UMPQUA HEALTH ALLIANCE

Transformation & Quality Strategy

UMPQUA HEALTH ALLIANCE CCO

2019

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:

Umpqua Health Alliance (UHA) is the CCO working closely with the Oregon Health Authority to manage Medicaid members that reside in Douglas County. UHA currently covers approximately 26,400 lives in Douglas County including the initial Medicaid population, the Affordable Care Act expansion members and a number of Dual Eligible members managed jointly with ATRIO, our partner in the Medicare Advantage program. Our equity partners are DCIPA, The Physicians of Douglas County, and Mercy Medical Center. UHA contacts with MedImpact for Pharmacy Benefit Management services.

UHA delegates dental services to the Advantage Dental, Non emergent transportation to Bay Cities Ambulance. For Behavioral Health services UHA has a longstanding contractual relationship with Douglas County's CMHP, ADAPT dba Compass; UHA's relationships with social and support organizations are centered around Compass.

UHA's Quality Improvement program is ongoing and comprehensive, dealing with a full range of services focused on:

- Quality performance metrics defined by the OHA
- Utilization management and prior authorization
- Case management and care coordination
- Close to 100% participation in the Primary Care Patient Centered Medical Home model (PCPCH)
- Five [internal] Performance Improvement Projects (PIPs), and the Statewide 2019 PIP
- Appeals and Grievances system
- Member satisfaction and CAHPS
- Active participation in the ongoing OHA Transformation & Quality Strategy.
- Special quality projects focused on specific community/membership:
    - New Day, a care coordination effort designed to assist pregnant members with substance use disorder, spousal abuse, and peri/postpartum depression.
    - Transitional Care, a UHA affiliated program that provides care management for those members with chronic disease, following hospitalization, using the Coleman Model of Care Management.
    - The New Beginnings is UHA's newest program which focuses on prenatal to age five populations. Program's framework supports the goal that health care providers and community driven programs work together to achieve better health outcomes for our youngest members.
    - UHA, has setup a program to encourage service providers to adopt National CLAS Standards.

The Leadership Team at Umpqua Health directs the spectrum of initiatives described in the UHA Transformation and Quality Strategy (TQS). Senior management assist in the development and implementation of all quality programs and oversee all programs focused specifically on addressing the social determinants of health, ensuring health equity and avoiding the pressures of structured racism within the practicing community. All quality initiatives including the performance improvement projects and TQS receive oversight and direction from the UHA board.

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):

Umpqua Health Alliance has formulated reporting criteria for Decision Support to query and identify unique members for targeted clinical engagement and population health management. The team utilizes the reporting capabilities of Milliman's MedInsight for Mara Risk scoring, and PreManage when working with Emergency Department (ED) providers. UHA also utilizes the inteligenz software package to generate provider performance report cards and the Coordinated Care Organization's (CCO) Metrics Manager to manage care gaps. In addition, we have a provider facing population health team who continuously interface with providers and their employees to discuss progress in completion of all CCO metrics, attest to PCPCH performance status, and discuss new programs to gauge provider interest.

The Quality Advisory Committee and the Clinical Advisory Panel meet quarterly, to oversee all ongoing quality initiatives under the TQS. All of the group findings report up to senior management and the Umpqua Health Alliance Board of Directors.

All quality projects are assessed utilizing the Plan, Do, Study, Act (PDSA) methodology since it serves our needs for action-oriented learning. It is also the model utilized by the Institute for Healthcare Improvement and is well recognized as a best scientific method.

The UHA Board has a strong link with our Community Advisory Council (CAC). The CAC chairperson is a member of the UHA Board, and attends all UHA board meetings. The chairperson also provides a monthly report to the UHA Board and shares any pertinent information learned at UHA Board meetings with CAC members.

The CAC also plays an integral role in transformation and quality activities. Members hear regular presentations on UHA projects and programs, where they have the opportunity to discuss their thoughts and concerns with UHA personnel. Their extensive knowledge of a wide range of UHA activities, coupled with their experiences as both consumers and community leaders, puts CAC members in a unique position to provide input on transformation and quality activities. Traditionally, CAC members have advised UHA on all Transformation Plan reports.

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

UHA's Community Health Improvement Plan (CHIP) is the guiding document for much of the CAC's work. CAC members are tasked with identifying community programs and projects that align with UHA's CHIP and overall mission. Through the application process, projects are chosen through the use of a scorecard that asks CAC members to evaluate an application through the lens of UHA's CHIP priority areas. Once these projects and programs are selected for funding, the CAC continues to work with project leaders to identify ways their programs can successfully address the TQS.

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:

Within the last year the UHA approach to managing this rural population has expanded to engage a broader range of health care providers, community –based organizations, foundations, behavioral health agencies and surrounding CCOs. Umpqua Health Alliance has transformed the approach to patient care beyond the scope of physical medicine to embrace the impact of behavioral health disorders, poor dental health and the complex collection of social determinants of health that create significant challenges in delivering on the goal of the Triple Aim in health care. UHA has especially been successfully in contracting with the Cow Creek Tribal Clinic; incorporating Tribe's Sovereign Language within the contract. UHA's Quality department is assisting the Tribal clinic to attain recognition for the highest PCPCH tier, and UHA is working with the Mercy Foundation to create a support program for tribal families with kids that have Type-I diabetes.

New innovative projects either underway or on the list of goals for 2018 include:

- A partnership with National Association of Mental Illness (NAMI) – Douglas County chapter to establish and operate the Chadwick Clubhouse. The Chadwick Clubhouse offers a place that provides quality of life and progress toward recovery for members. The Clubhouse Model of Psychosocial Rehabilitation is proven to decrease hospitalizations and incarcerations for members. The Clubhouse Model is built around recovery through meaningful work, and has been proven to lead to improved employability and re-integration into the community for members.
- A partnership with Douglas Public Health Network and Douglas Oral Health Coalition will provide oral health education to pregnant women, focusing on how oral health care during pregnancy can impact their child's oral health. Participants will also be given an oral health kit, including a three-month supply of xylitol.
- UHA contributed significant funding to Adapt, dba SouthRiver Community Health Center to co-locate primary care services at Adapt's behavioral health facility in Roseburg. This funding will allow SouthRiver to establish a primary care provider office within Adapt's Roseburg facility, addressing barriers to medical care for people with behavioral health care needs.
- UHA, in partnership with our area Parenting Hub, Early Learning Hub and Kindergarten Partnership and Innovation programs, is sponsoring parenting education opportunities. The parenting education opportunities aim to reach parents of children 0-5 and provide strategies

for these parents to develop healthy relationships with their children. These education opportunities strive to increase parents' understanding of resilience and healthy interactions with their children.

- UHA contributed funding to Umpqua Community Health Center, a Federally Qualified Health Center in Douglas County to establish an additional clinic in Douglas County. UCHC is establishing a clinic in northern Douglas County, an area which is traditionally underserved and has often been identified as the highest unmet need area in the state. The clinic is scheduled to open in summer 2019 in Drain.
- UHA is participating in a collaborative effort with Phoenix Charter School, Douglas CARES, and the Battered Persons' Advocacy to develop sustainable access and case management of school-based trauma-informed intervention, social-emotional education, skill building, and therapeutic services to children and families who attend Phoenix Charter School. The Rise Up Resilience program will provide and sustain a culture of coordinated cross-service sector mental health and healthy lifestyles services to a youth population with historically low access and high need.
- Umpqua Health Alliance is working with Valiant Seed to oversee the construction of a tiny home village in Roseburg. UHA is providing funding for the initial construction to prepare the land for four tiny homes that will be used to house four housing-unstable individuals, with a specific focus on providing housing for veteran female trauma survivors. Construction on the tiny home village will be complete by the end of 2019.
- UHA is collaborating with Adapt to present a Cultural and Linguistic Appropriate Services presentation and workshop in Douglas County. The presentation and workshop aim to add skills and knowledge that will improve provider effectiveness and engagement with clients and patients. The CLAS workshop will help enhance patient care in both a clinical and non-clinical setting by increasing empathy and helping providers set aside biases, and helping providers understand their own biases in order to make the necessary changes to effectively reach out and connect with their clients and patients.
- UHA provides funding to support the Friendly Kitchen/Meals on Wheels of Roseburg in their mission to feed Douglas County residents who are most at risk of not being able to access healthy, nutritious foods. The Friendly Kitchen/Meals on Wheels of Roseburg provides a nutritious meal to seniors and people with disabilities five days a week, either delivered to the person's home or provided at a congregate dining site. In addition, the Friendly Kitchen/Meals on Wheels of Roseburg provides two extra meals to sustain clients during the weekend for the clients identified as having the greatest need. Friendly Kitchen/Meals on Wheels anticipates producing as many as 62,400 meals for seniors and people with disabilities in 2019.

B. Review and approval of TQS

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

The entire program is reviewed/evaluated annually to determine whether certain projects merit continuation or whether new direction from the OHA signals project planning focus on new areas. The annual review falls under the Director of Quality Improvement and the VP of Clinical Strategy and Operations.

The review shall include a complete analysis of the entire quality program menu to include:

- Member complaints to determine adverse trends that require correction.
- Ensure members receive second opinions from a qualified professional for behavioral, dental, and physical health care as indicated in UHA's policies and member handbook.
- Status of current PIPs and value decisions to continue or to retire the PIP. Consideration to be replaced for a more meaningful effort based upon OHA requests or current organizational "hot topic".
- Current status of the CCO performance metrics.
- Review of special programs that focus on special needs members especially those with SPMI or other high MARA Risk scores.
- Review of delegated entity performance as it reflects on overall plan quality performance and/or future planning considerations.

Goals of the Annual Evaluation include:

- Resource allocation for budgetary planning
- Corrective Action Plan development where indicated
- Improve member service related QAPI directives
- Realign incentives for the coming year relative to all CLAS /cultural considerations
- Identify project champions for special recognition
- Findings to serve as a basis for future planning through a guided analysis of areas that demand
    - Closer inspection
    - Refined structure
    - More ordered planning
    - Increased analytic investment
    - Increased staffing
    - Response to member needs/suggestions
    - Provider feedback
    - OHA guidance
    - Best practices and/or

C. OPTIONAL

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

UHA is one of 15 CCOs serving the Oregon Health Plan (OHP). Our Roseburg-based organization, located in Douglas County, covers an expansive 5,071 square miles and extends from the Cascade Mountains at elevations of over 9,000 feet to sea level at the Pacific Ocean with nearly 2.8 million acres of commercial forestlands. Douglas County encompasses the entire Umpqua River watershed, much of which flows through dramatic canyons and narrow valleys. Both the County's rugged terrain and federal landholdings limit development and according to the Douglas County website www.co.douglas.or.us the United States Forest Service and Bureau of Land Management administer more than 50% of the county's land. Due to federal administration, these lands are not

subject to local property taxes, greatly diminishing the local government's tax base. As a CCO, UHA is focused on expanding access, improving care, and reducing unnecessary costs across the clinical space for more than 26,000 Douglas County residents on the Oregon Health Plan.

