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AllCare Health

Transformation and Quality Strategy

July 2024

Certified B Corporation

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Section 1: Transformation and quality projects

(Complete Section 1 by repeating parts A through E until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. **Project title:** Provider Training Program to Increase Language Access through the use of Appropriate Language Services

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

If continued, insert unique project ID from OHA: 53

B. **Components addressed**

1. Component 1: CLAS standards
2. Component 2 (if applicable): Health equity: Cultural responsiveness
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? 13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

C. **Project context:** Complete the relevant section depending on whether the project is new or continued.

New projects

Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

N/A

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

The focus of this project is not only to provide resources and training to the provider network but, also to help increase language access for our members. The more access our members have to appropriate and effective language services, the more comfortable and confident they will feel to seek healthcare and attend medical appointments. In 2023, AllCare Health continued to offer training, support and resources to medical offices and organizations to increase and strengthen language access services for our members and community. The AllCare Language Access team worked with and supported 41 medical offices in our service area. Language Access trainings occurred with 17 Primary Care, Specialists, Behavioral Health and Physical Therapy providers. Support services included the following: Facilitated meetings to review and develop workflows and policies, communicated and provided changes to the interpreter directory of local interpreters, Video Remote Interpreting (VRI) and telephone interpreting services, trained providers and clinic staff on the uses of interpreters and current language access regulations. Twenty-seven bilingual individuals from our community became certified health care interpreters through the AllCare Health interpreter training in 2023. AllCare offered a full scholarship valued at $27,000 for both of the Interpreter Training Classes held in 2023 in order to increase the number of interpreters in our community and to help make the class available to those who otherwise may not be able to afford it. AllCare will continue these trainings in 2024. Our goal and benchmark was to not only continue this project but also increase the amount of outreach done with the provider network. Results from this are reflected in how many Limited English Proficiency (LEP) members would have an encounter in 2023. The Covid-19 pandemic significantly impacted this project. As with many of the societal inequities for people of color, language services access was further exacerbated. Many of the employed Medical Interpreters AllCare trained were laid off during early lockdowns and have not returned. Remote encounters largely shifted to Video Remote or Phone Interpretation services that do not enforce provisions related to Certified and Qualified Interpreters. In reviewing REALD data, AllCare identified a disparity for LEP members needing Spanish interpreter services having much lower visit rates than those who spoke other languages. Lower visit rates were

also recognized for members needing an interpreter who identified as Hispanic or Latino Mexican and Other Hispanic or Latino. Members needing interpreter services with disabilities or who needed ASL interpreters did not have significantly lower visit rates. At this time, this project does not include SOGI information due to limited access to this data. AllCare has a revised Demographic policy that discusses a process for including SOGI data once it is available.

2. **Describe whether last year's targets and benchmarks were met (if not, why):** AllCare met most of last year's project targets and benchmarks. There was increased outreach and trainings provided to the provider network and an increase in encounters for our Spanish speaking members as well as members who identified as Hispanic or Latino Mexican and Other Hispanic or Latino. There was a decrease in overall encounters for the LEP population which is likely due to the lack of availability of interpreter services from our former Language Service Provider. Pictured below is data from 2023 on LEP Encounter rates. These are displays per preferred language and race. For CY2023 AllCare was able to increase the rate from 30% to 38% for Spanish speakers and an increase from 33% to 38% for Hispanic or Latino Mexican and Other Hispanic or Latino members. Spanish is the most common language spoken by our LEP member population.

Language	Member Count	% w/ Encounter
Cebuano	1	100%
Central Khmer	1	0%
Declined/Null	4	75%
English	134	51%
French	2	50%
German	1	100%
Gujarati	3	67%
Hindi	5	60%
Hmong	1	0%
Hungarian	1	100%
Korean	1	0%
Lao	2	50%
Mandarin Chinese	9	33%
Panjabi	2	0%
Portuguese	3	33%
Russian	6	67%
Serbian	1	100%
Spanish	860	38%
Thai	8	38%
Ukrainian	8	50%
Grand Total	**1053**	**41%**

Race	Member Count	% w/ Encounter
Hispanic or Latino Central American	17	35%
Hispanic or Latino Mexican	237	36%
Hispanic or Latino South American	14	29%
Indigenous Mexican, Central American or South American	11	36%
Middle Eastern	1	100%
Multiple Racial or Ethnic Identity	19	26%
Other	16	50%
Other Hispanic or Latino	178	41%
Other White	54	63%
Western European	3	67%
Eastern European	1	100%
Biracial or Multiracial	2	50%
Korean	1	0%
Slavic	1	0%
Micronesian	2	0%
Other Asian	5	20%
Laotian	1	100%
Chinese	7	57%
Filipino/a	3	67%
Asian Indian	8	63%
Cambodian	2	50%
White	10	50%
African American	2	0%
American Indian/Alaska Native	2	50%
Hispanic or Latino	90	36%
Unknown/Did Not Answer	366	41%

3. **Lessons learned over the last year:** AllCare recognized a trend of more languages needed than just the 'most popular' Spanish and ASL for interpreter services. In an effort to increase the availability of our resources, AllCare contracted with a different Language Service Provider that has many more languages on demand in addition to also contracting with more local State Qualified or Certified Health Care Interpreters. Currently, AllCare contracts with local Spanish, ASL, Samoan, Malay and Mandarin Chinese interpreters. The Language Service Provider that AllCare currently contracts with has over 300 languages available on demand and for schedule. AllCare is testing the Language Service Provider and monitoring feedback to ensure that the new provider is working effectively. AllCare has received positive feedback from the provider network and also internal staff utilizing the service. AllCare will continue tracking this trend. In 2024, AllCare plans to expand outreach to LEP members to further assist in coordination of interpreter services.

D. Brief narrative description

1. **Project population:** The focus of this project was to increase the language access resources available to Limited English Proficiency (LEP) members as well as provide education on culturally and linguistically appropriate care to healthcare providers. Members in priority populations as defined by Regional Health Equity Coalitions (OAR

950-020- 0010): (6) Culturally specific means led by individuals from the community served, using language, structures, and settings familiar to the members of the community (d) Hispanic/Latino/Latina/Latinx; Ensures that policy solutions and system changes build upon the strengths of the priority populations.

2. **Intervention (address each component attached):** In 2023 AllCare Language Access team worked with and supported 41 medical offices in our service area. Language Access trainings occurred with 17 Primary Care, Specialists, Behavioral Health and Physical Therapy providers. Support services included the following: - Facilitated meetings to review and develop workflows and policies - Communicated and provided changes to the interpreter directory of local interpreters, VRIs, and telephone interpreting services - Facilitated meetings were completed in-person and virtually depending on the needs of the medical clinic - Trained providers and medical clinic staff on the uses of interpreters and current language access regulations.
   In addition to building on increasing language access, AllCare has focused on providing information to the LEP community about their language access rights. Documents containing information about member rights, responsibilities, plan benefits, and resources were translated into additional languages. Language Access and Branding departments developed a Brochure in English (ASL / Hard of hearing) and Spanish detailing language access and Interpreter rights for our members. These were distributed to LEP individuals at public events.
   AllCare CCO was invited to speak with the members of SOHealthE, Southern Oregon's regional equity coalition, on April 5, 2023 to provide education about the AllCare CCO Plan including member benefits and rights. AllCare CCO is working with the internal Health Equity Committee and our community partners to further develop culturally specific material for the Latino/a/x and Hispanic populations.

