March 2023

IHN-CCO Transformation & Quality Strategy

InterCommunity Health Network CCO

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Section 1: Transformation and Quality Project Details

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438	Equitable Access to Traditional Health Workers	Health Equity: Cultural Responsiveness; Social Determinants of Health & Equity
441	Expanded Dental Health Delivery Model	Oral Health Integration
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440	Medicaid Efficiency and Performance Program	Utilization Review
434	Mental Health Home Clinic	Behavioral Health Integration
436	PCPCH: VBP & Consultant	PCPCH: Tier Advancement
437	Pharmacy Care Coordination for High-risk Members	Special Health Care Needs: Non-Dual
NEW	Under Pressure: Managing High Blood Pressure to Decrease Morbidity and Mortality Risks	SHCN: Full Benefit Dual Eligible; Serious and Persistent Mental Illness

OHA Transformation and Quality Strategy (TQS) **CCO:** InterCommunity Health Network CCO

A. **Project short title**: Equitable Access to Traditional Health Workers

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

If continued, insert unique project ID from OHA: 438

B. **Components addressed**

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Health equity: Cultural responsiveness
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☒ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and READLD data. This is broader than the specific TQS project.

IHN-CCO's 2022 community partnerships included the funding 50 community-based projects to support social determinants of health and equity to support the mission of ending health disparities. Through the COVID-19 pandemic, IHN-CCO increased efforts to support members with social determinants of health and equity (SDoH-E) in the most vulnerable populations, including communities of color, immigrant and refugees, the disabled, and LGBTQIA2S+ members. IHN-CCO has seen a 60% increase in the number of certified THWs serving members and has focused on the implementation of THW services in non-clinical spaces including housing/shelter organizations, dental practices, and churches. Projects have also addressed cross training or integrating multiple THW worker types in programming; i.e., Peer Doulas and Peer Support and Wellness specialists in early education.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and READLD and SOGI data.

Activity 1 description: Quantify and Assess THW Workforce including the THW network breadth and training needs

1.1 Baseline data received and analyzed for contracted THWs with IHN-CCO: IHN-CCO developed a new THW Provider roster tool intended to provide a fuller understanding of the demographics of contracted THWs. Contracts were reviewed to assess populations, regions, and prioritized needs. *COMPLETED*

1.2 Baseline data received and analyzed for non-contracted THWs in IHN-CCO's service area: Through the Delivery System Transformation committee and Traditional Health Worker Workgroup, IHN-CCO maintained and developed relationships with non-contracted THW programs, supported program development and assessed gaps in service. The newly hired THW Liaison built relationships with new partners and assessed contract readiness of each. *COMPLETED*

Activity 2 description: Foundation for strategic planning through the THW Workgroup and DST for investments in THWs in housing and culturally specific community-based organizations developed

2.1 Feedback loop completed with the Workgroup and DST and plan developed: IHN-CCO's THW Workgroup completed an extensive SWOT analysis in January 2022 that informed both funding decisions

and programming throughout the year (attached). Strategic planning related to identified needs included workforce development, organizational/administrative support, and pay equity. *COMPLETED*

Activity 3 description: Investments in additional THWs in housing and culturally specific organizations

3.1 Request for Proposal developed for THW pilot projects with the DST: The DST funding RFP was developed including priorities areas addressing Traditional Health Workers with community partners. *COMPLETE*

3.2 Investments made through pilot projects with the DST: The Delivery System Transformation Committee and SHARE Initiatives currently have 15 active projects for a total of nearly $1.3 million invested in projects involving THWs. Additional programming will be funded throughout 2023. *ON TRACK*

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

IHN-CCO's Traditional Health Worker Workgroup has informed all aspects of this project throughout. A subcommittee of the larger Deliver System Transformation, the THW workgroup consists of 45 members representing both practicing THWs and THW program administrators. Through the 2022 SWOT and strategic planning process, this workgroup has identified the need to expanding workforce development activities to include workforce retention and expansion. Among these needs the group identified priorities relating to THW provider training, support, and retention and access to the required continuing education units for state certification. Strategic planning includes the development of a THW Community of Practice (CoP) and the establishment of a Community Learning Collaborative (CLC) that includes a focus on THW continuing education.