Douglas County, Oregon is comprised of 12 incorporated cities including Roseburg – the county seat, Canyonville, Drain, Elkton, Glendale, Myrtle Creek, Oakland, Reedsport, Riddle, Sutherlin, Winston, and Yoncalla. As with many rural jurisdictions, the communities in Douglas County face the challenges of an in-migration of seniors as well as a baby boomer aging population, high rates of unemployment and poverty, few educational opportunities, high rates of tobacco and other drug use, and fewer local resources dedicated to addressing these and other known health risk factors. Nearly 70% of residents live outside the county seat of Roseburg, where most health services are provided. Douglas County is a federally designated medically underserved area, as well as a primary care shortage area.

The economy in Douglas County has traditionally been led by the timber and wood product industry. Even through recent economic downturns, timber and wood products are still one of the biggest sources of employment in the area. Healthcare is also a leading industry, with CHI Mercy Health, including Mercy Hospital, being one of the largest employers in Roseburg. The Cow Creek Indian Tribe, City, County and Federal government including the VA healthcare system, agriculture, the warehouse industry, building trades and education are other large employers in the region. Stagnant economic recovery continues to greatly impact the lives of all Douglas County residents, as we see one of the highest poverty and unemployment rates in Oregon as of 2017 14.3% of the population lived in poverty. According to the 2017 US Census Bureau report, 17% of Douglas County residents over the age of 25 have a bachelor's degree or higher compared to the Oregon State average of 30.8%. The median household income is $44,000, compared with the Oregon State average of $53,075. Poverty especially impacts vulnerable populations and children fall in the high risk sub-population category. In 2018, OHA shared SDoH data for UHA's members 0-17 years old which points to prevalence of a high level of social determinant factors:

Prevalence by Social Complexity Factor by Age Group

	0-5 years		6-11 years		12-17 years	
Social Complexity Factor	**n**	**Prevalence**	**N**	**Prevalence**	**n**	**Prevalence**
Child abuse/neglect	224	3.14%	134	1.88%	123	1.72%
Foster care	362	5.07%	440	6.16%	513	7.18%
Limited English proficiency	202	2.83%	119	1.67%	86	1.2%
Mental Health - Child	454	6.36%	897	12.56%	1,290	18.06%
Mental Health - Family	1,723	24.12%	1,317	18.44%	1,094	15.32%
Parent death	19	0.27%	50	0.7%	82	1.15%
Parent disability	112	1.57%	124	1.74%	144	2.02%
Parental incarceration	640	8.96%	653	9.14%	575	8.05%
Poverty - Child	1,355	18.97%	1,356	18.98%	1,299	18.19%
Poverty - Family	1,304	18.26%	1,172	16.41%	999	13.99%
Substance Abuse - Child	13	0.18%	61	0.85%	332	4.65%
Substance Abuse - Family	1,102	15.43%	971	13.59%	865	12.11%

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through F until all TQS components and subcomponents have been addressed)

A. **Project or program short title**: CLAS Standards and Provider Network project #1: Educate Provider Network regarding National CLAS Standards

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

B. **Primary component addressed**: CLAS standards and provider network

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

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

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

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

E. Oregon's racial and ethnic populations are growing at a faster rate compared to the National, with one in five (21%) or 800,000 Oregonians identified as a person of color. The Oregon legislature started the process through its Oregon Senate Bill 21 Service Equity Subcommittee, which developed policy and program recommendations related to long-term services and supports for culturally underserved older adults and people with disabilities; in its Program and Policy Strategies report, the subcommittee recommended that relevant offices and service partners including the Oregon Health Authority and **coordinated care organizations (CCOs)**, collaborate to create a delivery system that is culturally and linguistically responsive. One of the proposed strategy for achieving this recommendation was to encourage service providers to adopt the National CLAS Standards.

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

The main program benefits will include the following;

- Improved patient-provider communication, satisfaction, engagement, and patient adherence to treatment
- Improved provider self-reported perception and understanding of cultural competence
- Increased ability to provide patient- centered care
- Cost savings through reduced patient- provider communication delays, inpatient and urgent care costs, and shorter hospital stays
- Cost savings through the reduction of liability issues

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

Activity 1 description (continue repeating until all activities included): Recommend cultural competence continuing education opportunities to UHA Network Performance Committee; maintain a list of OHA approved CE opportunities – Share CE/CME opportunities, with providers, in person and in monthly newsletter.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: The number of regulated health care professionals who completed cultural competence continuing education:

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	80	12/2019	100%	12/2020

Activity 2 description: Highlight CLAS standards on all engagements with providers

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Document number of engagements with providers related to CLAS:

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	100	12/2019	100%	12/2020

(Complete Section 2 by repeating parts A through F until all TQS components and subcomponents have been addressed)

A. Project or program short title: Access project #1: Member Services and Provider Network Adequacy

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

B. Primary component addressed: Access

iv. Secondary component addressed: CLAS standards and provider network

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

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

☐ Behavioral health integration ☐ Oral health integration

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

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

D. Background and rationale/justification:

At the beginning of 2018, UHA began sending quarterly surveys to network providers to collect each office's current availability and wait times for the relevant standards for its particular specialty or specialties. On a random basis, approximately two times a year, or on an as-needed basis, UHA performs secret shopper calls to determine if the office's current wait times align with the responses provided in its surveys. Additionally, UHA is looking at other solutions such as the ability to request schedules from practices from their practice management software to determine the time from initial member request for an appointment to the date of the appointment. UHA has a Provider Relations Director that visits the PCP and Specialist offices monthly to ensure that the efficiently measures of wait times are being meet. During visits the Provider Relations Director reviews the survey results while building a rapport with the office managers to ensure times align with the responses provided in its surveys.
UHA will monitor, at least biannually, availability standards as further outlined in our policy and procedures standards (N8 – Monitoring Network Availability Policy).

E. Project or program brief narrative description:

To ensure relevant standards for its particular specialty or specialties, UHA will send quarterly surveys to network providers to collect each office's current availability and wait times, and conduct random secret shopper calls to determine if the office's current wait times align with the responses provided in its surveys.

F. Activities and monitoring for performance improvement:

Activity 1 description: UHA intends to do the following beginning in 2018:

•Send quarterly surveys to network providers to collect each office's current availability and wait times for the relevant standards for its particular specialty or specialties.

•Randomly, approximately two times a year or on an as-needed basis, perform secret shopper calls to determine if the

office's current wait times align with the responses provided in its surveys.

☐ Short term or ☒ Long term

Activity 1 progress (narrative): In 2018, four (4) Access-to-Care surveys were emailed to contracted PCPs, Specialists, dental care and behavioral health providers.

Activity 1 progress (optional data, run charts, etc.):

How activity will be monitored	Baseline	Progress to date (current status or data point)	Target / future state	Target met by (12/2019)
Quarterly provider survey	PCP: 79% Specialists: 75% BH provd: 73% DCO: 100%	To be reported	Increase percentage to 50% of contracted PCP, specialists, and mental health providers	

Challenges in progressing toward target: Low response rate from Specialist offices
Strategies to overcome challenges: Implement a robust strategy, which will include increased frequency of reminders by email and phone.

A. Project or program short title: Grievance and Appeal System project #1: Access and Provider Interaction

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

B. Primary component addressed: Grievance and appeal system

vii. Secondary component addressed: Access
viii. Additional component(s) addressed: N/A
ix. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Access: Availability of services

iii. Additional subcomponent(s) addressed: **N/A**

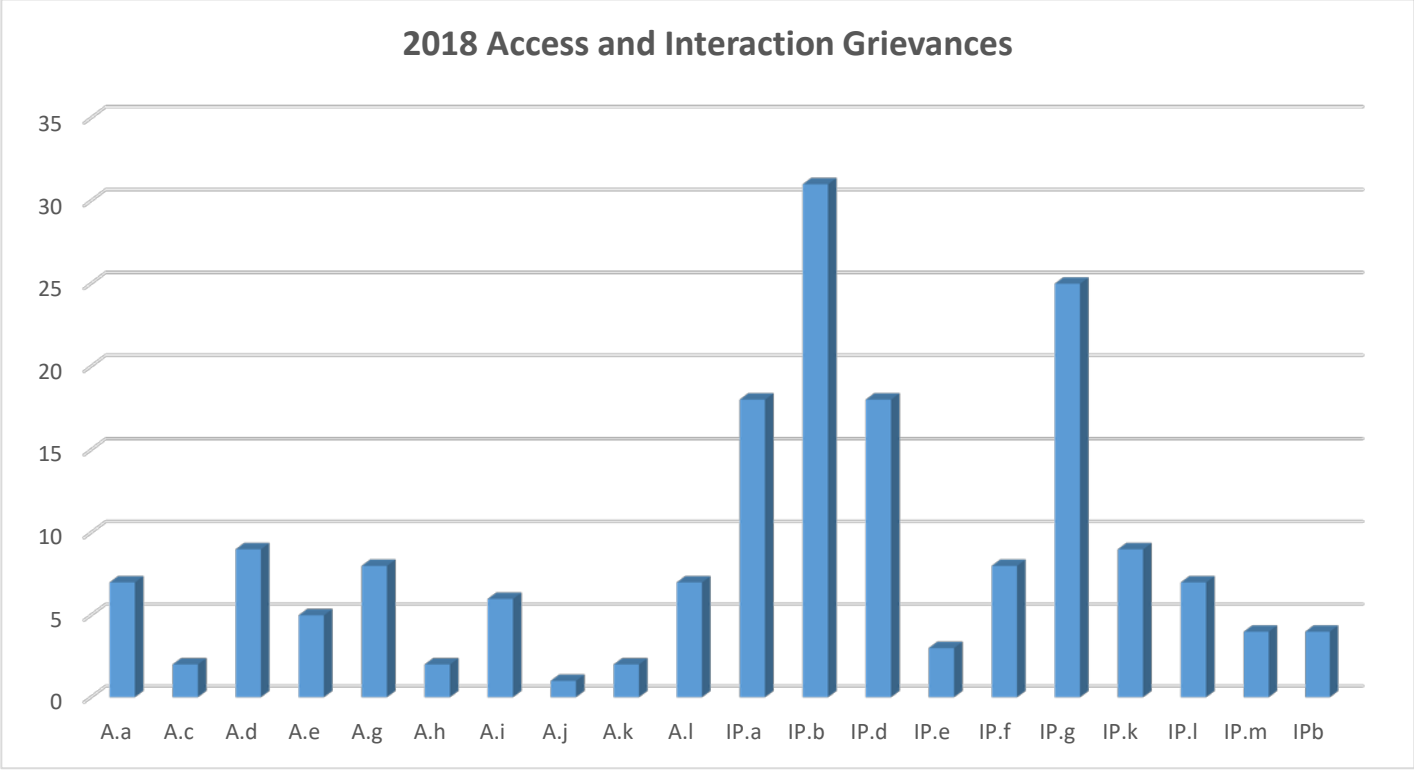
D. Background and rationale/justification:

UHA makes continual efforts to improve access to care. Appeal and grievance data is recorded consistent with Oregon Administrative Rule (OAR) 410-141-3230, 410-141-3235, and 410-141-3255. This information is monitored to identify trends and issues requiring additional interventions. Grievances regarding access and interactions with provider (or plan in some cases) are categorized according to state requirements under the following along with subcategories:

ACCESS - "A"
A.a) Provider's office unresponsive, not available, difficult to contact for appointment or information.
A.b) Plan unresponsive, not available, difficult to contact for appointment or information.
A.c) Provider's office too far away, not convenient
A.d) Unable to schedule appointment in a timely manner.
A.e) Unable to be seen in a timely manner for urgent/emergent care
A.f) Provider's office closed to new patients.
A.g) Referral or 2nd opinion denied/refused by provider.
A.h) Referral or 2nd opinion denied/refused by plan.
A.i) Provider not available to give necessary care
A.j) Eligibility issues
A.k) Female or male provider preferred, but not available
A.l) NEMT not provided, late pick up w/missed appointment, no coordination of services

A.m) Dismissed by provider as a result of past due billing issues
A.n) Dismissed by clinic as a result of past due billing issues
INTERACTION WITH PROVIDER OR PLAN - "IP"
IP.a) Wants to change providers; provider not a good fit.
IP.b) Provider rude or inappropriate comments or behavior
IP.c) Plan rude or inappropriate comments or behavior
IP.d) Provider explanation/instruction inadequate/incomplete
IP.e) Plan explanation/instruction inadequate/incomplete
IP.f) Wait too long in office before receiving care
IP.g) Member not treated with respect and due consideration for his/her dignity and privacy
IP.h) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.
IP.i) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity
IP.j) Member has difficulty understanding provider due to language or cultural barriers.
IP.k) Lack of communication and coordination among providers
IP.l) Dismissed by provider (member misbehavior, missed appts. etc.)
IP.m) Dismissed by clinic (member misbehavior, missed appts. Etc.)

These categories have historically served as indicators for issues that may require outreach, member/provider education, or recommendations/changes regarding the provider network. Multiple categories may apply to a single grievance and would be logged appropriately to include all applicable categories and subcategories; the number of reportable grievances will always exceed the number of unique members associated with the grievances. In 2018, UHA received 176 grievances related to Access and Interactions.



E. Project or program brief narrative description:

UHA will review grievance data on a quarterly basis and follow internal improvement processes to reduce the number of access and interactions grievances in 2019.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Data is reported on a quarterly basis and will be analyzed for access and interaction to identify trends and opportunities for improvement. Recommendations and outreach will be done as appropriate. Success will be measured through the reduction of grievances in these categories over the course of 2019.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (12/2019)	Benchmark / future state	Benchmark met by (MM/YYYY)
176 total grievances related to access and interaction in 2018.	Reduce 2019 total grievances related to access and interaction by 5%.	12/31/2019 (data not reportable until after 3/15/2020).	162.2 (5% reduction from 2018 baseline) grievances related to access and interaction.	Add text here.

A. Project or program short title: PCPCH Project #1: Improve Population Health

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

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

x. Secondary component addressed: Value-based payment models

xi. Additional component(s) addressed: HIT

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

☐ Behavioral health integration ☐ Oral health integration

D. Primary subcomponent addressed: HIT: Patient engagement

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

Background and rationale/justification: UHA has a robust quality structure which supports the state-level CCO Health System Transformation plan. UHA's policy to achieve Health System Transformation is based on expanding the implementation of the CCO Model-of-Care, i.e. the PCPCH model. UHA has a pay for performance (P4P) program in place that encourages its PCP network to attain the Tier-5 PCPCH recognition from the OHA Transformation Center.
To achieve maximum PCPCH Tier-5 recognition UHA's QI department facilitates recruitment of PCP practices to engage in the Technical Assistance provided through OHA's Transformation center. We also provide support for PCPCH recognition in the form of workflow analysis and documentation.

E.

F. Project or program brief narrative description:

UHA Quality department has developed a PCPCH training manual, which will be used as a tool to train and assist the Clinics in their journey to attain the highest PCPCH tier recognition.

G. Activities and monitoring for performance improvement:

Activity 1 description: Increase the number of assigned members to providers with a Tier 4 or higher recognition

☐ Short term or ☒ Long term

OHA Transformation and Quality Strategy (TQS) **CCO:** Umpqua Health Alliance

How activity will be monitored	Baseline	Progress to date (current status or data point)	Target / future state	Target met by (12/2019)	Benchmark / future state	Benchmark met by (MM/YYYY)
Increase in assigned members to PCPCH Tier 4 or higher providers	Tier 4+: 55% of members	Tier 4+:	Tier 4+: 75% of members	12/2019	Add text here.	Add text here.

A. **Project or program short title**: SHCN project #1: Decrease avoidable readmissions by streamlining Transitions of care (TOC).

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

B. **Primary component addressed**: Special health care needs

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

xiv. Additional component(s) addressed: HIT

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

X Behavioral health integration X Oral health integration

C. **Primary subcomponent addressed**: HIT: Patient engagement

v. Additional subcomponent(s) addressed: HIT: HIE

Background and rationale/justification: In the 4th quarter of 2017, Umpqua Health Alliance (UHA) established a

Transitional Care (TC) department to work specifically on hospital readmission reduction. The first few months centered on care coordination and selection of an effective model, that could serve as the foundation of a long-term program. In March 2018, the transitional care department launched a three-prong approach for readmission reduction. The three areas of focus include the Eric Coleman *Care Transition Interventions* (CTI) coaching model, care coordination that involves UHA and MMC nurse case managers and discharge planners, and access to provider services.

1). Health coaching using the *Care Transitions Interventions* model is the first aspect of our TC program at UHA. This model was selected because it is uniquely focused on coaching patients and caregivers to develop the skills, confidence, and tools they need to assert a more active role in their care. Coleman model research revealed that patients who received CTI coaching were shown to be significantly less likely to be readmitted to the hospital and the effects were sustained for a minimum of five months after the end of the one-month intervention period. The model incorporates two face-to-face encounters with the patient, one during the hospitalization and a second in the home after discharge. After the home visit, the interventions continue with three follow up phone calls at various intervals over the next three weeks.

High-risk patients are identified by using a validated tool to determine 30-day readmission risk allowing the staff to focus appropriately. After medical record review, staff conducts the hospital visit, which provides an introduction of the program and sets up the intention to promote a smooth transition to the next care setting. During the face-to-face visit, the following tasks are completed:

- Conduct a medication reconciliation by reviewing of pre-hospitalization medications, hospital medications and constructing a complete medication list.
- Discuss ongoing medication management.
-

- Explain the use of a Personal Health Record (PHR) and emphasize the importance of bringing the PHR to all medical appointments.
- Discuss self-management of conditions by reviewing the red flags associated with the patient's condition(s) worsening and identifying what action to take if they occur.
- Address the social determinants of health.
- Refer to appropriate mental health services as needed.
- Coordinate care with the primary care home.

2). Care coordination is the second aspect of our TC program. Care coordination includes efforts for a wide variety of patients and is not limited to those in the coaching program. A mainstay of care coordination is the interaction with UHA and MMC nurse case managers and discharge planners. It is an essential element of a smooth and thorough transition to the next care setting. Work in this area includes:

- Addressing the social determinates of health such as homelessness, ability to communicate by phone, and facilitation of transportation to follow up care.
- Facilitate referral to local Aging Persons and Disability for screening of multiple types of services including caregiver's resources, faculty placement and other community resources.
- Coordinating with mental health and substance use facilities in our area.
- Assisting in scheduling follow up appointments and facilitating the establishment of a primary care medical home.

3). Access to provider services is the third aspect of our TC program. Frequently patients do not have either a primary care provider or timely access to theirs. In those cases, TC has a nurse practitioner who can see the patient in a timely manner. A focus of those visits is to complete medication reconciliation and address any barriers to getting medications filled and purchased. Another area of focus is to arrange follow up care at their current medical home or the new one. Additionally, medical needs are addressed during these visits.

Since inception, key elements of the program were established including a methodology for patient selection, a consistent approach to delivery of the program and development of a quality metric tracking system.

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

This program focuses on Transitions-of-Care (TOC); to impact avoidable re-admissions.

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

Activity 1 description: Increase the number of assigned members to providers with a Tier 4 or higher recognition – UHTC plans is to add another nursing position to increase the volume of patients receiving our TC services. UHA leadership is working with local substance use and mental health organizations to improve the access to their services. TC has started meeting with local clinics and presenting data of the percentage of follow up visits within seven days after hospital discharge. We are making progress. In 2017 the average percentage for follow up within seven days was 27.8 and to date in 2018 it is 41.2. We will continue to stress the importance of timely post-hospital discharge follow up visits.

F.

☐ Short term or ☒ Long term

How activity will be monitored	Baseline	Progress to date (current status or data point)	Target / future state	Target met by (12/2019)	Benchmark / future state	Benchmark met by (MM/YYYY)
Monitored quarterly.	Average of 2017 & 2018: 12.6%		10% reduction of all-cause readmission	End of the Q4 of 2019	Program began in Q2 2018 and it is felt one quarter is not sufficient time to see a reduction in readmission.	Add text here.

H. **Project or program short title**: SPMI project #1: Emergency Department Diversion – Focused coordinated care for frequent Emergency Department utilizers with SPMI

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

I. **Primary component addressed**: Utilization review

xvi. Secondary component addressed: Special health care needs

xvii. Additional component(s) addressed: Integration of Care

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

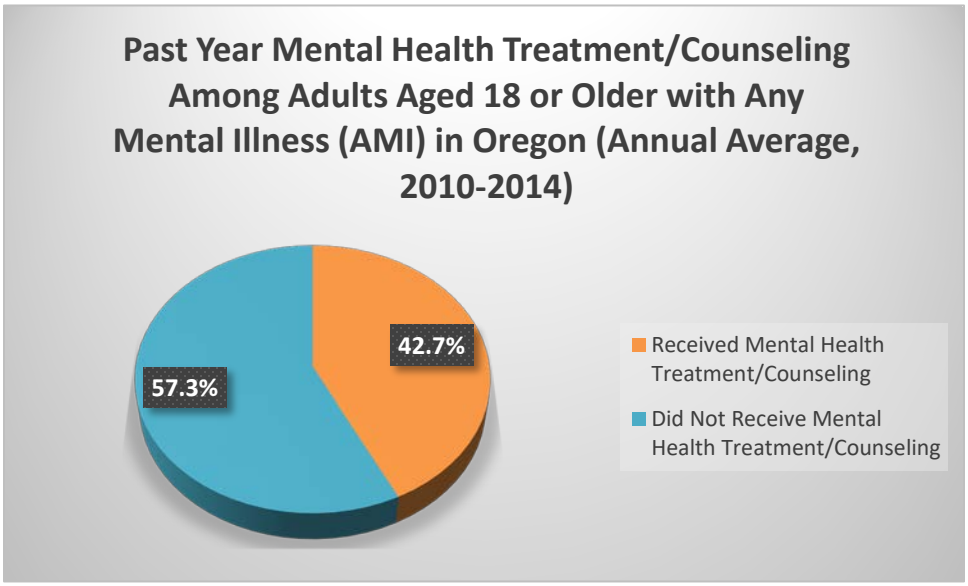
☒ Behavioral health integration ☒ Oral health integration