E. **Activities and monitoring for performance improvement** (duplicate until all activities and measures are included)

Activity 1 description: Current data shows 41% of LEP individuals had an encounter in 2023. AllCare's total LEP encounter rate decreased for 2023 and we would like to work on increasing all encounters for LEP members by 5% with a target of 46%. AllCare recognized that the previous Language Service Provider was not able to keep up with the needs of our LEP members and decided to contract with a new Language Service Provider that had more than 300 languages available on demand or to schedule. AllCare is actively working with the providers in our provider network to set them up with this resource and train on how to utilize it. AllCare will continue to monitor and review the LEP encounter rate as a whole, but will also focus on the Spanish speaking members since they have the highest need and number of LEP members. AllCare would like to increase the Spanish LEP encounter rate by 5% with a target of 43%.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Language access encounters Spanish Speaking LEP members			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current data shows 38% of Spanish Speaking LEP individuals have had an encounter.	Increase any encounter rate for Spanish Speaking LEP members by 5% with a target of 43%	06/01/2025	Increase any encounter rate for Spanish Speaking LEP members to 46%	06/01/2026
Monitoring measure 1.2	Language access encounters all LEP members			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current data shows 41% of LEP individuals have had an encounter.	Increase any encounter rate for LEP members by 5% with a target of 46%	06/01/2025	Increase any encounter rate for LEP members 48%	06/01/2026

Activity 2 description: Patients that receive interpreter services from OHA Certified or Qualified Interpreters.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Increase number of patients that receive interpreter services from OHA Certified or Qualified Interpreters.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
13% of LEP visits received a Certified/Qualified interpreter as reported by our Provider Network	Increase number of interpreter services provided for LEP members to 17%	06/01/2025	Increase number of interpreter services provided for LEP members to 20%	6/01/2026

Activity 3 description: Number of Provider Offices working with the AllCare Language Access Team

☒ Short term or ☐ Long term

Monitoring measure 3.1	Increase number of provider offices that receive support from AllCare Language Access Team			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
AllCare Language Access team worked with and supported 41 medical offices / 17 Offices received training on Language Access	Increase number of clinics receiving support from Language Access team by 10% with a goal of 45 offices and 10% increase of trainings to a total of 19	06/01/2025	Increase number of clinics receiving support from Language Access team with a goal of 47 offices and increase of trainings to a total of 22	06/01/2026

A. **Project title:** Continuous Glucose Monitor Expansion/ Increased Diabetic Oral Health Care

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

If continued, insert unique project ID from OHA: 499

Components addressed

1. Component 1: SHCN: Non-duals Medicaid
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

B. **Project context:** Complete the relevant section depending on whether the project is new or continued.

New projects

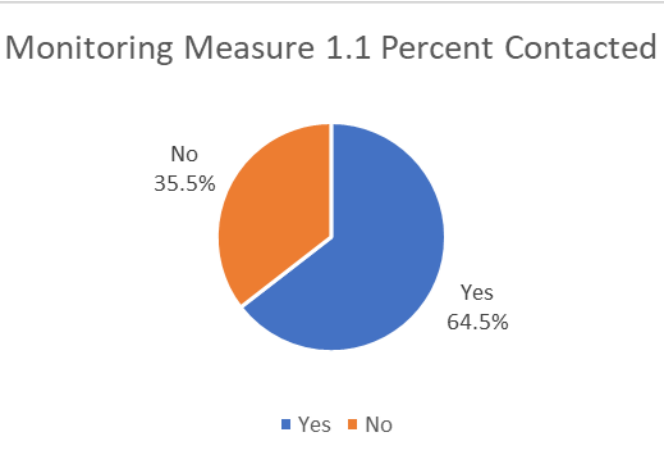
Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

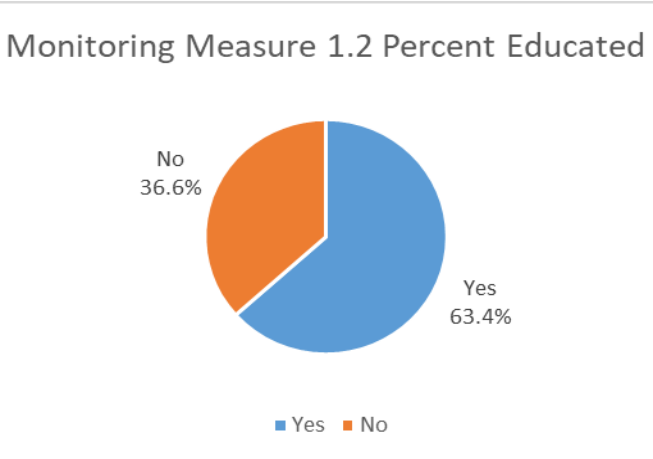
N/A

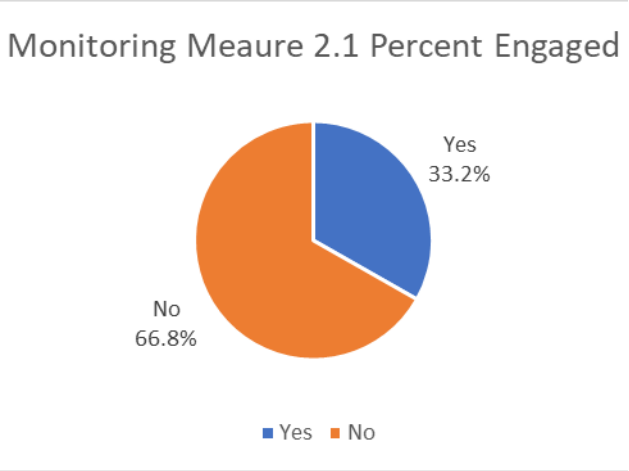
Continued projects

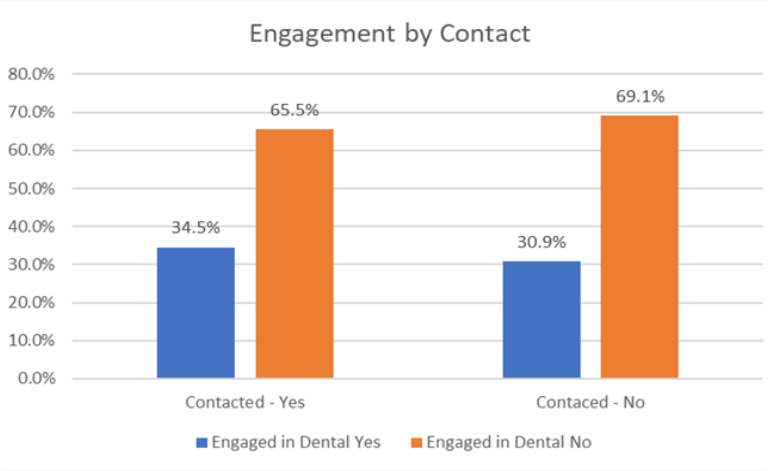
1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** AllCare CCO focuses on improving care for our type 2 diabetics (T2D) population by increasing access to continuous glucose monitors (CGM) through changing utilization management policies and encouraging engagement in care management. This focus population has higher rates of periodontal disease, and annual check-ups can help providers catch and treat disease earlier, resulting in better health outcomes. In addition, poor oral health can make a person's diabetes more difficult to manage. Measuring oral health care in adults with diabetes is important to our equity goals because we know that people subjected to historical and contemporary injustices are more likely to be affected by diabetes. In 2023, AllCare CCO analyzed the data over the full calendar year and determined that our reported population increased due to membership gain and/or new Diabetes diagnosis. A majority of our members in the focus population identified as white, and speak English. The AllCare CCO Care Coordination Leadership team has partnered with our Health Equity team to explore potential methods of expanding our outreach to encourage engagement with our non-white, non-English speaking members. AllCare CCO reviewed the rate of oral health care for the focus population by each REALD component but did not identify any significant disparities. This is likely due to the very high number of white, English speakers currently included. There was not an identified disparity for members with a disability. AllCare CCO intends to review the data using SOGI information as soon as it's available.