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

Activity 1 description (continue repeating until all activities included): To increase THW collaboration, expand worker knowledge, and develop THW led career paths IHN-CCO will facilitate the development of a Community of Practice for all THW types in the IHN-CCO Region. The CoP is intended to:

- foster support and collaboration among THW workers
- inform training materials to deepen understanding of the scope of work for worker types
- develop career development recommendations
- provide feedback and support to programs utilizing THWs on best practices in supervision, career development, and scope of work

☐ Short term or ☒ Long term

Monitoring measure 1.1	Establishment of Community of Practice			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No CoP	CoP is established	03/2023	n/a	n/a

Monitoring measure 1.2	Member survey of THW Satisfaction			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
None	Members survey conducted to assess accessibility and satisfaction with THW programming	04/2024	Survey adjusted annually to address previous years' feedback	n/a

Activity 2 description: To address concerns regarding access to expanded career opportunities for THWs, IHN-CCO will facilitate a community partner led model designed to centralize educational opportunities throughout our communities through a shared training calendar and education management system. The Community Learning Collaborative (CLC) will seek input from THW providers, community partners, and assess member survey feedback to establish educational priorities.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Develop a Community Learning Collaborative to centralize career development and Continuing Education opportunities for THWs			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Access to CEUs and career development opportunities are	CLC establishes and maintains training calendar for community partners	09/2023	Maintained training calendar	04/2024
Monitoring measure 2.2	Integrate member survey of THW Satisfaction data			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
None	CLC trainings address issues and areas identified by members in training planning	12/2024	Ongoing trainings linked to member needs	12/2025

SWOT Analysis IHN-CCO THW Workgroup
2022

Strengths	Weaknesses
• High interest in THW services and programs • Flexibility to offer services across various populations • DST strong support of THW entities • Good training for Doulas, CHW, Peer Support and Peer Wellness Support locally • Local community members entering THW workforce • CBOs are leading the work and setting the tone for the work • IHN-CCO through DST has supported and given financial resources in the millions to pilots • THWs of all kinds seen as partners in supporting IHN members to access healthcare • THWs well received by IHN members • DST pilots allowed for innovative ideas and learning • Meets needs of vulnerable IHN members and links them to medical care homes and other critical supports for SDoH • Meet IHN members where they are • Assist IHN members in accessing the right care at the right place • Allows supports for individuals outside of their medical home	• Lack of billing access • Need more capacity • CBOs cannot bill for CHW, Peer, PSW services • Credentialing challenging with OHA, NPI#s • CBOs do not have institutional knowledge on how to access medical systems for credentialing~ NPI, One Health port • State doesn't have a system but want the services • CBO/IHN contracting, lack of follow through, changing staff, internal issues • PayScale for THWs • Issues for treatment providers who could bill, how to bill • OHA credentialing challenging, not responsive • OHA credentialing for training and continuing ed not responsive • Lack of point of contact in IHN for CBOs who want to learn more about THW services especially billing • Lack of continuing education credentialed training • Challenges to scope of practice for THWs • Moving from pilot to contract can be cumbersome with no clear pathway on how that would work or if it would be viable • Lack of technology for THWs in the field and within their CBO.

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Opportunities	Threats
• DST allows for innovative small projects to try out transformational ideas • THW workforce an opportunity for individuals that align with communities to find meaningful work • Help each other • THW workgroup can inform IHN and OHA to shape future work • Continuing education modules could be developed to meet need • IHN could have a designated staff person to serve as THW liaison to onboard and educate CBOs who are interested in THW work • Chance to reshape medical system • Chance to rebuild a redesign med system • Amplify member's voices • Build resource network for THWs • Build/develop supervision groups for CHWS, Peers, PWS, etc. • Develop and implement systems change • Build organizational capacity for CBOs with polices, practices, technology, case management that is linked to billing or touchpoint system. • Ability to meet needs of high need IHN members to increase quality of their cost and lower IHN's cost of care	• Lack of continuing education options • Losing people after training because it takes so long for OHA to get them credentialed • Trying to force non-medical staff and services into a medical model • Lag in IHN follow through for information and contracts • Lack of MH resources and supervision supports for THWs • THW burnout • COVID • Lack of strong supervision • Complexity of IHN touch report threaten small organizations' ability to comply with requirements for contracts • If we can't integrate funding more smoothly, organizations will give up and not continue • If small CBOs that serve a unique subset of IHN members cannot continue due to complexity, then those IHN members who need the most support will access care through emergency rooms at the highest cost

A. **Project short title**: Expanded Dental Health Delivery Model

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

If continued, insert unique project ID from OHA: 441

B. **Components addressed**

i. Component 1: Oral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

As of 2/13/2023, IHN-CCO has 81,844 individuals assigned to a dental plan. 24,084 of those individuals have a chronic condition and 55% of those individuals are assigned to Capitol Dental Care. Only a portion of those individuals utilize their dental benefit and currently struggle with management of their condition due, in part, to missed opportunities for dental-medical integration, collaboration, and communication. These individuals account for one-third of Capitol's IHN-CCO identified utilizing population.