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

vi. Additional subcomponent(s) addressed: Access: Timely access

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

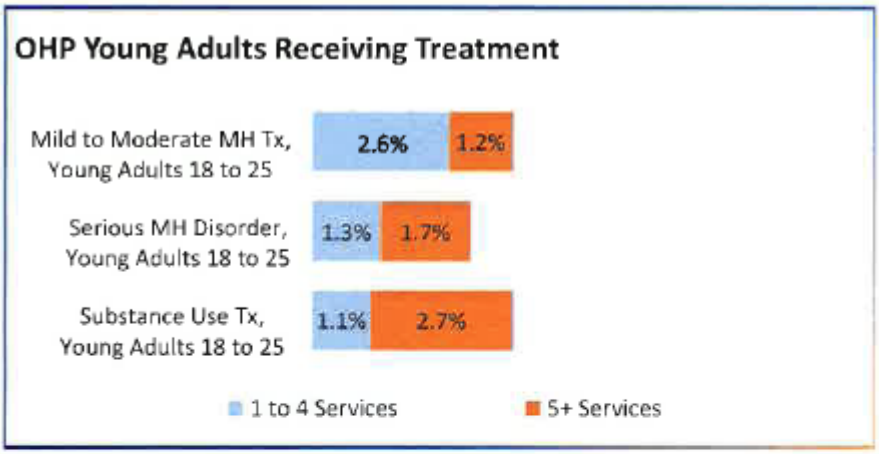
QUALITY: DOUGLAS COUNTY INFO:

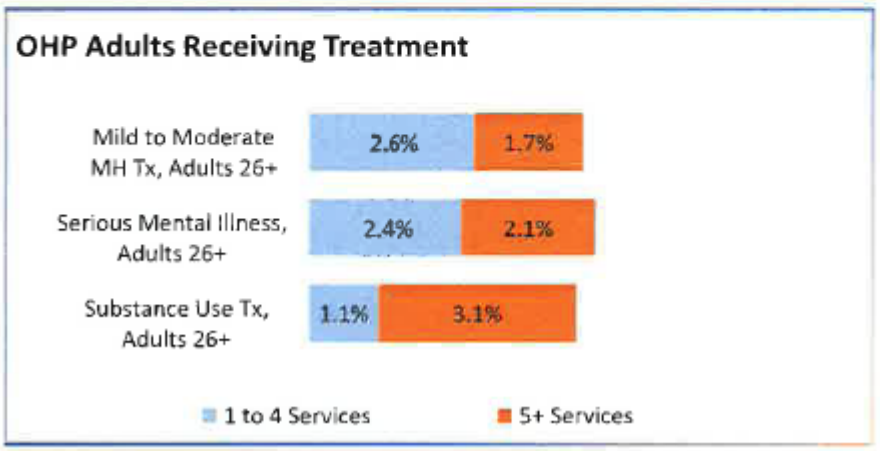


Severe and persistent mental illness (SPMI) is a major public health concern in the United States effecting 9.3 million adults aged 18 and older according to the National Center for Biotechnology Information. Among the top 10 states with the largest percentage of population with SPMI in 2015 is Oregon with an estimated 4.83%. The increasing concern is the barriers to receiving appropriate healthcare and specialty care for people with complex needs.

Oregon defines SPMI members as an individual diagnosed with at least one of the following conditions as a primary diagnosis: schizophrenia and other psychotic disorders; major depressive disorder; bipolar disorder; anxiety disorders limited to obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD); schizotypal personality disorder; or borderline personality disorder. These members include: children; youth; young adults; adults; and individuals in state custody (foster care, juvenile justice, and individuals with intellectual developmental disabilities).

Those with SPMI need access to a continuum of care since these conditions are episodic and the severity of symptoms can vary overtimes. SAMHSA described in the 2015 Behavioral Health Barometer that 318,000 (45.9%) Oregonians with Any Mental Illness (AMI) received Mental Health Treatment/Counseling, slightly larger than the nation average of 42.7% from 2010 to 2014. Specifically, in 2017, 2.6% OHP young adult members (age 18-25) with mild to moderate mental health



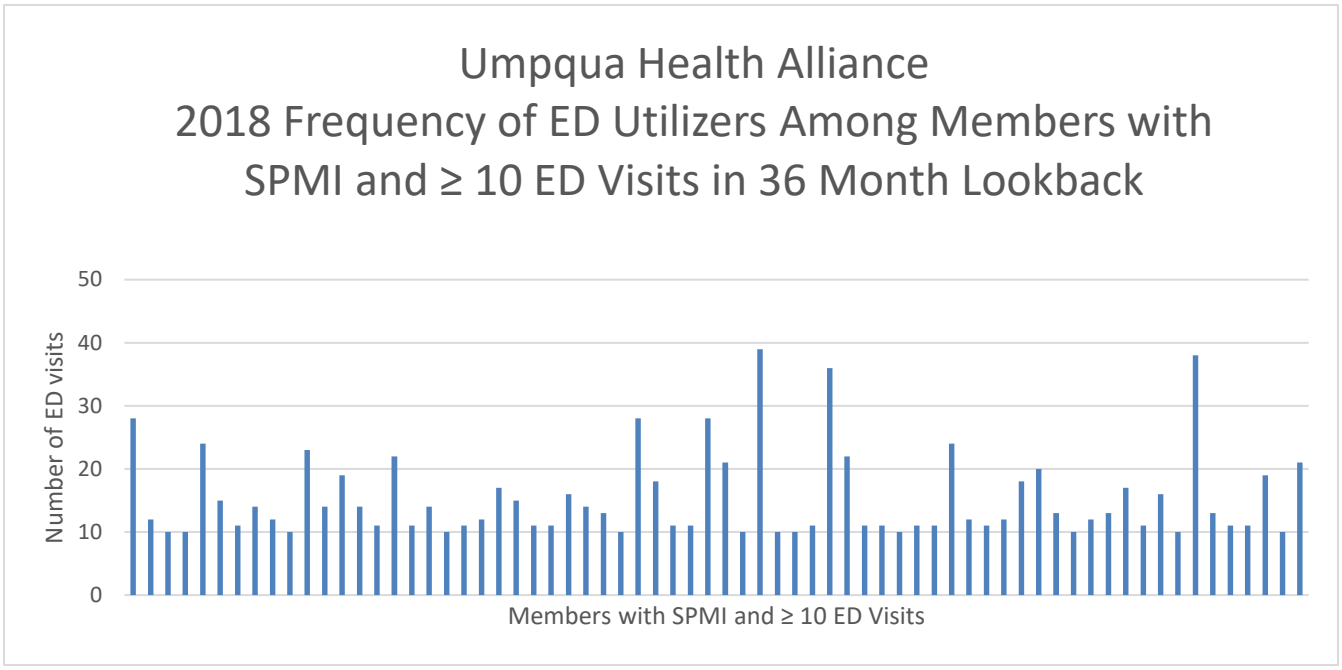


diagnosis received 1-4 services while 1.3 % of those with serious mental health disorders received treatment and 1.1% of those with substance use received treatment according to the Oregon Health Authority. They continued to report that OHP adults age 26 and older, 2.6% with mild to moderate mental health diagnosis received 1-4 services while 2.4% of those with serious mental health disorders received treatment and 1.1% of those with substance use received treatment.

Due to the difficulties of navigating resources, members experiencing SPMI have higher rates of preventable health conditions and higher rates of ED utilization. Oregon Health Authority has identified in 2017, of the top 20 diagnoses among members with SPMI, suicide and intentional self-injury making up 2.6% of all ED visits and substance use disorders (SUD) making up 3% of ED visits.

By reducing ED utilization and improving the way adults with SPMI receive appropriate levels of care and increase access to community-based supports, Umpqua Health Alliance (UHA) members will be able to live more successfully in the community while improving the lifelong health of our members, increasing the quality and availability of care and containing the cost of care so it is affordable for everyone.

In 2018, Umpqua Health Alliance had 16.9% of the 26,867 members diagnosed with SPMI. Of these members, there were a total of 5,672 ED visits. UHA identified a gap of 2,105



members who qualified for the Disparity: ED Utilization with Mental Illness measure but did not meet. This CCO incentive measure determined the rate of patient visits (ages 18 and older) who are experiencing mental illness and have a visit to the emergency department in a 36-month lookback window. Moving forward in 2019, UHA's ED Diversion cohort will focus its efforts on the patients that did not meet and had 10 and more ED visits.

UHA will base our ED Diversion program on the Coordinated Specialty Care Model, an evidence-based model of care designed to help early identify and engage SPMI adults and adolescents with SPMI in treatment with specialized mental health providers and community mental health clinics. According to the Department of Health and Human Services Center for Medicare and Medicaid Services, this model takes a multidisciplinary, team-based approach to providing comprehensive services. The package of services includes outreach to cultivate referral networks, engage with patients, families and caregivers and coordinate services among treatment team members, medication management, case management, primary care providers, educational resources and community resources.

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

Coordinated care is essential to provide services to those with severe and persistent mental illness due to its complexities. As emergency department utilization continues to be a focus area for UHA, we will continue to work on decreasing its inappropriate usage. The internal Behavioral Health unit at Umpqua Health Alliance is led by our MSN, RN manager. The team includes Intensive Case Management Coordinators (ICM) that have credentials such as NCACII, CADCII, CADCI and CPS and are supported by Case Management Specialists. UHA is in the process of adding a Tradition Healthcare Worker and Social Worker to the team as well. They will work alongside our supporting departments including: Member Services Provider Relations, Quality Improvement, Marketing and Decision Support.

Externally, our team will coordinate care with partners such as: local mental health providers (treatment & counseling), SUD treatment services, primary care physicians, oral health coalition, counseling services and housing and food assistance programs.

The team will review charts and member data from PreManage and EMR Centricity files of the 62 identified members from the 2018 Disparity: ED Utilization with Mental Illness measure that had 10 or more ED visits in a 36-month lookback. After

confirming their eligibility, the team will contact the member to create a relationship with and engage the member in the ED Diversion project. Once voluntary engagement is agreed upon by the member, they will be followed by an ICM that assists each member in developing flexible care plans to facilitate team services across health and social care boundaries. Coordination includes:

- Timely and appropriate referrals to needed services
- Identification and problem-solving around barriers
- Identification and elimination of redundancy of services
- Ensuring communication with the family and their care team

Using trauma informed strategies that include goals, progress notes, and a plan for engagement in services, these plans will demonstrate evidence based practices of effective coordination with PCP and specialty providers as well as the community resources. They will actively reach out to members to arrange for follow-up appointments with the member's primary care provider, behavioral health care provider, and/or dental provider. This includes connecting patients with addiction services is provided when indicated, and if a patient has not established care with a provider, staff help the member connect with the appropriate services.