2. **Describe whether last year's targets and benchmarks were met (if not, why):** In 2023, the AllCare CCO Care Coordination team focused on reaching out to members who would benefit from a continuous glucose monitor (CGM). In monitoring measure 1.1, the AllCare Care Coordination team started with a baseline of 0%. The AllCare CCO Care Coordination Leadership set a target of contacting 15% of eligible members. The AllCare CCO Care Coordination team has surpassed this target, reaching 64.5%. As a result, the AllCare CCO Care Coordination Leadership has set a new target of 75% as the initial target and the benchmark of 50% has been exceeded. For monitoring measure 1.2, focus was given to educating diabetic members on the importance of getting regular dental care, specifically diabetic oral health exams. The AllCare Care Coordination team started with a baseline of 0%. The AllCare CCO Care Coordination Leadership set a target of 15% of eligible members provided with targeted diabetic education on the importance of oral health. The AllCare CCO Care Coordination Leadership has set a new target of 75% as the initial target and benchmark state of 50% was exceeded. Lastly, the final monitoring measure, 2.1, focused on whether the member received oral health care. AllCare Care Coordination's baseline was at 16.8%, and the AllCare CCO Care Coordination Leadership set a target of 25%. AllCare CCO met this target with 33.2%. The target rate is close to the benchmark, AllCare CCO Care Coordination Leadership has increased this benchmark to 45%. The pie charts below provide a visual indication of our outreach progress.









3. **Lessons learned over the last year:** The AllCare CCO Care Coordination team frequently identified during outreach, that members do not understand or are not aware that they have dental benefits. Education regarding benefits was provided in addition to oral health education during outreach calls. If a dental visit has not taken place in the last 12 months, members are mailed an oral health kit and tangible educational resources as an incentive to schedule an appointment. Simultaneously, we will reach out to our Senior Director, Oral Health Services & Community Engagement team member to coordinate an urgent dental appointment if needed. Overall, the primary barrier identified is access to dental appointments. To address this barrier, our Director of Population Health and the Senior Director, Oral Health Services & Community Engagement met with the Dental Care Organizations to strategize ways to improve access to ensure members receive needed oral health screenings and care.

C. Brief narrative description

1. **Project population:** Special Health Care Needs: Non-Duals Medicaid with a diagnosis of Type 1 or Type 2 Diabetes
2. **Intervention (address each component attached):** AllCare CCO Care Coordination team will outreach to the qualified diabetic population to engage in Care Coordination services working to ensure these members understand care coordination services, their disease pathway, have a care plan and are provided targeted diabetic education on the importance of oral health care. Once they have engaged the member, Care Coordinators will build supportive relationships with the member and their care team, remove barriers to care, support member's education in their own health goals and provide members with additional support needed to engage with their oral health team. Additional support can include assistance with transportation, referrals and appointment support to ensure the member is able to complete diabetic oral health exams and any other necessary dental care. AllCare CCO acknowledges the ongoing instability in the dental workforce. Dental Coordination Organizations (DCOs) receive lists of diabetic patients every quarter and reach out to schedule oral health exams for members. In collaboration with local DCOs, AllCare CCO has recognized the lack of resources and has partnered with one local DCO to bring a dental van to the community once a month to serve our diabetic members. AllCare CCO's Care Coordination teams will also support our members' dental care transportation and work to remove any additional barriers to care.

D. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Outreach to eligible members & enroll into Care Coordination

☒ Short term or ☐ Long term

Monitoring measure 1.1	Initiate contact with identified members determined to be suitable for CGM			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
64.5% of eligible members contacted.	75% of eligible members contacted by care coordination team	12/2024	100% of eligible members contacted by care coordination team	12/2025
Monitoring measure 1.2	Diabetic education on importance of dental exam			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
63.4% of eligible members provided targeted education	75% of eligible members provided targeted education on importance of oral health	12/2024	100% of eligible members provided targeted education on importance of oral health	12/2025

Activity 2 description: Eligible members engage in oral health care

☐ Short term or ☒ Long term

Monitoring measure 2.1	Oral health care			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
33.2% of eligible members had an oral health care visit	38% of eligible members have an oral health care visit	12/2024	45% of eligible members will have an oral health care visit	12/2025

A. **Project title:** Full Benefit Dual Eligible Hypertension

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

If continued, insert unique project ID from OHA: N/A

B. **Components addressed**

1. Component 1: SHCN: Full benefit dual eligible
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

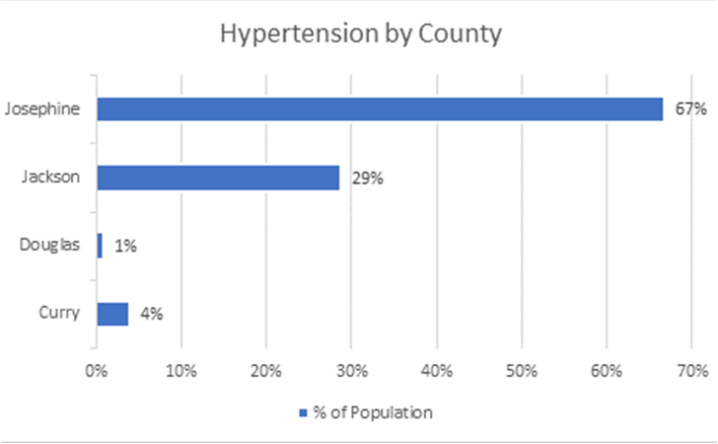
C. **Project context:** Complete the relevant section depending on whether the project is new or continued.

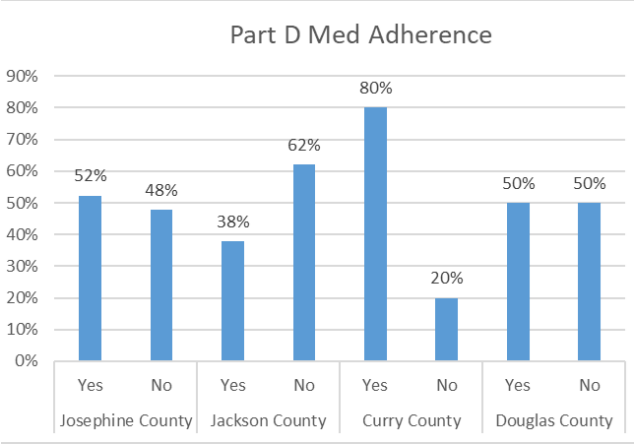
New projects

Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

The national initiative Million Hearts prioritizes evidence-based targets to improve cardiovascular health. Hypertension, known as the “silent killer,” can cause significant morbidity before symptoms arise. This diagnosis may affect at higher rates people from other racial and ethnic minority groups, due to social determinants of health (SDOH) such as health literacy, socioeconomic status, and low awareness rates, dietary habits and access to healthcare. Preliminary review of AllCare CCO internal data revealed low utilization of home blood pressure

monitoring, medication compliance, and overall chronic disease management for our Full Benefit Dual Eligible (FBDE) population. AllCare CCO's focus is to increase the use of automated blood pressure cuffs, medication compliance, and education for all FBDE members engaged in care coordination services through our Population Health department. AllCare CCO has found that 71% of members in this population have a self-reported disability, while 29% do not have a self-reported disability. Based on our REALD data analysis, we discovered that the majority of our targeted population is of Caucasian descent and mainly communicates in English. AllCare CCO Care Coordination Leadership has conducted further data analysis and has identified a total of 8 additional members who self-identified as Black or African American and opted out of Care Coordination services. Our AllCare CCO Care Coordination team will conduct targeted outreach to ensure that all members' needs are being met. The AllCare CCO Care Coordination team has partnered with our Health Equity team to explore potential methods of expanding our outreach and engagement with all members. AllCare CCO has analyzed the data and determined that the identified population percentages for primary Hypertension are as follows: Josephine County: 67%, Jackson County: 29%, Douglas County: 1%, and Curry County: 4%. AllCare CCO acknowledges that some data may not include a small percentage of our members due to them having Medicare coverage outside of AllCare CCO. The charts below represent a visual display of the data.





