate product awareness by arranging demonstrations of the eReferrals and community health record to provider clinics and groups.

Short term or  Long term

**Monitoring activity 3 for improvement:** The CCO will track a number of measures of improvement: number of dental clinics, DCOs, and physical health clinics enrolled with the Reliance eReferrals platform and community health record; number of eReferrals generated by dental clinics and physical health clinics; and submission of dental claim data into the Reliance system. Because enrollment of physical health clinics and organizations in eReferrals is already high, no additional targets or benchmarks will be monitored for those organizations.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Number of organizations enrolled with the Reliance eReferrals platform: 2 dental clinics 0 DCOs	Number of organizations enrolled with the Reliance eReferrals platform: 4 dental clinics 2 DCOs	12/31/2019	Number of organizations enrolled with the Reliance eReferrals platform: 6 dental clinics 3 DCOs	12/31/2020
Number of organizations enrolled with the Reliance community health record: 2 dental clinics	Number of organizations enrolled with the Reliance community health record: 4 dental clinics	12/31/2019	Number of organizations enrolled with the Reliance community health record: 6 dental clinics	12/31/2020

0 DCOs 5 physical health clinics	2 DCOs 8 physical health clinics		3 DCOs 10 physical health clinics	
0 referrals generated electronically by dental clinics and sent to physical health clinics. 0 referrals generated electronically by physical health clinics and sent to dental clinics.	20 referrals generated electronically by dental clinics and sent to physical health clinics. 20 referrals generated electronically by physical health clinics and sent to dental clinics.	12/31/2020	20 referrals generated electronically by dental clinics and sent to physical health clinics. 20 referrals generated electronically by physical health clinics and sent to dental clinics.	12/31/2020
No dental claims data is flowing into the Reliance system.	Dental claims flow into the Reliance system.	12/31/2019	Dental claims flow into the Reliance system.	12/31/2019

**A. Project or program short title:** [Grievance & Appeal Project #1: Using Appeals and Grievances Data to Improve Care](#)Continued or slightly modified from prior TQS?  Yes  No, this is a new project or program**B. Primary component addressed:** [Grievance and appeal system](#)

- i. Secondary component addressed: [Access](#)
- ii. Additional component(s) addressed:
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [Access: Timely access](#)

- i. Additional subcomponent(s) addressed:

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

In 2018, PacificSource made significant improvements in reporting and reviewing appeal and grievance data. An internal workgroup was established to review the data, identify trends, and develop strategies to address identified issues. During this process, the workgroup determined that complaint data categorization was subjective, so the workgroup developed and adopted a process to ensure data was categorized in a standard way.

PacificSource also conducted an analysis of systems in place to demonstrate trends in appeal and grievance data and implement of interventions to respond to concerns. Through this process, PacificSource identified a need to continue improving data collection, data integrity, and collaboration with subcontractors and internal teams.

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

In 2019, PacificSource will build on the prior year's work. The workgroup will continue to meet monthly to review data on our [Grievance and appeal system](#), using the improved categorization process and including particular focus on [Access: Timely access](#). The data will allow the group to develop and deploy targeted interventions. Starting this year, the workgroup will adopt a closed-loop process, reviewing the previous month's monitoring results and the status of previously-identified improvement activities. The workgroup anticipates increased dialog among internal teams and more engagement with subcontractors and providers as a result of this higher level of monitoring.

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

**Activity 1 description:** Develop process for periodic monitoring of identified improvement activities and progress towards goals with appeals and grievances workgroup, Provider Network staff who conduct targeted intervention with contracted providers, and CCO's quality committees.

Short term or  Long term

**Monitoring activity 1 for improvement:** An appeals and grievances dashboard will support reporting on progress and outcomes for monthly meetings and will inform interventions conducted by Provider Network. The dashboard will be shared quarterly with the Quality Improvement Committee and the Clinical Quality and Utilization Management Committee.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Dashboards are in development.	Dashboard is developed.	6/1/2019	Dashboard reviewed on identified schedule.	12/1/2019

**Activity 2 description:** Update IT systems to automate integration of grievance and appeals and grievances data from subcontractors with data collected by PacificSource.