IHN-CCO recognizes Hypertension and Diabetes as two priority areas for chronic care improvement. These conditions are prominent in the IHN-CCO population and improving management of these conditions are key to improving overall health outcomes for regional population health. Key to managing these conditions is improved behavioral and oral health integration.

The top 10 chronic conditions affecting the IHN-CCO member population as of December 31,2021, Crystal report server. (The data reflected in the prior year have not changed substantially.)

Chronic Condition	Number of Members	Percent of population
Anxiety Disorders	13,241	17.61%
Depressive Disorders	9,991	13.29%
Tobacco Use	7,210	9.59%
Drug Use Disorders	4,905	6.53%
Post-Traumatic Stress Disorder	4,667	6.21%
Hypertension	4,510	6.00%
Learning Disabilities, ADHD, Conduct Disorders and Hyperkinetic Syndrome	4,123	5.48%
Diabetes	3,558	4.73%
Fibromyalgia, Chronic Pain and Fatigue	3,113	4.14%
Obesity	3,038	4.04%

IHN-CCO measures oral health integration through a series of state and HEDIS quality measures.

1. Controlling High Blood Pressure (CBP)
2. HbA1c Poor Control
3. Oral Evaluation for adults with diabetes
4. Preventative Dental of Oral Service Utilization – Ages 1 to 5
5. Preventative Dental of Oral Service Utilization – Ages 6 to 14

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

IHN-CCO is partnering with Capitol Dental, a leader in innovation, to pilot the I-EPDH (Integrated Expanded Practice Dental Hygienist) expanded delivery model of care. This model utilizes an EPDH practicing at the top of their licensure as a Primary Care Dental Provider in a dental office to incorporate traditional dental care with tele-dentistry and the increased management of chronic conditions such as diabetes and hypertension. Tele-dentistry is also utilized in this model of care. The I-EPDH model of care differs from the traditional model of care. It is typically conducted in dental offices where the dentist is the Primary Care Dental Provider who sees the patient first before the patient is scheduled for preventive and therapeutic care. The overall goal of this model is to increase access to care, at a lower cost, and improve the long-term health outcomes for our members.

The focus populations will be IHN-CCO members that have a listed diabetes or hypertension diagnosis.

Uncontrolled hypertension can hinder an individual's access to their dental treatment, as standard practice of care is to refrain from delivering local anesthesia in individuals who report higher than a reading of 160/100. Individuals will be referred to their primary care provider, but often the Dentist does not have this information on hand. This TQS project is aiming to better connect the individual with their Dentist and Medical Provider to ensure better access to care and services.

Diabetes has a bidirectional relationship with Periodontal Disease (gum disease or Periodontitis). Meaning that hyperglycemia affects an individual's oral health, while Periodontitis affects glycemic control. By implementing the A1C level testing we aim to educate this knowledge to the patient and have a higher likelihood of managing an individual's A1C and communication and collaboration in the individual's health through a closed loop referral workflow.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The EPDH can provide care at appointments for new patients thereby freeing up appointment slots in the Dentist schedule for other restorative and surgical care. The new patient appointment would consist of a disease assessment, intra/extra oral exam and photos, x-rays, charting of the patient's conditions, hygiene services (prophy, SRP, debridement), sealants, application of SDF and fluoride, prescribing of medicaments and placement of temporary restorations as per collaborative agreement. A tele-dentist offsite would provide the comprehensive exam and treatment plan. If the patient required follow up care, the patient would be referred to one of our other dental offices for that treatment.

In addition to routine care, the I-EPDH will integrate blood pressure checks and test A1C levels. This will allow for integrated efforts that directly impact dental prognosis of individual's affected by Periodontal Disease. Capitol Dental Care is currently utilizing their internal software to integrate effective tracking of these test results and implementing referral workflows that will assist in connecting the individuals to their Primary Care Provider. In the first year of this TQS project, IHN-CCO provided reimbursement of the efforts conducted by the I-EPDH. This funding mechanism assists with establishing integration, sustainability of the workflow change, and increased quality of tracking a high-risk population.