Continued projects

4. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** N/A
5. **Describe whether last year's targets and benchmarks were met (if not, why):** N/A
6. **Lessons learned over the last year:** N/A

D. Brief narrative description

1. **Project population:** AllCare CCO Full Benefit, Dual Eligible members, engaged in Care Coordination services with a diagnosis of primary Hypertension.
2. **Intervention (address each component attached):** Despite discontinuing the MEPP projects, we have chosen to personalize our outreach for Hypertension and continue with this vital work in 2024. AllCare CCO recognizes the importance of continuing to support our members diagnosed with Hypertension. In 2023, we observed significant benefits to our members from this support. AllCare CCO is committed to delivering the best possible care to all members. This specific outreach program focuses on Full Benefit Dual Eligible (FBDE) population that are engaged in Care Coordination services. To achieve this goal, AllCare CCO Care Coordinators initiated outreach to all eligible members, with a particular focus on helping members who had opted-in to Care Coordination services. AllCare CCO Care Coordinators engaged members in Care Coordination, offering them support to manage their primary Hypertension diagnosis. The AllCare CCO Care Coordination team identifies whether the member has a blood pressure cuff at home. If they don't, our team will assist the member in obtaining a blood pressure cuff. Once we confirm that the member has a blood pressure cuff, we provide clear instructions on how to use the device, record their readings daily and share this information with their care team. Self- monitoring for members diagnosed with Hypertension or other conditions that could contribute to

high blood pressure such as diabetes or kidney problems, is essential. Educating members on the importance of understanding and monitoring their blood pressure numbers empowers them to feel more in control of their health, can aid in early diagnosis, treatment control, and help them engage in physical activity and improve their diet and medication tracking and use. The AllCare CCO Care Coordination team also offers additional education on their care plan, including medication and the importance of adhering to their prescribed plan. The AllCare CCO Care Coordination Dietitian will contact all identified members diagnosed with primary Hypertension to discuss their condition and diet. This is to help support their provider's treatment plan and health guidelines, ensure that the members are educated about maintaining a healthy diet, support their condition, and assist them in removing any barriers to a healthy diet. AllCare CCO Care Coordinators will utilize available REAL-D, SDOH and SOGI data to address identified health inequities and barriers to health in support of managing the member's condition.

E. **Activities and monitoring for performance improvement** (duplicate until all activities and measures are included)

Activity 1 description: Automated Blood Pressure Cuff

☒ Short term or ☐ Long term

Monitoring measure 1.1	Automated Blood Pressure Cuff outreach			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
35% members are identified with a blood pressure cuff.	50% of eligible members contacted by care coordination team and have an automated blood pressure cuff	12/2024	65% of eligible members contacted by care coordination team	12/2025
Monitoring measure 1.2	Education from Dietitian on Heart Healthy Diet			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 % of eligible members will receive targeted education from our Dietitian	20% of eligible members targeted on education provided by our Dietitian	12/2024	35% of eligible members will be contacted by our Dietitian	12/2025

Activity 2 description: Management of condition

☐ Short term or ☒ Long term

Monitoring measure 2.1	Education on Medication Adherence Part D			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of eligible members received targeted medication education	20% of eligible members targeted on medication adherence and the importance of taking medications daily.	12/2024	35% of eligible members will be adherent in their medication regimen	12/2025

A. **Project title:** Increasing engagement of individuals diagnosed with a SPMI

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

If continued, insert unique project ID from OHA: 412

B. **Components addressed**

1. Component 1: Serious and persistent mental illness
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. **Project context:** Complete the relevant section depending on whether the project is new or continued.

New projects

Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

N/A

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**
   The original focus of this project was to increase engagement in mental health services for individuals newly diagnosed with a Serious and Persistent Mental Illness (SPMI). AllCare provided our mental health partners with a weekly report of members who were newly diagnosed with a SPMI diagnosis and our partners utilized phone outreach to these individuals with the intent of providing education on local services, brief SDOH screenings, instruction on how to access the services, and to assist members in scheduling appointments. During this project, it was noted by our mental health partners doing the outreach, that the member feedback regarding the outreach was negative in nature. Members stated they felt their privacy was being intruded upon when contacted regarding their recent diagnosis and mental health services available. For this reason, the project was halted for evaluation in Q2 of 2023. During Q3, the AllCare data team ran reports to determine how each of our contracted clinics were doing on the measure. It was found that most behavioral health clinics scored 70% or higher, and most of the medical clinics scored 40% or lower in getting newly diagnosed individuals follow-up care for mental health within one year of diagnosis.
   This helped determine that there should be a shift in focus to the primary care medical clinics and assisting them in connecting their patients to mental health services when they have been diagnosed with a mental illness. After meeting with office managers from some of the medical clinics, we learned that medical providers could benefit from training on how open access works at the local mental health clinics, and that medical providers needed a streamlined referral pathway. In Q4 2023, AllCare published a modified referral form informed by our mental health providers, which gives medical clinics the ability to request the referral be expedited if the individual has been newly diagnosed with a mental illness. We also provided a training for our medical providers on how mental health clinics run open access, how open access is utilized by members, and how to best support members to gain access to mental health services. This information seemed to be well received by the medical providers.
   AllCare also proposed adding a mental health access measure to the 2024 Value Based Payment (VBP) programs for primary care medical and mental health clinics. The mental health clinics have agreed to this additional measure. The medical providers did not add the measure as they have had difficulty with the Initiation and Engagement of Substance Use Disorder Treatment incentive measure, and had concerns regarding similar challenges. We will be meeting internally and with the medical providers throughout 2024 to address perceived challenges and ensure the measure is achievable. The hope is to add the measure to the 2025 Primary Care VBP.

To ensure this project continues to move forward during 2024, the CCO has taken on the responsibility of outreach to members within the identified population. It is hoped that if the CCO is doing the outreach, our members will feel less like their privacy is being breached as this would be a reasonable topic for Care Coordinators to provide outreach for. AllCare will be monitoring feedback regarding the CCO outreach to ensure there are no negative feelings from our members.
READ data was assessed to identify disparities for any of our members. AllCare has a revised Demographic policy that discusses a process for including SOGI data for assessment once it is available. When doing a comparison of non-English speaking individuals with a SPMI, the largest group was Spanish speaking members, who make up 1% of the project population. Of these, 52% are engaged and 48% are not engaged in mental health services. AllCare has begun to engage in outreach to the larger mental health agencies to evaluate interpreter services and explore what barriers may exist to using interpreter services. Through conversation with larger provider offices, we have found that therapists want to ensure they can use the same interpreter for the same member, for each session. Relationship is a key component to successfully engaging in the therapeutic process, and when the interpreter changes each session, building rapport becomes challenging. AllCare's interpreter training program is partnering with the behavioral health department to see if there are modifications to the training that would be helpful in preparing interpreters to work in the mental health field.