Short term or  Long term

**Monitoring activity 2 for improvement:** The major milestones in the process to integrate data submitted by subcontractors will be tracked.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Subcontractor data is not currently integrated into PacificSource data sets.	IT system integrates appeals and grievances data from subcontractors.	06/2019	Integrated data is used to populate Appeal and Grievance dashboard.	10/2019

**Activity 3 description:** Establish a sustained monitoring process to periodically review the appeals and grievances processes delegated to subcontractors.

Short term or  Long term

**Monitoring activity 3 for improvement:** The major milestones in the process to develop policy and process for monitoring subcontractors will be tracked.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
A policy and process for reviewing subcontractor data and performance has not been documented.	A policy and process for reviewing subcontractor data and performance has been developed and approved.	6/1/2019	A policy and process for reviewing subcontractor data and performance has been developed and approved.	6/1/2019

**A. Project or program short title:** [Severe and Persistent Mental Illness \(SPMI\) Project #1: Reducing ED Utilization for Members With Severe and Persistent Mental Illness](#)

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

**B. Primary component addressed:** [Severe and persistent mental illness](#)

- i. Secondary component addressed: [Special health care needs](#)
- ii. Additional component(s) addressed: [Health information technology](#)
- iii. If *Integration of Care* component chosen, check all that apply:
  - Behavioral health integration
  - Oral health integration

**C. Primary subcomponent addressed:** [HIT: Health information exchange](#)

- i. Additional subcomponent(s) addressed:

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

Clinics participating in the Columbia Gorge CCO have been working to reduce the rate of emergency department use by people with chronic mental illness by using health information technology to identify patients using these services. They have done this by using [Health Information Technology](#) to access data from the Emergency Department Information Exchange, a specialized example of [HIT: Health information exchange](#). It allows clinics to receive reporting on their patients who meet the OHA definition of a member with [Severe and persistent mental illness](#) (SPMI) and the subset of those SPMI members with ED visits. These members are a category of those with [Special health care needs](#) and merit continued focus. The following clinics in the Columbia Gorge have implemented this technology solution: One Community Health, Mid-Columbia Outpatient Clinics, Columbia Gorge Family Medicine, Deschutes Rim Health Clinic, and the region's community mental health program, Mid-Columbia Center for Living.

While many clinics have set up access to data feeds about emergency department utilization, they have struggled to receive and use the information in an effective way. Moving forward, we plan to support clinics to develop workflows, standardize how they respond to the information they receive from health IT, and learn to adjust their workflows based on experience.

**E. Project or Program Brief Narrative Description:**

In 2019, PacificSource will work with clinics to develop workflows that specify how clinic staff utilize HIE data to identify members and deploy targeted interventions. PacificSource will select two key providers, one specialty behavioral health and one primary care, to develop and pilot processes that make efficient use of HIT reporting function and clinic resources. CCO staff will document specific work flows and how they change over time, as well as track the range of interventions provided and ED utilization in the target population.

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

**Activity 1 description:** Identify at least one primary care and one specialty behavioral health clinic that will develop and refine workflows that utilize HIT to facilitate timely identification of members with SPMI who have recently had an emergency department visit. The goal of the workflows will be to use the HIE data to provide identified members with outreach, education, care coordination, and access to care in non-emergent settings.

Short term or  Long term

**Monitoring activity 1 for improvement:** The CCO will track the number of clinics identified to pilot workflows and their progress in testing and refining workflows.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
No clinics have been identified to pilot workflows.	At least one primary care clinic and one specialty behavioral health clinic have agreed to pilot workflows.	9/2019	At least one primary care clinic and one specialty behavioral health clinic have developed and are actively testing workflows.	12/2019

**Activity 2 description:** Monitor and report the rate of emergency department visits by people with SPMI to participating clinics.

Short term or  Long term

**Monitoring activity 2 for improvement:** CCO analytics staff will use claims data to establish a baseline for emergency department visits by members with SPMI for provider groups that are piloting workflows and will establish a process for reporting this rate periodically for the group’s patients.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Establish baseline rates of emergency department use by members with SPMI.	Review baseline data with participating clinics.	09/2019	Monthly reporting of emergency department use by members with SPMI continues.	12/2019