The ICM will work with discharge planners at both the inpatient and ED level to coordinate appropriate transition to behavioral health services in the community including services through the delegated community mental health providers. Interdisciplinary Team (IDT) meetings are coordinated monthly, or as needed, to address more extensive community needs for members with multiple comorbid conditions and SPMI. Community members involved in these IDT meetings are SUD

treatment providers, community mental health providers including ACT team, DHS, dental providers, probation and parole, adult or child protective services and child welfare, and specialty and PCP providers. Treatment plan goals are discussed with providers in an effort to better coordinate care and facilitate meeting member's needs.

Barriers of social determinants of health such as transportation, food, housing, domestic violence etc. issues are navigated by our newly joined Community Health Workers. They will assist the member in peer-delivered support by collaborating with community resources to wrap the member in needed services. They will work with the ICM to improve the behavior health outcomes and address barriers to the integration of care by collaborating with behavioral, physical and oral health providers to allow patients to receive the right care at the right time and in the right place.

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

Activity 1 description (continue repeating until all activities included): Identify and engage top utilizers by using criteria and metric data from the CCO Disparity: ED Utilization with Mental Health incentive measure that have had 10 or more ED visits in the last 36 months.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Run quarterly claims reports, ED monitoring report and PreManage to identify of these top utilizers who continue to utilized the ED inappropriately. Create flexible care plans for each of these members and actively remain engaged with member as needed.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Create care plans for the 69 UHA members with SPMI and ≥10 visits to the ED.	25% care plans created	09/2019	35% care plans created	12/2019

Activity 2 description: Increase community integrated treatment through crisis services, ACT, supported housing, peer delivered services, and criminal justice diversion.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Utilize community partnerships to promote and facilitate services. Increase

utilization of CHW to navigate access to available resources. Collect data on the number of referrals from our internal team to community partners and external resources such as behavioral health treatment and counseling services, ACT, SUD services, SDOH resources.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
TBD: Number of referrals to applicable external resources.	Increase utilization of outside referrals sources by 10%	09/2019	Increase utilization of outside referrals sources by 15%	12/2019

Activity 3 description: Decrease the frequency of ED visits in 2019 for ED Diversion cohort.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Using the developed, flexible care plans that facilitate team services across health and social boundaries demonstrate evidence-based practices of effective coordination with PCP and specialty providers as well as the community resources.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2018: 1045 total ED visits by top 69 members	Decrease total number of ED visits by 3%	9/2019	Decrease total number of ED visits by 5%.	12/2019

A. Project or program short title: SDoH project #1: New Beginnings: Coordination of care for members prenatal to five years

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

B. Primary component addressed: Social determinants of health

xix. Secondary component addressed: Health equity
xx. Additional component(s) addressed: Add text here
xxi. If *Integration of Care* component chosen, check all that apply:
☒ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Access: Timely access

vii. Additional subcomponent(s) addressed: Health equity: Data

D. Background and rationale/justification:

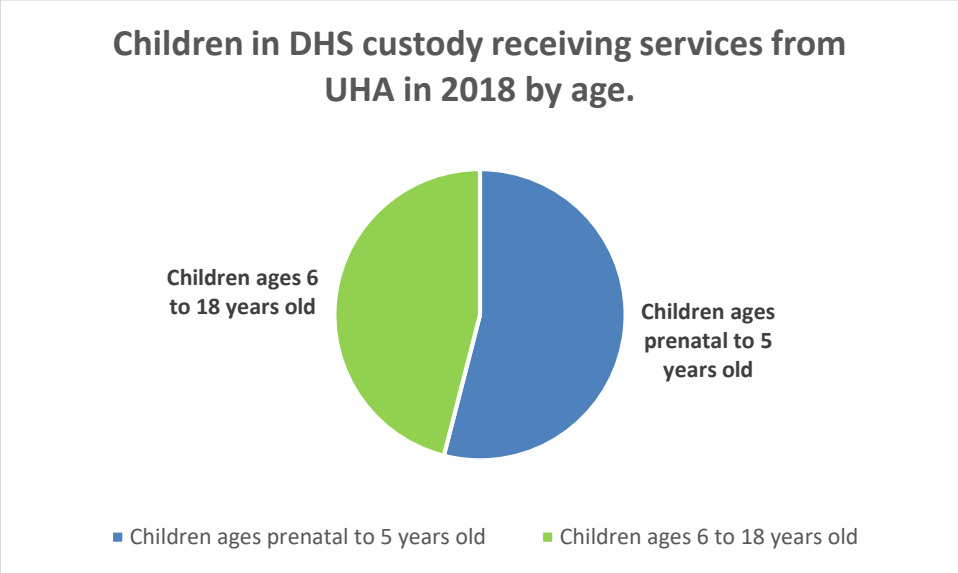
QUALITY: DOUGLAS COUNTY DATA:

Umpqua Health Alliance (UHA) currently serves Douglas County in improving the lifelong health of all Oregonians, increase the quality, reliability and availability of care for all Oregonians and lower or contain the cost of care so it's affordable for everyone. UHA, through its newest program New Beginnings, will be focusing on the prenatal to age five populations of approximately 3,125 lives or 12% of our total membership (26,759 lives). It is during this age the effects of social complexities will most dramatically affect the heath and developmental outcomes of these individuals and their families' dynamics. Oregon Health Authority determined in the table below that the average child faces approximately 2.41 social complexities that could inhibit their growth.

The early years of a child's life, specifically prenatal to age five, has a significant impact on physical and social development. For children affected by chronic social determinants of health; poverty, mental health issues, violence, substance use or lack of stable housing and nutritious food, their ability to develop the needed skills to succeed in school and cope socially are negatively impacted. The additional effects of being raised in situations of excessive stress result in the lack of adaptive behaviors needed to solve simple problems that are reflected in the child's readiness for Kindergarten. These challenges also decrease their lifelong health trajectory causing dental issues, chronic health problems and increased health risk factors, especially seen in those whom are a part of the foster care system.

New Beginnings will be focusing efforts on children, prenatal to five years, with indications of ACEs and high

complexity due to one or more of the following: multi-system involvement, two or more caregiver's placements within the past six months, moderate to severe behavior challenges, at risk of losing current caregiver placement, or school or daycare placement. UHA will also closely care manage children in State Custody, (foster care, juvenile justice, and individuals with intellectual developmental disabilities). In 2018, Umpqua Health Alliance covered an average of 842 member lives per month that are involved in Children Services Division.



In 2018, we monitored the children that were placed in DHS custody, to ensure that they were seen by their health care provider, dental provider, and mental health assessment. In 2018, we helped a total of 185 children, ages 0 to 18. Helping them get connected to services and working with DHS and outside providers, to create wrap around services for these children. Of the 185 children assisted in 2018, 54% 1 were ages 0 to 5.

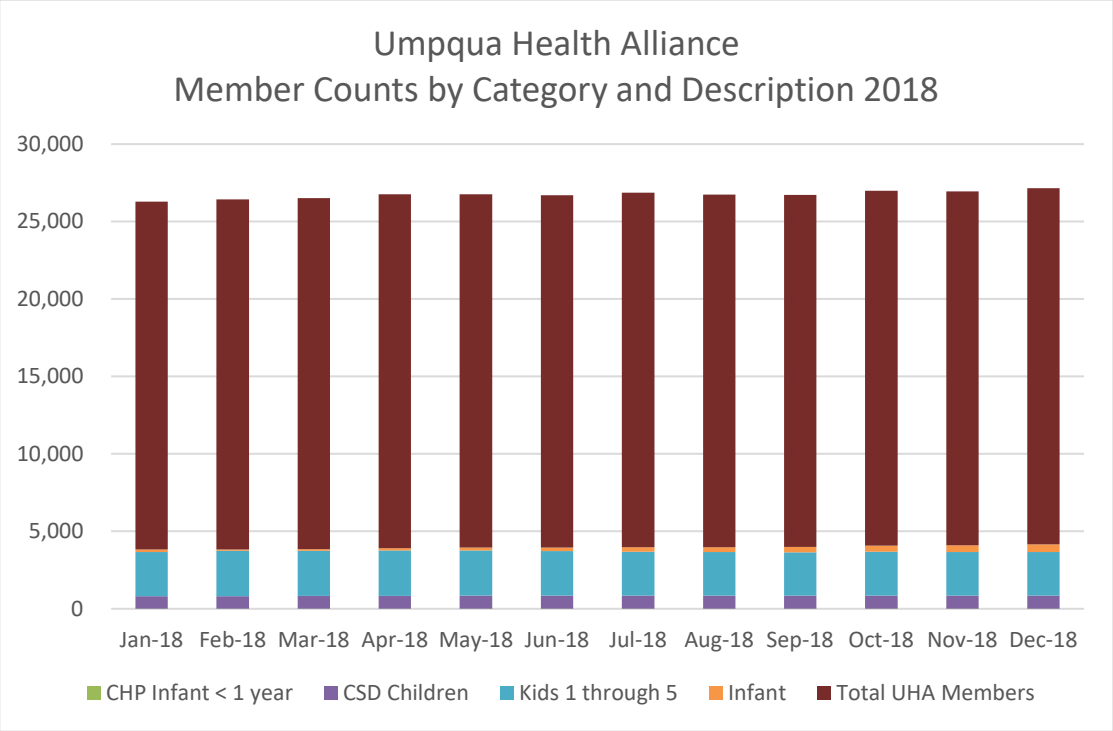
The children and families in Douglas County are facing significant barriers to their healthcare needs due to social determinants and the need of an increased focus of efforts on preventative assistance from medical and behavioral providers, developmental services, early intervention, targeted support services and behavioral health treatment. Together through coordinated care, each child's unique needs and the requirements of specialized help can be more effective and efficient. Creating a system of care to better serve members and the interactions with the providers and community resources/programs, will positively impact the development of vulnerable children and will wrap services around their needs for continual support. In addition, the focus on creating peer support for these families, through our traditional healthcare worker, will assist in addressing basic needs to establish a foundation for primary parents to ensure that children are remaining in the home with their families.

Early identification of high risk children with social complexities and emotional and medical risk factors will be imperative to improve the health outcomes through prevention and early intervention. Umpqua Health Alliance will ensure identified children have timely access to services and are assessed for adverse childhood experiences using ACE assessments. The case managers will develop customized care coordination plans for the parents and children, and provide access to resources through a community health worker.