2. **Describe whether last year's targets and benchmarks were met (if not, why):** Last year's targets were not met. In Activity 1, the goal was to increase engagement with the adult SPMI population from 78% to 80% by 01/2024. This number instead decreased during 2023 to 60%. We believe this was a result of stopping the outreach being provided by our mental health partners. As described above this outreach was stopped due to member feedback.
For Activity 2, the first monitoring measure was to increase engagement of individuals diagnosed with Major Depressive Disorder (MDD) from 70% to 75%. This number too decreased, and dropped to 55% by the end of 2023. We again believe this was due to stopping the outreach efforts. For the remaining measures in Activity 2, there were no individuals identified as newly diagnosed with MDD Severe with Psychotic Features.
Progress was made on Activity 3. A value-based payment (VBP) measure was created to focus on increasing services to individuals newly diagnosed with a mental illness. This measure was rolled out for participating mental health providers at the start of 2024. We are hoping to introduce a similar VBP measure, with the same goal of increased access, for our participating PCP's in 2025.

   This chart provides summary of changes in engagement over the past 3 years:

Members	2021 Percent Engaged	2022 Percent Engaged	2023 Percent Engaged
SPMI Members	66%	78%	62%
Diagnosis Categories	**2021 Percent Engaged**	**2022 Percent Engaged**	**2023 Percent Engaged**
BIPOLAR	74%	84%	73%
MAJOR DEPRESSIVE	57%	70%	55%
MANIC EPISODE	86%	82%	63%
OBSESSIVE COMPULSIVE	59%	75%	49%
POST TRAUMATIC STRESS	84%	89%	66%
SCHIZOPHRENIA AND PSYCHOTIC	78%	86%	79%
SCHIZOTYPAL	100%	100%	50%
Grand Total	**66%**	**78%**	**62%**

3. **Lessons learned over the last year:** During the first half of 2023 it became clear through member feedback that having our mental health partners do outreach to newly diagnosed individuals was not well received by the

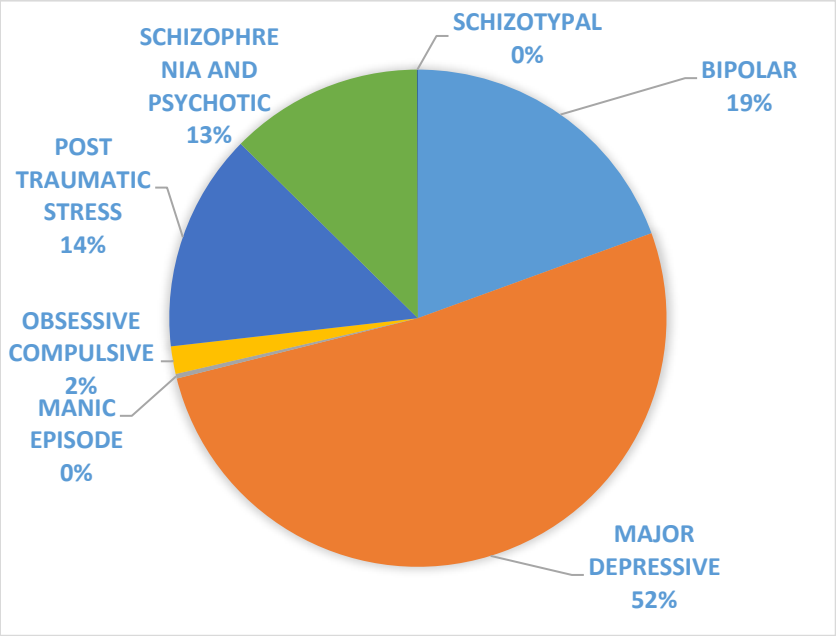
population. Members stated they felt their privacy was being intruded upon when contacted by the mental health provider regarding the recent diagnosis and mental health services available. Through the QI process, it was decided by the group to discontinue this intervention and go back to the drawing board to develop a new plan. Although the medical clinics have opted to not implement the mental health access VBP measure this year, we are hopeful that through additional discussion, this will be added in 2025.

D. Brief narrative description

1. **Project population:**
The population denominator is identified as any member receiving a mental health service encounter meeting the numerator service criteria in the 24-month identification window where diagnosis of mental illness is in the first three diagnosis codes, is a SPMI diagnosis. For Activity 1 the individual must also have a perc code identifying them as disabled. An individual will be excluded if they have been in hospice care during the measurement year, had a gap of eligibility greater than 45 days during the measurement year, or if the service was provided at a laboratory.

   The population numerator is defined as any members receiving at least one outpatient mental health service meeting at least one of the following criteria, applied by claim line, in the 12-month measurement year, and after the denominator event:
   1. Receipt of an outpatient service with a procedure code in the MH-Proc1 value set
   2. Receipt of an outpatient service with:
      a. Servicing provider taxonomy code in the MH-Taxonomy value set AND
      b. Procedure code in MH-Proc2 value set OR MH-Proc3 value set AND
      c. Primary diagnosis code in the SPMI-Diagnosis value set combined
   3. Receipt of an outpatient service with:
      a. Procedure code in MH-Proc4 value set AND
      b. Any diagnosis code in the SPMI-Diagnosis value set combined
   4. Receipt of an outpatient service with:
      a. Servicing provider taxonomy code in the MH-Taxonomy value set AND
      b. Procedure code in MH-Proc5 value set AND
      c. Any diagnosis code in the SPMI-Diagnosis value set combined
   5. Receipt of an outpatient service with:
      a. Procedure code in MH-Proc3 AND
      b. Primary diagnosis code in the SPMI-Diagnosis value set combined
2. **Intervention (address each component attached):** The goal of this project is to increase mental health access, specifically for individuals who have been diagnosed with an SPMI diagnosis and have been identified as having a disability. Current interventions include direct outreach by AllCare staff to identified members, and a VBP measure created for mental health providers. Future interventions include a similar VBP measure for participating medical clinics.
   The outreach provided by AllCare staff will be specific to individuals diagnosed with SPMI, who are also identified as having a disability. As can be seen in the chart below, about 1/3 of members diagnosed with SPMI are also identified as having a disability. The pie chart provides a visual of the individuals who have a disability, which SPMI diagnosis they are carrying.

Disability	Members with SPMI Dx	Engaged in MH Services	Not Engaged in MH Services	Percent Engaged	Percent Not Engaged
No	2917	1713	1204	59%	41%
Yes	1626	1092	534	67%	33%
Grand Total	**4543**	**2805**	**1738**	**62%**	**38%**



E. **Activities and monitoring for performance improvement** (duplicate until all activities and measures are included)

Activity 1 description: Increase mental health access for individuals who have been diagnosed with an SPMI diagnosis and have been identified as having a disability through outreach completed by the CCO.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Increase MH access SPMI+disability			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
67% members w/ disability receiving follow-up after SPMI dx	70%	01/2025	73%	01/2026

Activity 2 description: Engage both mental health and physical health providers in a value-based payment structure to increase mental health access for individuals who have been diagnosed with an SPMI

☐ Short term or ☒ Long term

Monitoring measure 2.1	Increase mental health access for SPMI members diagnosed by mental health providers. Receive follow-up appointment within 90 days of initial diagnosis.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
89% members receiving follow-up after SPMI diagnosis	92%	01/2025	95%	01/2026
Monitoring measure 2.2	Increase mental health access for SPMI members diagnosed by PCP's. Develop VBP measure with participating PCP's based on follow-up appointment for members diagnosed with SPMI			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

VBP measure not included in 2024 Primary Care VBP	VBP measure developed and proposed for 2025	10/2024	Improve follow-up appointment for members diagnosed by PCPs by 5%	01/2026

A. **Project title:** Behavioral Health Integration

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

If continued, insert unique project ID from OHA: N/A

B. **Components addressed**

1. Component 1: Behavioral health integration
2. Component 2 (if applicable): CLAS standards
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? 12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area