During the first year of the project (2022), the contractual discussions, provider education, and ordering the necessary inventory expanded across a longer timeframe than originally anticipated. During the second year of the project (2023), partners will explore a formal framework of closed loop referrals from dental services to appropriate contacts with community level partners, the CCO, and the larger hospital system.

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

Activity 1 description (continue repeating until all activities included): Demonstrate that the I-EPDH model of care is equal to or better in improving access than the traditional model of delivery system.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of comprehensive exams seen on average per month.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
44.4	Maintain same level of performance.	12/2023	Maintain same level of performance.	12/2023
Monitoring measure 1.2	Number of average days to first preventive care procedure.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
7.8	3%-point decrease from baseline.	12/2023	3%-point decrease from Target.	12/2023
Monitoring measure 1.3	Number of average days to complete first therapeutic care procedure.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
18.7	3%-point decrease from baseline.	12/2023	3%-point decrease from Target.	12/2023

Activity 2 description: Integration of traditionally medical defined testing within the I-EPDH model of care.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Decrease in the average annual A1C levels in individuals diagnosed with Diabetes.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline is undetermined.	3%-point increase from baseline.	12/2023	3%-point increase from target.	12/2023

Activity 3 description: Increase communication between dental provider and medical provider regarding patient health outcomes.

☐ Short term or ☒ Long term

Monitoring measure 3.1	An increase of closed loop referrals for individuals suffering from hypertension.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline is undetermined.	3%-point increase from baseline.	12/2023	3%-point increase from target.	12/2023
Monitoring measure 3.2	An increase of closed loop referrals for individuals with a reported A1C level of 5.4 or higher.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline is undetermined.	3%-point increase from baseline.	12/2023	3%-point increase from target.	12/2023

OHA Transformation and Quality Strategy (TQS) CCO: InterCommunity Health Network CCO

A. Project short title: Grievances and Appeals

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

If continued, insert unique project ID from OHA: 116

B. Components addressed

i. Component 1: Grievance and appeal system
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

To better serve and understand member grievances and recognize opportunities for improvement, the Quality Improvement Committee (QIC) engaged/developed the Provider Network Taskforce (PNTF) to exam and investigate grievance data for the 2022 plan year. In reviewing grievances pre-pandemic in 2019 and post-pandemic in 2022, Access to Care is continuing to be a struggle for members. This category has increased by 2.0% from 2021 and 2022. Getting appointments to see providers is still an issue due to provider shortage in PCP and Dentists across the three counties (Benton, Linn, and Lincoln). PNTF is continuing to analyze the Access to Care grievances that encompasses mental/emotional, oral, and physical health. IHN-CCO saw a 5.03% decrease in access related grievances from 2019-2020; however, in 2021-2022 IHN-CCO has seen 2.0% increase in access related grievances. This increase is due to providers' offices are now fully open to see patients again. Therefore, this creates more demand for providers, which in turn, creates a delay in accessing providers for members.

Grievances	2019	2020	2021	2022	Percent Difference (2021 to 2022)
Access to Care	180	147	174	196	2.0% Increase
Rate per 1000	3.2	2.32	2.42	2.50	0.08 Increase
Interaction with Provider/Plan	311	382	447	413	4.03% Decrease
Rate per 1000	5.5	6.02	6.22	5.26	0.96 Decrease
Quality of Care	168	179	124	110	1.59% Decrease
Rate per 1000	3.00	2.03	1.72	1.40	0.32 Decrease

Although decreases were observed for grievances related to Quality of Care, grievances related to Interaction with Plan or Provider have steadily increased from 2019-2022.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

To better understand opportunities for improvement based on member feedback data, IHN-CCO continues to aggregate and analyze grievance data to identify trends and causal factors. In 2021, IHN-CCO has standardized how Appeals and Grievances (A&G) are monitored by the QIC. The Appeals and Grievances manager brought quarterly A&G reports to the QIC for review. Given concerns around access and the disproportionate impact of pre-pandemic and post-pandemic to populations already marginalized, the QIC requested that REALD data be integrated in the analysis of A&G data. Additionally, the QIC tasked two of its internal taskforces (TF) with monitoring grievance data. The PNTF focused on grievances related to Access, and Interaction with Provider, and Quality of Care. Member Experience TF (METF) focused on member touchpoints and completed an inventory as part of their Member Journey Mapping project. The PNTF led by the Manager of Network Strategy and Contracting (NSC) assigned a Provider Relations Representative to conduct a quarterly in-depth analysis focused on provider relations to observe grievance root cause trends and develop action recommendations. Results of this analyses were reported to the PNTF for review, approval of action steps.