Prior Year Evaluation

Location	Age group	Data Type	2010	2011	2015	2016	2017
United States	0 to 4	Number	20,188,773	20,122,646	19,915,730	19,919,577	19,938,860
	0 to 4	Percent	27%	27%	27%	27%	27%
Oregon	0 to 4	Number	237,559	235,817	231,774	234,147	235,968
	0 to 4	Percent	27%	27%	27%	27%	27%

https://datacenter.kidscount.org/data/tables/101-child-population-by-age-group#detailed/1/any/false/871,870,573,867,133/62/419,420



Social Complexity Factor	Oregon: Child-Level Factor	Oregon: Parent/Family-Level Factor	Umpqua Heath Alliance: Prevalence
Child Abuse or Neglect – Captured by ICD-9 and ICD-10 diagnosis codes related to service	5.3% (20,589)		2.2% (438)
Foster Care – Child receiving foster care services DHS OR Kids since 2012	13.0% (50,672)		5.5% (1,083)
Mental Health – Child received mental health services through DHS/OHA	33.1% (129,212)		13.9% (2,755)
Poverty – Child received Temporary Assistance for Needy Families (TANF)	40.6% (158,650)		16.8% (3,327)
Substance Abuse – Child received substance abuse treatment through DHS/OHA	4.5% (17,763)		1.9% (383)
Limited English Proficiency – Language other than English listed in primary language field		20.5% (80,262)	8.2% (1,620)

Mental Health – Parent received mental health services through DHS/OHA		40.0% (156,221)	16.7% (3,327)
Parental Death – Death of parent/primary caregiver in Oregon		1.3% (5,172)	.6% (113)
Parental Disability – OHA disability due to parent disability		3.0% (11,892)	1.4% (270)
Parental Incarceration – Parent incarcerated or supervised by the Department of Corrections in Oregon (primarily felony level crimes, excludes city-county jail)		19.1% (74,707)	7.8% (1,551)
Poverty – Parent received Temporary Assistance for Needy Families (TANF)		31.2% (121,952)	13.0% (2,573)
Substance Abuse – Parent received substance abuse treatment through DHS/OHA		20.0% (113.124)	12.0% (2,382)

Oregon Health Authority

E. Project or program brief narrative description:

The New Beginnings program was created to help in transforming the way health care providers and our community programs work together for better health outcomes for our youngest members. Our goal is to continue making strides with our community partners, to create a system of care that better serves our members.

The internal Behavioral Health unit at Umpqua Health Alliance is led by our MSN, RN manager. The team includes Intensive Case Management Coordinators (ICM) that have credentials such as NCACII, CADCII, CADCI and CPS and are supported by Case Management Specialists. UHA is in the process of adding a Tradition Healthcare Worker and Social Worker to the team as well. They will work alongside our supporting departments including: Member Services Provider Relations, Quality Improvement, Marketing and Decision Support.

Externally, New Beginnings will continue to foster partnerships with community resources including SUD treatment services, counseling services, Primary Care Physicians, Family Development Centers, child advocates, abuse prevention services, early intervention specialists, schools and childcare services, hospitals, Early Learning HUB, child education resources, DHS, housing and food assistance programs, WIC, oral health providers, ESD, and systems of care groups.

UHA's team will identify children that meet the programs criteria through Emergency Department reports, CollectiveMedical (PreManage), DHS, claims and enrollment reports and community referrals from partners and providers. These referrals are received via secure email, phone, fax, our current provider platforms, and a recent program called UPLIfT, a community collaboration referral system. The ICM will ensure evidence based screening and assessments are completed on all identified children including ACEs assessments, motivational interviewing, trauma informed care and InterQual.

The ICM will then engage candidates via outreach by letter and phone calls. They will also coordinate with the member's current provider team and community partners as a resource for members. Once engagement is agreed upon by the family, the ICM will develop flexible and unique coordinated care plans to optimize health outcomes for the child and their families. Coordination includes: timely and appropriate referrals to needed services; identification and problem-solving around barriers; elimination of redundancy of services; and ensuring communication with the family and their care team. This collaboration with community partners and primary care providers will facilitate team services across health and social care boundaries. Using trauma informed strategies that include goals, progress notes, and a plan for engagement in services. These plans will demonstrate evidence

based practices of effective coordination with PCP and specialty providers as well as the community resources, with

a goal in improving the health outcomes of these vulnerable children. The ICM and the THW will then follow-up and meet face-to-face as needed with members and their families to create peer support relationships and accompany members to appointments, assist in providing healthcare education and navigate available community resources. Through these interactions, Umpqua Health Alliance will lower the barriers of social determinants and positively impact the health outcomes of these vulnerable children.

Activities and monitoring for performance improvement:

Activity 1 description: Identify high – risk children, aged birth to five years of age based on their social, emotional and medical risk factors, and address their barriers.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Collaborate with community partners and PCP to promote referrals for case management services. Ensure that screenings and assessments have been completed to identify needs and devise care plans.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
TBD: Number of children identified that meet criteria	1% increase per quarter	09/2019	TBD	12/2019

Activity 2 description: Increase coordination of care by promoting programs that provide access to treatment, resources, and education.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Foster partnerships with the local health care providers and community-based programs to bring awareness of the program and the services provided. Utilize community partnerships to promote and facilitate services such as early learning hubs and wrap around services. Prioritize access to SUD services for pregnant women, parents, families, and children. Including access to MAT, withdrawal management, and recovery support services for parents and behavioral health screenings and treatment for children.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
TBD: Number of referrals to community partners	Increase referrals by 5%	06/2019	Increase referrals by 7%	12/2019

Activity 3 description: Work to improve the health outcomes for vulnerable children who are affected by substance abuse disorders, behavioral health issues, or social determinates.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Develop a care plan for the children/families, based on and responsive to accurate and appropriate assessments. These will include goals, progress notes, and a plan for engagement in services. Demonstrate evidence based practices of effective coordination with PCP and specialty providers as well as community resources. Coordination includes: timely and appropriate referrals to needed services; identification and problem-solving around barriers; identification and elimination of redundancy of services; ensure communication with the family and their care team.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
TBD: Number of engaged children participating in New Beginnings	60% of identified children will be engaged in New Beginnings.	06/2019	60% of identified children will be engaged in New Beginnings.	12/2019

A. **Project or program short title**: SHCN project #2: New Day Program 2: Prenatal to postpartum care for pregnant women

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: Integration of care (physical, behavioral and oral health)
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. **Background and rationale/justification**:

Quality: INSERT DOUGLAS COUNTY SPECIFIC DATA:

In 2018, there was a total of 42,067 live births in Oregon. Of these, 1,052 or 3% of them were born in Douglas County. Umpqua Health Alliance served 410 of the pregnant mother members as the primary Medicaid health plan.

The New Day program was founded in Q2 of 2017 and has since provided behavioral support in pregnancy and coordinated care of 108 of women with a 77% success rate of completing the program (number calculated without including eligibility termed members or pregnancies resulting in fetal demise). Preliminary findings determined that UHA did not meet the CCO quality metric for Postpartum Care in 2018. However, of those who did met, 33% of these women were engaged in the New Day program.

Umpqua Health Alliance has identified the target population for New Day as CCO members whom are pregnant with any past or present SUD, mental illness and/or 2 or more social determinants of health. The ongoing complications of SUD, severe and persistent mental illness and other social determinant factors such as transportation, domestic violence, poverty, poor nutrition and lack of safe housing place significant challenges for both physical and behavioral abilities to properly care for a new child. The burden of such issues creates barriers for the moms to cope with the pressures of losing custody of the child and obtaining adequate and timely healthcare services.

With the abuse of opioids in Douglas County continuing to rise, so does the number of babies born who suffer from the effects of addiction. Neonatal Abstinence Syndrome (NAS) is one the most severe complications for newborns that results in neonatal intensive care units for extended durations in addition to affects to both short and long term outcomes. Common short term withdrawal effects include loud, high pitch crying, sweating, yawning and gastrointestinal disturbances. Furthermore, the long term effects of this severe withdrawal process may result in difficulties with breast feeding, multiple gastrointestinal/nutritional deficiencies, delays in meeting developmental milestones and the significant, highly likely risk of long term cognitive impairment. “From 2004 to 2014, the incidence of neonatal abstinence syndrome (NAS) in the United States increased 433%, from 1.5 to 8.0 per 1,000 hospital births. The latest national data from 2014 indicate that one baby was born with signs of NAS every 15 minutes in the United States (1). NAS is a drug withdrawal syndrome that most commonly occurs among infants after in utero exposure to opioids, although other substances have also been associated with NAS” (https://www.cdc.gov/mmwr/volumes/68/wr/mm6801a2.htm?s_cid=mm6801a2_e&c_cid=journal_search_promotion_2018).

Knowing that abrupt discontinuation of opioid use during pregnancy can result in complications ranging from premature labor, fetal distress, or fetal demise, the identification of New Day’s target population and appropriately coordinating of evidence based treatments is the greatest opportunity to reduce pregnancy risk and to lower the number of infants born with effects of NAS.

The current standard of care for pregnant women with a SUD is opioid-assisted therapy with methadone, but evidence suggests that buprenorphine also should be considered. Medically supervised tapered doses of opioids during pregnancy often result in relapse to former use. During the intrapartum and postpartum period, special considerations are needed for women who are opioid dependent to ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies. Patient stabilization with opioid-assisted therapy is compatible with breastfeeding. Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists. All infants born to women who use opioids during pregnancy should be monitored for neonatal abstinence syndrome and be treated when indicated (Substance Abuse and Mental Health Services Administration. *A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders*. HHS Publication No. (SMA) 16-4978. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016).

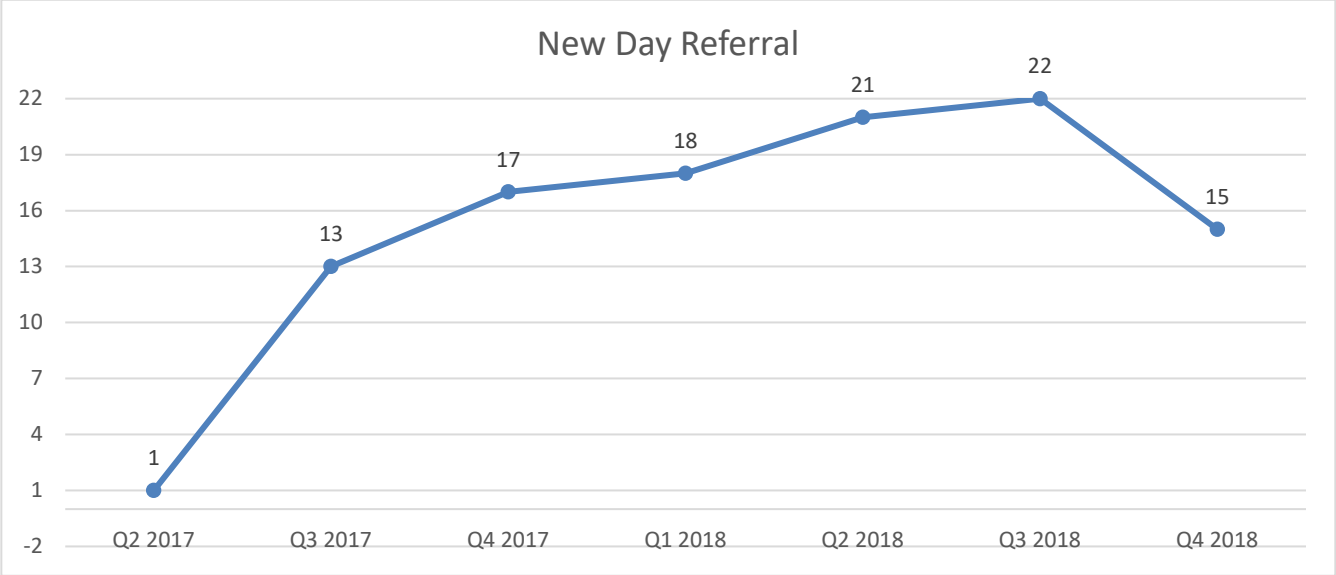
Of the 65 births with mothers that were engaged in New Day in 2018, there were only 4 NICU stays with 2 stays related to NAS. Comparatively, of the total 410 live births UHA served, 28 or 6.8% were diagnoses with NAS.