C. **Project context:** Address Behavioral Health treatment in Primary Care with a focus to increase percentage of marginalized population receiving care at target clinics

New projects

Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

Review of CCO membership data indicates that 42% of AllCare Health's membership has a behavioral health diagnosis, and of that percentage, about half engage in mental health treatment. Many members that find barriers to engaging in behavioral health systems continue to see their primary care provider. To increase behavioral health utilization and improve member outcomes, we have integrated behavioral health to identify and treat members where they present for care. Behavioral Health Integration (BHI) provides space to improve identification of behavioral health diagnoses and engagement in treatment in a primary care setting, while providing feedback to the primary care team regarding progress in traditional psychotherapy referral and follow-up. Clinic collected REALD and SOGI data was reviewed for this population and presents very low numbers, <2%, of marginalized populations engaged at target clinics for care. As part of the BHI initiative, leadership will work with the targeted clinics to develop strategies for intentional outreach and staff training beyond their current practice to encourage engagement with these members. The progress to date has demonstrated an anecdotal benefit to members and primary care providers. With a focus on Key Performance Indicators for engagement, we intend to demonstrate positive engagement outcomes and efficacy of the treatment model. In December of 2023, measures indicated that the embedded case manager had 138 hours of production with a reach of approximately 16%.

Continued projects

4. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** N/A
5. **Describe whether last year's targets and benchmarks were met (if not, why):** N/A
6. **Lessons learned over the last year:** N/A

D. **Brief narrative description**

1. **Project population:**
   AllCare CCO membership presenting for care at the targeted clinics of Cedarwood, Illinois Valley, and Glendale Family Practices.
2. **Intervention:**

Activity 1.1: Behavioral Health Engagement
The following process was implemented at the targeted clinics to increase Behavioral Health engagement for members scoring a 10 or higher (indicating moderate to severe) on the Patient Health Questionnaire-9 (PHQ-9) or the Generalized Anxiety Disorder – 7 (GAD-7) screening tools which are used to identify depression and anxiety:

a. Text-based patient interface of PHQ- 9 scoring 10 or higher - automatic referral to BHI Care Manager and Psychiatrist to begin intervention and/or
b. Exam room screen with Medical Assistant, and identification of current mental health diagnosis or Depression/Anxiety screen PHQ-9 and GAD-7 score 10 or higher - provide "warm connection" , the provider team introduces the member, to embedded Care Manager. This Warm Connection assists in lending the member's trust in their primary care team to the case manager
c. BHI Care Manager brief intervention and tracking, concurrent with Psychiatric review, determination, consult with primary care, and documented in patient chart.
d. Care Manager to follow-up, per plan, for 6-12 weeks followed by titrated 1,6, and 12-month relapse follow-ups.
e. At 6-12 week active close, Care Manager to provide "Warm Referral", the case manager introduces the member to intake staff, to outpatient mental health therapy as needed. This warm referral assists in lending the member's trust in the case manager to the intake staff.
f. Consulting Psychiatrist and Care Manager to note in clinic EHR for Primary Care Provider review.

Activity 1.2: Provider team in-person access to BHI Care Manager at least 50% of clinic hours of operation
The integration model is most effective when the primary care team is able to provide a "warm connection", in-person referral. In first quarter 2024 the data shows the primary care team is making an electronic referral to case management 65% of the time. To improve practice of the model, we will review and update processes to encourage in-person referral at least 50% of the clinic's hours of operation for 2025 and 80% by 2027.

Activity 2: Increase percentage of marginalized membership receiving care at targeted clinics
Review of clinic collected REALD and SOGI data for the target population indicated the majority of members who engaged in care were white, cisgender, heterosexual, English speakers. It is important to increase the percentage of diverse and marginalized member participation at targeted clinics to reflect the county's population. A target of 4% in 2025 more accurately reflects the county's population, moving to a goal of 7% for 2027 will demonstrate the targeted clinics as clinics of choice for marginalized populations. Strategies to increase diverse membership will include:

- Gender Affirming Practice training
- Crisis de-escalation with Trauma-Informed Care training
- Cultural responsiveness
- Inclusive language for outreach and clinic signage
- Process for accessing interpreter/language line at time of "Warm Connection"
- Addition of medically certified Spanish speaking Care Manager

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Identify and connect patients with behavioral health diagnosis with Care Manager

☐ Short term or ☒ Long term

Monitoring measure 1.1	Care Manager Reach (Utilization)			
Baseline or current state	**Target/future state**	**Target met by**	**Benchmark/future state**	**Benchmark met by**
16%	22%	12/2025	30%	12/2027
Monitoring measure 1.2	Provider team access to Care Manager for "Warm Connection" (Access)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
35%	50%	12/2025	80%	12/2027

Activity 2 description: Increase percentage of marginalized membership receiving care at targeted clinics

☐ Short term or ☒ Long term

Monitoring measure 2.1	Increase percentage of marginalized population members receiving care at targeted clinics.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2% of clinic population	4% of clinic population	12/2025	7% of clinic population	12/2027

A. **Project title:** Support Increased Access to Oral Health Services within a Physical Health Setting and Oral Health Referrals to Community Services

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

If continued, insert unique project ID from OHA: 55

B. **Components addressed**

1. Component 1: Oral health integration
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. **Project context:** Complete the relevant section depending on whether the project is new or continued.

New projects

Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

N/A

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**
   In 2023, our dental subcontractors continued to experience an extreme shortage of dentists and hygienists, which in turn, did not yield the desired results we had hoped for this project. AllCare continued to support the hygienist in the behavior/physical health setting and kept in close contact with her regarding the challenges she faced. In Curry County, we were able to continue the work with the HRSA grant and Coast Community Health to open a four chair clinic within the Federally Qualified Health Center which is due to open in mid-September 2024. There has been a dentist and support staff hired, living arrangements secured, remodeling is taking place and we feel this will successfully open on the date selected. In reviewing REALD data, it showed that members

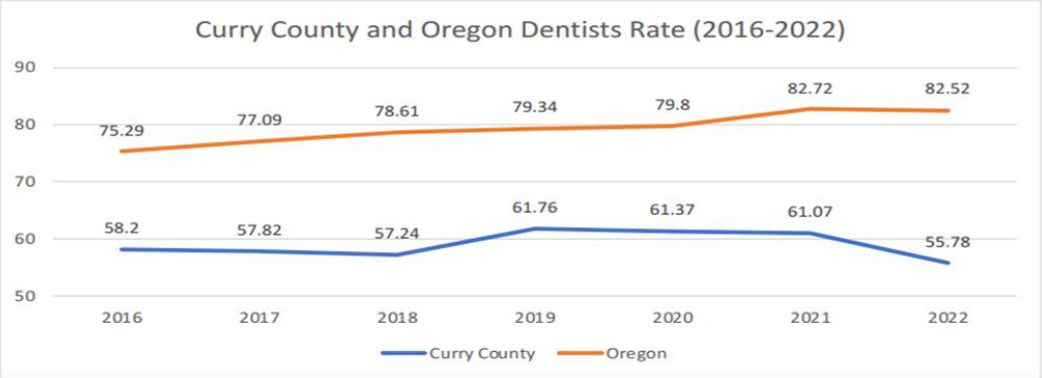
identifying as African American or Native Hawaiian, Pacific Islander had marginally lower rates for receiving oral healthcare than other CCO members. There were no significant disparities found by looking at language spoken or disability status. When breaking the data down by age, it shows that 23% of adults vs. 58% of children had a visit. The larger percentage of children receiving oral healthcare is likely due to all the work done in the area to ensure preventive oral health services are provided in schools. When the data is reviewed by county, Curry and Douglas County have a rate of 33%, Jackson County has a rate of 25% and Josephine has a rate of 37%. SOGI Data will also be included in this analysis once it is available.