Here is an example of the action steps identified in provider related grievances analysis:

1. Results are not presented but Network Strategy & Contracting does use them for Quality Improvement (QI) initiatives.
2. Provider Data Management (PDM) team is working with Provider Services Team on a new platform that will automatically perform provider roster data downloads to facets, which is how the IHN-CCO directory is updated. Providers will have to attest every 90 days that their information is accurate.
3. NSC recognizes the need for MH Providers & PCPs and makes every effort to contract with any eligible PCP that displays interest in joining IHN-CCO's network.
4. NSC – Timely access is mentioned at all quarterly webinars as well emails sent to those that are selected in our random audit of BH and Primary Care providers.

Additionally, the PNTF worked with IHN-CCO's Network Relations Consultant to conduct an in-depth analysis of Dental related grievances. This analysis was then shared, with recommendations for Dental Plan level, CCO level, and Clinic level, to IHN-CCO's Dental Health Advisory Committee.

The METF completed multiple objectives, including an inventory of member touchpoints, and with the support of leadership a Member Journey Map was completed in 2022.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

To better serve and understand member grievances, Appeals and Grievances Department is continuing to track and trend grievances/complaints that members have encountered when they have received care or were delayed in receiving care from providers. Grievances tracked the six major categories: Access to Care, Interaction with Plan/Provider, Consumer Rights, Quality of Service, Quality of Care, and Client Billing. Appeals and Grievances Manager presents data/reports to Quality Improvement Committee (QIC) on a quarterly basis. Based on information presented, IHN-CCO has developed taskforces to remedy and provide resolution to the top three categories (Access to Care, Interaction with Provider/Plan, and Quality of Care), these taskforces dissect the issues that are continuing to resurface. Provider Network Taskforce works with providers in providing continue education, recruiting new providers, engaging with our Samaritan Health System to enhance care in both e-visits and in person visits. The Member Experience Taskforce worked with subject matter experts from functional areas and have completed an IHN-CCO Member Journey Map in 2022. This journey allows IHN-CCO to see the progression as a member enters IHN-CCO from conception to the destination, such as assigning PCP and DCO, accessing care to these providers, receiving care by these providers. At the end of their journey, we want to measure how smooth or fraught their journey was through the whole process. This will provide a greater view into the lens of a member, which in turn, will provide opportunity for improvement for IHN-CCO.

In October of 2022, the Grievance Committee has come to a pause due to internal Organizational changes. But the data is continually being reported to QIC on a quarterly basis. QIC is continuing to examine top category grievances to ensure that appropriate actions are taken place to remedy the gaps between members, providers, and IHN-CCO. IHN-CCO is in

the progress of collaborating with Samaritan Health Service (SHS) Care Hub with transition of cares. This allows IHN-CCO and SHS Care Hub to work in collaboration to coordinates care planning activities with hospital inpatient care team prior to discharge. This collaborates with inpatient care team to complete comprehensive assessments (including SDOH, Behavioral Health screening, and home assessment), and identification of transitional needs by member or family within 48 hours of discharge. Which not only support the member but also provide support to the member's family/caregivers for any care gaps identified. How this is measure is through a satisfaction survey that will be conducted post 30 days discharge.