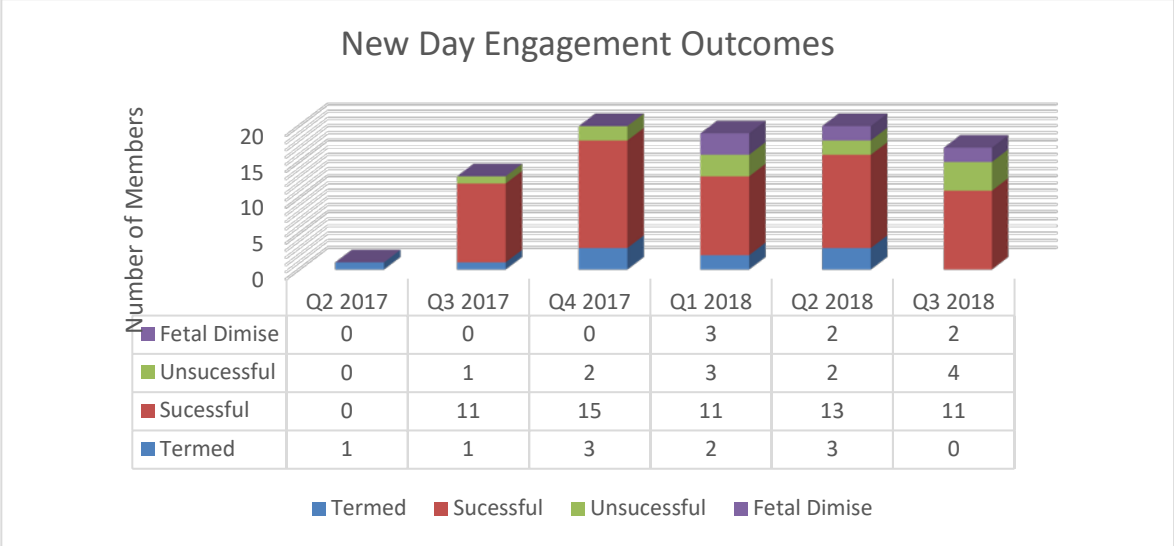
In order to positively impact the health outcomes of these pregnant women and their newborn babies, UHA has determined early identification and care coordination through member engagement in the New Day Program will reduce barriers and improve access to treatment and services for behavioral and physical healthcare needs.

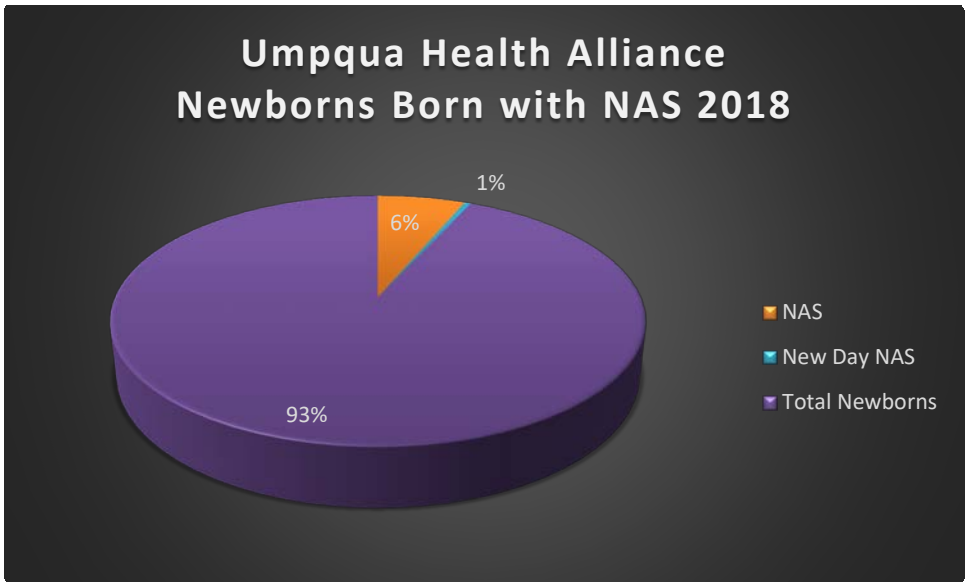
Prior to 2019, New Day spent majority of outreach attempts through provider and community partner referrals. New Day will continue this collaboration but will also be expanding outreach to directly contacting members, performing assessments and motivational interviewing to increase early engagement and to inform the members of the importance of prenatal care during the first trimester of their pregnancy and remain engaged until 56 days postpartum. During these interaction, ICM will be connecting the member with educational resources as well as increasing access to medication assisted treatment, withdrawal management, residential services, outpatient services and ongoing recovery support services.

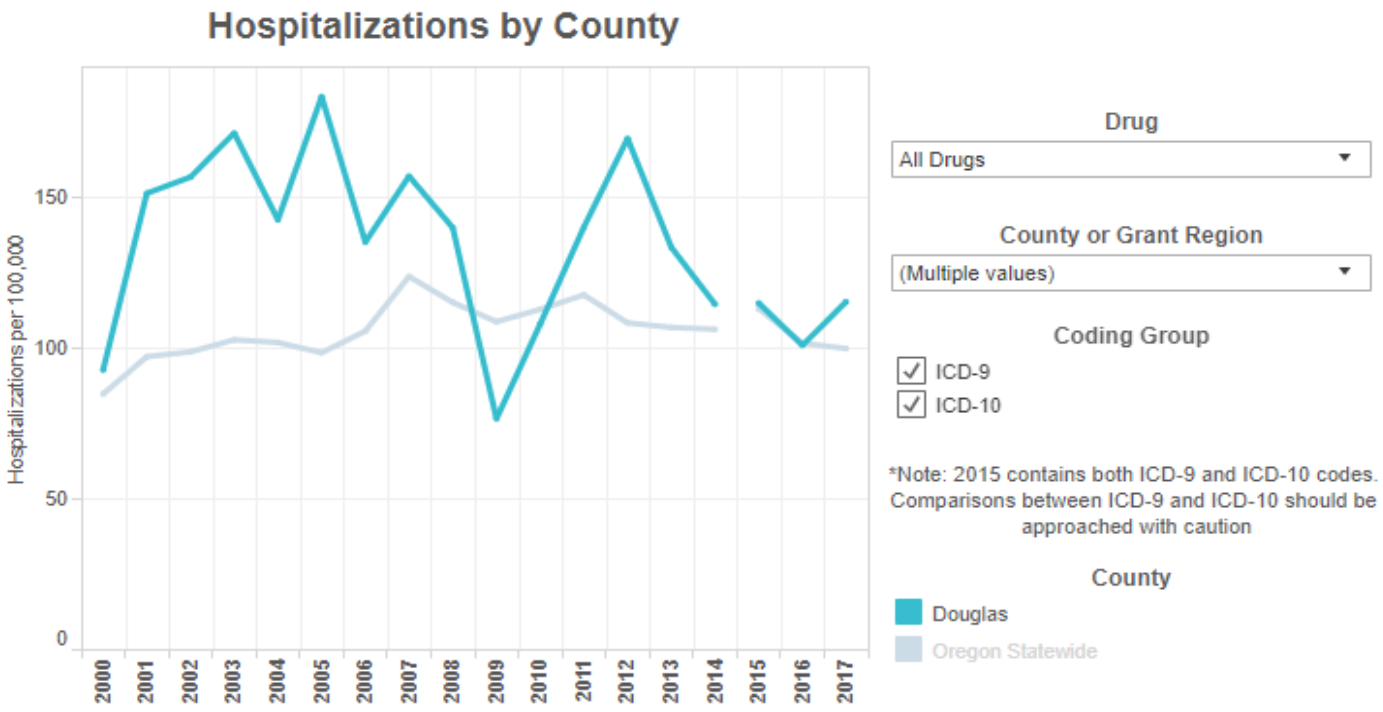
New Day will also be adding to the New Day team by hiring a Community Health Worker to bring awareness of the available community resources for members to overcome many social determinants such as transportation, food, housing and support against domestic violence.

Additional improvements will include a new care coordination platform to better management the needs of UHA's members and incorporating evidence-based assessments and care plans for members.


New Day Referral
22
19
16
13
10
7
4
1
-2
1
13
17
18
21
22
15
Q2 2017
Q3 2017
Q4 2017
Q1 2018
Q2 2018
Q3 2018
Q4 2018


New Day Engagement Outcomes
Number of Members
20
15
10
5
0
Q2 2017 Q3 2017 Q4 2017 Q1 2018 Q2 2018 Q3 2018
Fetal Dimise 0 0 0 3 2 2
Unsucessful 0 1 2 3 2 4
Sucessful 0 11 15 11 13 11
Termed 1 1 3 2 3 0
Termed
Sucessful
Unsucessful
Fetal Dimise

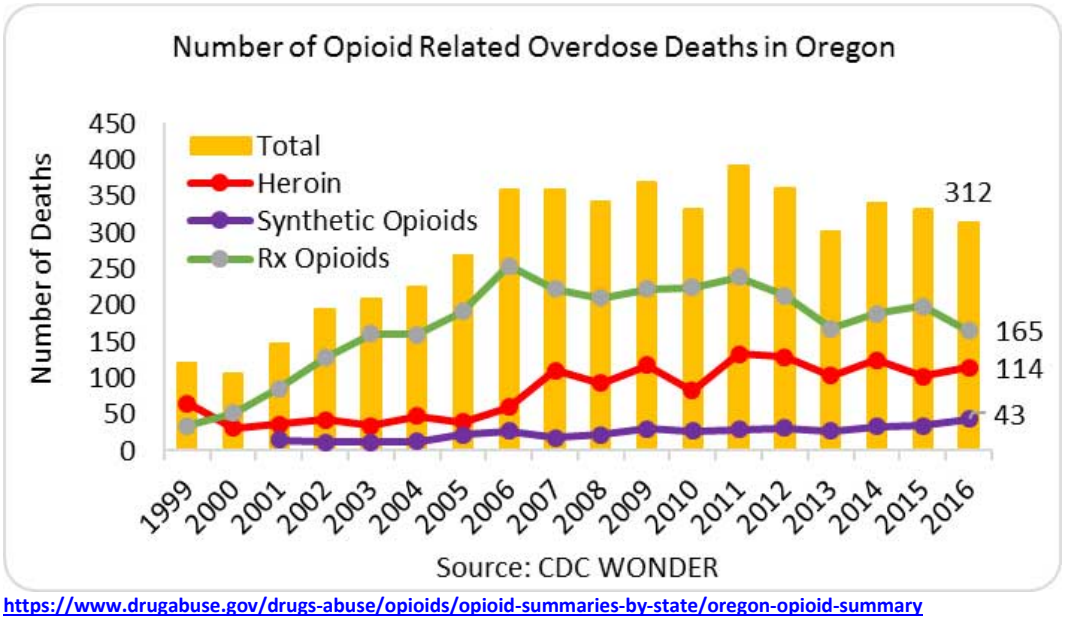

Umpqua Health Alliance
Newborns Born with NAS 2018
1%
6%
93%
NAS
New Day NAS
Total Newborns