2. **Describe whether last year's targets and benchmarks were met (if not, why):** In 2023, our dental subcontractors were hit with extremely high vacancies in the dental offices with little or no success in recruiting providers. This was due in part to the lack of students entering the field of dentistry or dental hygiene, and the continued number of workforce dentists and hygienists leaving the area or retiring early. As a result of these challenges, the designated hygienist was not able to go into the behavioral/physical health setting as frequently as she had before. She was needed to fill in at the clinics or in the schools to help provide necessary services. As a result of the success in Curry County, we have decided to shift the focus of this project toward Curry specific expansion and access, followed by Josephine County. Josephine County has a location secured for a new dental clinic with a new dental partner. We are unsure of the ability to integrate into the AllCare Medical Group clinics at this time due to the shortage of hygiene providers and the lack of providers entering the workforce. Unfortunately, in 2023, the number of follow up visits to the dental home decreased due to the limited number of hygienists available to work at the non-traditional settings so we didn't meet our goal of 10%. AllCare would like to continue this part of the project, but would like to set a target to an increase of 5%. Regarding community partners using Unite Us, dental partners are still navigating usage and the system itself. Referrals are gradually being sent which shows a slight increase. However, we did not meet the target of three, and will change to a target of increasing referrals by two per month. We did notice that our FQHC dental partners received a good number of referrals and we will collaborate with them and Unite Us to see what we can do to increase the referrals sent and received. We would like to explore best practices used in their environment that has contributed to their success. The figures below show the number of dentists per 100,000 and student dental care rates in Curry County.

Dentists Rate

Figure 96 shows the number of dentists per 100,000 residents in Curry County. In 2022, there were 55.78 dentists (13 dentists) per 100,000 residents, a decrease from the previous year of 61.0 (14 dentists) per 100,000. Curry County lagged behind Oregon in dentist rate per 100,000 residents from 2016 to 2022.

Figure 96: Curry County and Oregon Dentists Rate (2016-2022)



Source: County Health Rankings Data (2016-2022)

Students Dental Care

Oregon's 2020 Student Health Survey reports the percentage of middle and high school students who did not receive any dental care during the last year which includes a check-up exam, teeth cleaning or any other dental work. In Curry County, 31 percent of 6th graders did not receive any dental care which is approximately double that of Oregon's statewide average of 15.9 percent. For 8th graders in Curry County, 25.8 percent did not receive dental care over the last year, and this is also higher than Oregon's statewide average of 18.2 percent of 8th graders not receiving dental care. There is no data for 11th graders in Curry County not receiving dental care in 2020.

Figure 97: Percentage of Middle and High School Students Who Received Dental Care During Past Year (2020)

PERCENTAGE OF MIDDLE AND HIGH SCHOOL STUDENTS WHO RECEIVED NO DENTAL CARE DURING THE PAST YEAR, 2020		
Did not receive dental care during the past year (including a check-up, exam, teeth cleaning, or other dental work).		
STUDENTS	CURRY COUNTY	OREGON
6th graders	31.0%	15.9%
8th graders	25.8%	18.2%
11th graders	Not available	23.2%

Adapted from the 2020 Oregon Student Health Survey

3. **Lessons learned over the last year:** There have been many lessons learned, but unfortunately few solutions have been found to assist with trying to improve the situation. Recruitment is very stretched nationwide, and offices are competing with each other to get dentists before they even graduate school. We have also learned that patience is a virtue and securing providers to come work at a location is even more difficult in Curry County.

D. Brief narrative description

1. **Project population:** low-income individuals and families; persons with disabilities; and individuals who identify as lesbian, gay, bisexual, transgender or queer, or who question their sexual or gender identity.
2. **Intervention (address each component attached):** By working with the FQHC in Curry County to implement and expand dental services, we will achieve oral health integration into a location where both physical and behavioral health services are offered. We will also work to expand services in Jackson County since that area showed a big disparity, as well as increasing access for our adult population. We will be looking at direct contracting with FFS providers in Jackson County to increase the number of available providers and increase the available access points. We have also partnered with a local DCO to bring a dental van to the community once a month to serve our diabetic members.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: AllCare will continue to increase oral health access and services into behavioral and physical health clinics in Jackson, Josephine, Curry and Southern Douglas Counties. ☒ Short term or ☒ Long term

Monitoring measure 1.1	AllCare's Sr. Director of Oral Health Services & Curry Community Engagement will continue to monitor the progress of the number of patients seen at the clinic in Brookings at the FQHC			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently the clinic is slated to open on September 16, 2024 and AllCare will contract to see patients there.	Monitor the opening of clinic and ensure the clinic location where dental services are provided to the members of Curry County are appropriate.	9/2024	Monitor the number of patients seen for the remainder of 2024 after opening by running reports on encounters.	12/2024

Monitoring measure 1.2	AllCare's Sr. Director of Oral Health Services & Community Engagement will continue to monitor the percentage of patients seen at non-dental locations as well as the percentage of follow up visits, and work with the oral health professionals to assist members in scheduling and attending appointments.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Follow up visits to the dental home decreased significantly, from 60% to 40% due to the lack of an available provider in the integrated setting.	Increase the number of follow up visits to Dental Home by patients seen by the hygienist in integrated settings by 5% (45%)	12/2024	Increase the number of follow up visits to the Dental Home by patients seen by the hygienist in integrated settings by 10% (50%)	06/2025

Activity 2 description: The DCO's, dental partners and providers, and community stakeholders are beginning to implement referrals for different social services needed. AllCare will continue to engage Unite Us with the partners to improve use of the Connect Oregon platform for referrals from the dental office to services in the community.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Unite Us Referrals			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Community partners using Unite Us, dental partners are still navigating usage and the system itself. Referrals are slowly being sent which is a slight increase however we did not meet the target of 3, and will decrease to a target of 2.	Targeted oral health professionals and clinics identified and goal is to increase the number of referrals sent by 2 per month. We will be working with Unite Us and our FQHC partners to utilize best practices to increase referrals.	12/2024	Pull data related to referrals and utilization of the CIE to establish baseline utilization. Collaborate with the DCO's, Community Partners and Unite Us to increase referrals made by dental offices using Unite Us data. Increase referrals sent by 4 per month.	06/2025

A. **Project title:** Patient Centered Primary Care Home (PCPCH)

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

If continued, insert unique project ID from OHA: 54

B. **Components addressed**

1. Component 1: PCPCH: Member enrollment
2. Component 2 (if applicable): PCPCH: Tier advancement
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No

5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. **Project context:** Complete the relevant section depending on whether the project is new or continued.

New projects

Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

N/A

Continued projects

Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):

As predicted in our previous TQS submission, there was a drop in the percentage of the AllCare CCO membership assigned to a PCPCH clinic. As of 12/31/2023, AllCare CCO enrollment for members with physical health coverage was 64,450. Of those members, 56,850 (88.21%) were assigned to one of the 46 recognized PCPCH clinics in our service area. These numbers reflect a decrease in the percentage of members assigned to a PCPCH clinic (91.2% in 2022). AllCare has reinstituted a position (PCPCH Program Advisor) that is solely focused on supporting our partners in becoming recognized PCPCH clinics and maintaining or improving recognition status. We have also added a role, MSO (Management Services Operations) Programs Manager, that provides support for clinics (that opt-in) in all VBP programs, including PCPCH. While the year end results are disappointing, we anticipate improvement in 2024 with the expanded capacity of these two roles. The new recognition standards may pose some challenges, but our goal of improvement remains. AllCare is continuing to offer a PMPM, (Per Member Per Month) payment to clinics in our network based on PCPCH tier level, panel size and location. The graduated payment structure has been helpful when working with clinics who are close to achieving a higher tier level as it allows us to readily demonstrate financial impact.

Member Assignment by PCPCH Tier Level

Tier 3	Tier 4	Tier 5	2023 Total Membership assigned to a PCPCH clinic	2022 Total Membership assigned to a PCPCH clinic
(13) 28.3%	(28) 60.8%	(5) 10.9%	88.21%	91.2%

We have reviewed REALD data and will review SOGI data once it is available to us. Upon reviewing the REALD data, we noticed that the greatest disparity is among our African American members who are assigned to a PCPCH clinic.

REALD PCPCH Enrollment by Race

Race- Grouped	PCPCH		Grand Total	Percentage assigned to a PCPCH clinic
	N	Y		
White	4702	35277	39979	88%
African American	124	545	669	81%
American Indian/Alaska Native	107	878	985	89%
Asian	108	573	681	84%
Hispanic or Latino	641	3439	4080	84%
Native Hawaiian and Pacific Islander	37	186	223	83%
Other/Unknown	1991	15393	17384	89%

READALD data shows an equitable distribution of members with and without a disability assigned to a PCPCH.

PCPCH Enrollment by Disability

Disability	PCPCH		Grand Total	
	N	Y		
N	5591	40714	46305	88%
Y	2119	15577	17696	88%
Grand Total	7710	56291	64001	88%

READALD data shows a 3% lower percentage of members who speak Spanish being assigned to a PCPCH.

PCPCH Enrollment by Language

Language	PCPCH		Grand Total	
	N	Y		
English	7340	54084	61424	88%
Spanish	308	1683	1991	85%
Other	22	171	193	89%
Undetermined	10	177	187	95%
Did not answer	2	48	50	96%
Chinese	3	39	42	93%

*Additional member data excluded due to low population sizes

The PCPCH Program Advisor will continue to perform outreach to all practices prioritizing those that have higher rates of members who identify with minoritized groups and members who speak non-English languages.

1. **Describe whether last year's targets and benchmarks were met (if not, why):** The target of an annual increase of 3% in members assigned to a PCPCH clinic for 2023 was not met. While there was only a decrease of 112 members assigned to a PCPCH clinic, the total enrollment for 2023 increased by 2,340 which impacted our overall percentage. Additionally, changes in leadership at clinics and some closures at previously recognized clinics negatively impacted the AllCare PCPCH membership totals. Internally, the staff member in the Provider Programs Coordinator role took on additional responsibilities not related to PCPCH. This change highlighted the importance and impact of having an individual in this role who can be solely focused on PCPCH support and improvement.
2. **Lessons learned over the last year:** Our decline in the percentage of members assigned to a PCPCH clinic demonstrates the importance of having a person on staff at AllCare who is focused specifically on supporting clinics seeking to achieve, maintain or improve recognition status. With the knowledge that the recognition criteria will be changing effective January 1, 2025, it emphasizes the necessity to provide our partners as much support as we can.

D. Brief narrative description

1. **Project population:** AllCare CCO members with physical health coverage
2. **Intervention (address each component attached):**
   PCPCH: Member Enrollment & PCPCH Tier Advancement – AllCare CCO recognizes and believes that by rewarding high quality, efficient care we can support our providers and, most importantly, our members, in achieving better health outcomes. This is the basis for our plan to increase member assignment to recognized PCPCH clinics and to encourage upward tier recognition. AllCare CCO incentivizes provider offices for PCPCH recognition based on tier level, panel size, and geographical location. PCPCH payments are made using a per-member-per-month (PMPM) model. PMPM rates are adjusted for practices for the following reasons: 1) PCPCH tier level; 2) number of members assigned to the practice; and, 3) greater distance from a designated city center. Additionally, AllCare will provide information and support as clinics prepare for future attestations under the new PCPCH quality standards.

E. **Activities and monitoring for performance improvement** (duplicate until all activities and measures are included)

Activity 1 description: Because PCPCH clinics have been shown to provide high quality, cost-effective care for their patients, AllCare Health CCO will work to increase the percentage of its members who are assigned to providers at PCPCH recognized clinics.

As with recognized clinics, member assignment will be prioritized by those performing at higher levels. Clinics performing below the quality benchmarks will be offered additional support as they work to improve their outcomes.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Increase percentage of members assigned to PCPCH recognized clinics			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
88.21% of AllCare members assigned to PCPCH recognized clinics as of 12/31/2023	3% increase from baseline annually	12/2024	93%	12/2025

Activity 2 description: Increase number of clinics that are PCPCH recognized and/or increase tier at a level 3 or 4.

In an effort to promote tier level advancement, we will utilize our PCPCH Program Advisor to provide consulting services in an ongoing, supportive role with practices during and after the PCPCH certification process. The PCPCH Program Advisor will work to advise practices to attest to the standards that practices have confidence in meeting, while encouraging them to explore ways to incorporate continuous improvement modalities.

Strategies used to promote participation include:

- Initiating contact via email and by phone to orient practice staff to the PCPCH program model
- Providing education on the benefits of PCPCH program participation and the proven positive impacts becoming a PCPCH practice has on clinical outcomes

- Offering guidance in the following ways:
    - Sharing AllCare CCO's current payment methodology along with an example of the practice's monthly payout based on members currently assigned at each tier level (tier 3 and higher)
    - Reviewing the PCPCH Technical Assistance Guide with practices and giving clarification on standard criteria
    - Assisting practices with assessing current state, and identifying barriers and opportunities for improvement in order to successfully satisfy PCPCH standards.
    - Making workflow recommendations to improve alignment with PCPCH measure intent and purpose.
    - Providing on-site PCPCH support to practices to prepare for PCPCH verification survey and offer to be present during the survey process
    - Advising practices who are interested in achieving 5 STAR recognition to prioritize satisfying criteria for at least 13 of the 16 5 STAR designation measures
    - Helping practices select and interpret clinic quality measures, and provide guidance data collection and reporting of selected measures
    - Suggesting that practices adopt a team-based approach to care and develop new processes such as care coordination, screening for social determinants of health, and integration of behavioral health and dental services.

- Recommending that practices optimize reporting functions in their electronic health record system and claims data to drive improvement activities
- Offering training to practices on developing Plan-Do-Study-Act (PDSA) cycles to demonstrate improvement efforts
- Continuing to enhance understanding of organizational conditions and identify the best practices of high performing clinics
- Providing on-site PCPCH support to practices in preparation for PCPCH verification survey
- Keeping abreast of changes to PCPCH program including updates to quality measures and any revisions to standards and informing practices of any changes that may be relevant to the practice in a timely manner.

As it pertains to PCPCH, the MSO Programs Manager provides more hands-on technical assistance with inner office policies, data extraction and auditing of clinical data. This allows clinics to allocate their resources toward providing an increased level of patient care.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Increase weighted tier rating			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
OHA Tier Weighted Formula: 68.51% Total Members as of 12/31/2023: 64450 Tier 1: 0 Tier 2: 0 Tier 3: 8025 Tier 4: 47421 Tier 5: 1404 Total Members assigned to PCPCH practices as of 12/31/2023: 56850	Increase weighted value by 3% to a target of 71.5%	12/2024	Annual improvement targets of +3% apply until AllCare attains current statewide CCO average.	12/2025 (+3% from baseline)

Section 2: Supporting information (optional)

Submit your final TQS by July 15 through the CCO Contract Deliverables Portal. (The submitter must have an OHA account to access the portal.)