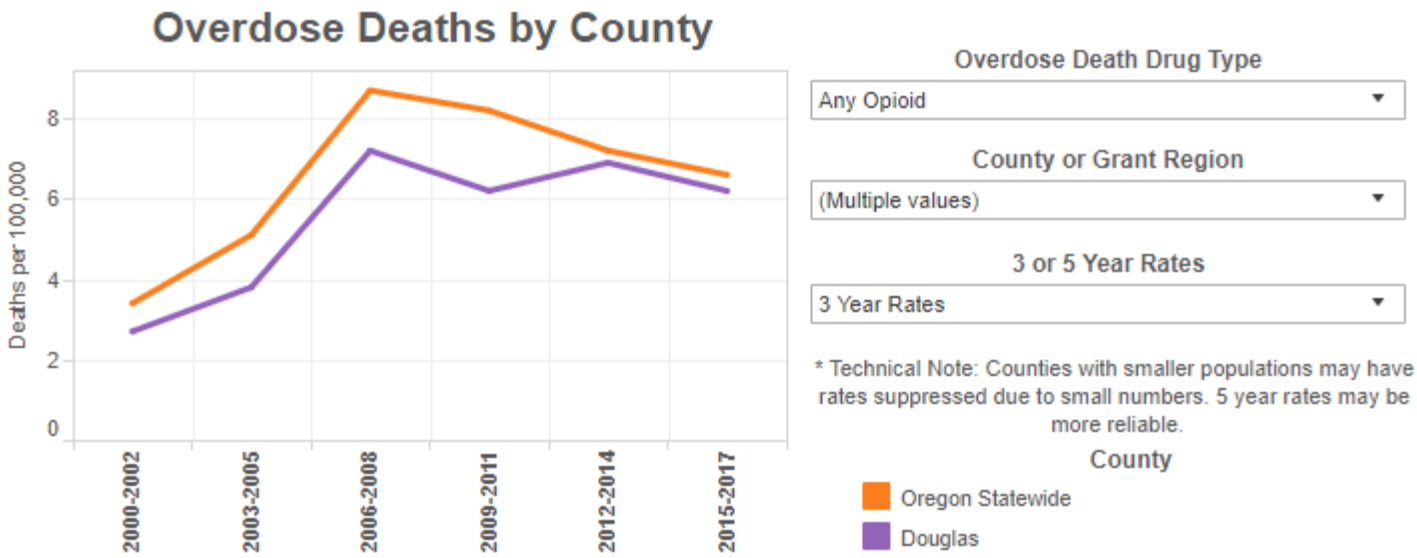
* Technical Note: Counties with smaller populations may have rates suppressed due to small numbers. On October 1, 2015, the coding scheme for hospital records changed from ICD-9 to ICD-10. Any comparison of data between ICD-9 and ICD-10 CM should be approached with caution.

**Note: Hospitalizations by age will be included in future dashboards when more years are available in ICD-10

https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx



https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/oregon-opioid-summary



https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx

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

The internal Behavioral Health unit at Umpqua Health Alliance is led by our MSN, RN manager. The team includes Intensive Case Management Coordinators (ICM) that have credentials such as NCACII, CADCII, CADCI and CPS and are supported by Case Management Specialists. UHA is in the process of adding a Tradition Healthcare Worker and Social Worker to the team as well. They will work alongside our supporting departments including: Member Services Provider Relations, Quality Improvement, Marketing and Decision Support.

Externally, New Day's community partners include specialty providers for behavioral health treatment and counseling, in-network PCP and OBGYN's, hospitals, criminal justice system, coalitions for oral health, breastfeeding and other supports, DHS, WIC, UCAN, CORE Home Nurse Visitors, Perinatal Task Force and other community resources to meet member's needs such as food, housing and transportation assistance.

New Day will use evidence based screening and assessments when applicable. These will include: SBIRT, ACEs assessment, Biopsychosocial assessment, GAD Anxiety Screening, Motivational Interviewing, Trauma Informed Care, PHQ-9 Depression Scales. AUDIT-C, DAST-10, GAD-7 and InterQual, New Day will increase engagement, community collaboration and care planning for members to receive appropriate and timely access to care and services.

Members will be identified through several avenues, including the maternity list provided by OHA, emergency department encounters in PreManage, and community referrals. Referrals are received via secure email, phone, fax, UPLIfT (a community collaboration referral system) and via our provider platform. These referral source include OBGYN providers, DHS, Battered Persons Advocacy, behavioral health providers, SUD providers, probation and parole and other community resources. ICM will engage candidates via outreach by letter and phone calls. They will also coordinate with the member's current provider team and community partners as a resource for members. Once engagement is agreed upon, the ICM will develop coordinated care birth plan with member for placement at Family Birthplace to optimize health outcomes for mother and baby. Additionally, the program will coordinate services including transportation and temporary housing/lodging, WIC assistance, and preparation/equipment for breastfeeding. Each member transitions to different levels of care for behavioral health and/or SUD will receive a care plan. Referral will also be provided to SUD treatment facilities/medicated-assisted treatment services to ensure appropriate level of care. The program will monitor progress and communicate all interaction to the mother and baby. Support is also provided postpartum to transition the mother from OB care to medication-assisted treatment (when indicated) with PCP, and to support child safety though parenting classes and to support access to timely pediatric appointments through referrals to New Beginnings, a newly established Umpqua Health program to support children prenatal-age 5 years.

By providing behavioral support services and care coordination for pregnant women facing barriers or challenges that have a

negative effect on all aspects of their pregnancy, specifically those struggling with SUD, SPMI and or social determinants of health, UHA will provide peer support to engaged members through UHA's traditional healthcare worker. This Community Health Worker will assist the member is social support to provider appointments and navigate community resources.

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

Activity 1 description: Early identification of pregnant women with SUD, mental illness and social determinants of health.

☐Short term or ☒ Long term

Monitoring activity 1 for improvement: Collaborate with community partners and OBGYN's to promote referrals for case management services. Contacting members directly from data collection resources to provide screening and assessments.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2018: 76 (13%) of identified members referred to New Day from community partners/providers.	Increase number of referrals by 3%.	06/2019	Increase number of referrals by 3%.	12/2019

Activity 2 description: Increase coordination of care with health care providers and community partners by promoting programs that provide access to treatment, resources, and education. Working to improve the health outcomes for pregnant women and their babies, through creating care plans with interventions for successful birth of a healthy baby. Reduce the number of NICU inpatient services by engaging and providing access to medication assisted treatment, SUD, and mental health treatment services.

☐Short term or ☒ Long term

Monitoring activity 2 for improvement: Foster partnerships with the local health care providers and community-based programs to bring awareness of the program and the services provided. Utilize community partnerships to promote and facilitate wrap around services. Increase utilization of THW to educate and bring awareness of available resources for pregnant mothers and expecting fathers. Prioritize access through referrals to SUD services for pregnant women; including access to medication assisted treatment, withdrawal management, residential services, outpatient services and ongoing recovery support services.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2018: 11.7% of pregnant members received SUD treatment.	3% of members engaged that meeting SUD criteria will be referred to treatment.	6/2019	3% of members engaged that meeting SUD criteria will be referred to treatment.	12/2019

Activity 3 description: Working to improve the health outcomes for pregnant women and their babies, through creating care plans with interventions for successful birth of a healthy baby; Coordination of prenatal and post-partum care with OBGYN in compliance with state quality metrics.

☐Short term or ☒ Long term

Monitoring activity 3 for improvement: Demonstrate evidence based practices of effective coordination with OBGYN and specialty providers. Coordination includes: timely and appropriate referrals to needed services; identification and problem-solving around barriers; identification and elimination of redundancy of services; ensure communication with the family and their care team.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2018: 24.9% met the >69.3% Postpartum Care Measure.	27% qualifying members will meet the Postpartum Care Measure.	06/2019	29% qualifying members will meet the Postpartum Care Measure.	12/2019

Activity 4 description: Increase the number of members engaged in the program.

☐Short term or ☒ Long term

Monitoring activity 4 for improvement: Contact identified members from internal and external reports and referrals via letters and phones calls and through community partners access to screen and assess members for SUD, behavioral and medical healthcare services and/or resources.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2018: 8.2% of total 788 pregnant members were engaged in New Day program.	10.2% member engagement	06/2019	12.2% member engagement	12/2019

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through F until all TQS components and subcomponents have been addressed)

A. **Project or program short title**: Access Project #2 Tracking 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: HIT
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: Availability of Services

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

Members have the right to a second opinion from a qualified Health Care Professional within the CCO's provider network or outside of the provider network if not available otherwise. It is the responsibility of the CCO to arrange for members to be seen by an out of network provider at no cost to the member.

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

The target of this project is to improve how second opinions are monitored and tracked through utilization review. In order to standardize our review process we will implement a new work flow to accurately categorize second opinion requests and we will use PDSA cycle throughout the transition. Additionally, we will ensure that all second opinion requests for out of network providers will be reviewed in accordance with OAR 410-141-3225.

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

Activity 1 description (continue repeating until all activities included): Optimize work-flow to accurately track out-of-network 2nd Opinions

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: In order to accurately measure the number of second opinions to out of network providers we will need to adjust the current workflow for reviewing these requests. When a prior authorization for a second opinion is received it will need to be categorized as a second opinion to accurately track the volume. We can then process a report of the number of requests we received and present this information at our monthly Utilization Management Committee to monitor for trends.

Baseline or current state	Target / future state	Target met by (06/2019)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not able to accurately measure the number of second opinions for CCO population.	100% accuracy measuring second opinions for out of network providers	Accurately measure 100% of second opinions for out of network providers by end of second quarter 2019.	Add text here.	Add text here.

Activity 2 description: Track TATs for out-of-network second opinions

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: To ensure that we are providing our members with timely availability to out of network second opinions we need to track the review times of all prior authorizations we receive for second opinions. This will require having an accurate measure of the volume of second opinion requests and creating a report that can be presented to our Quality Advisory Committee (QAC) each quarter.

Baseline or current state	Target / future state	Target met by (12/2019)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not currently tracking second opinions.	Review TATs for out of network providers, for 100% of second opinions	Quarterly Reporting	Add text here.	Add text here.