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

Activity 1 description: Root-cause analysis

☐ Short term or ☒ Long term

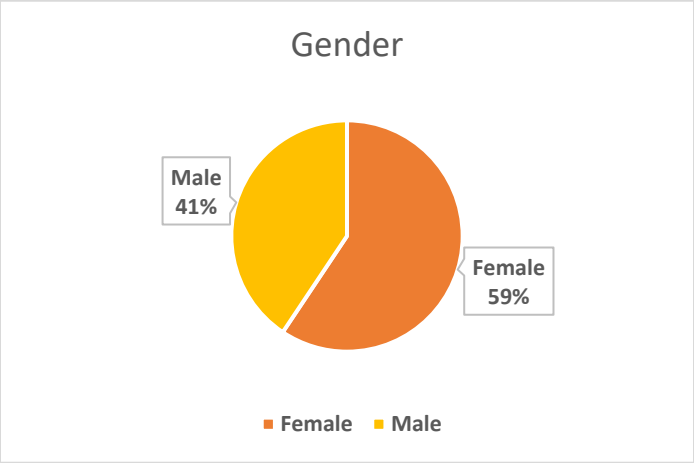
Monitoring measure 1.1	Root-cause analysis addressed			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
20% of Grievance RCA assessments are addressed in QIC	40% of Quarterly Grievance RCA is addressed	07/01/2023	50% of Quarterly Grievance RCA is addressed	12/31/2023

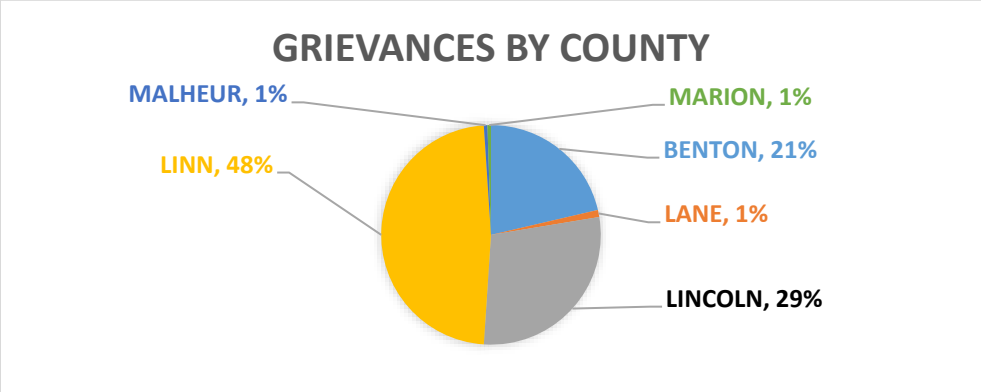
Activity 2 description: SHS Care Hub

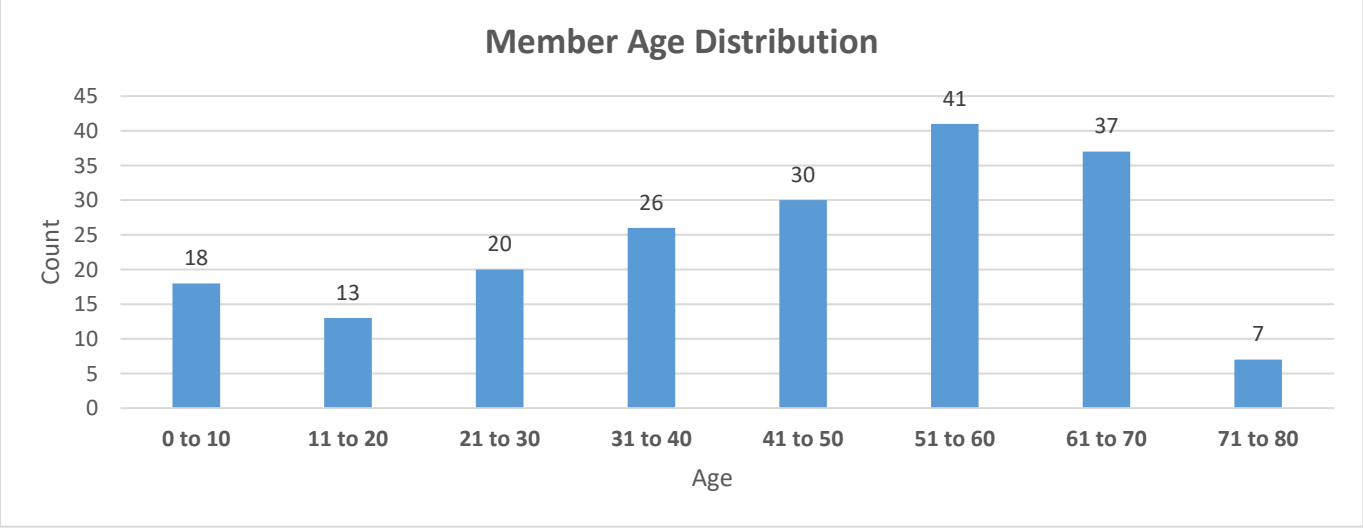
☐ Short term or ☒ Long term

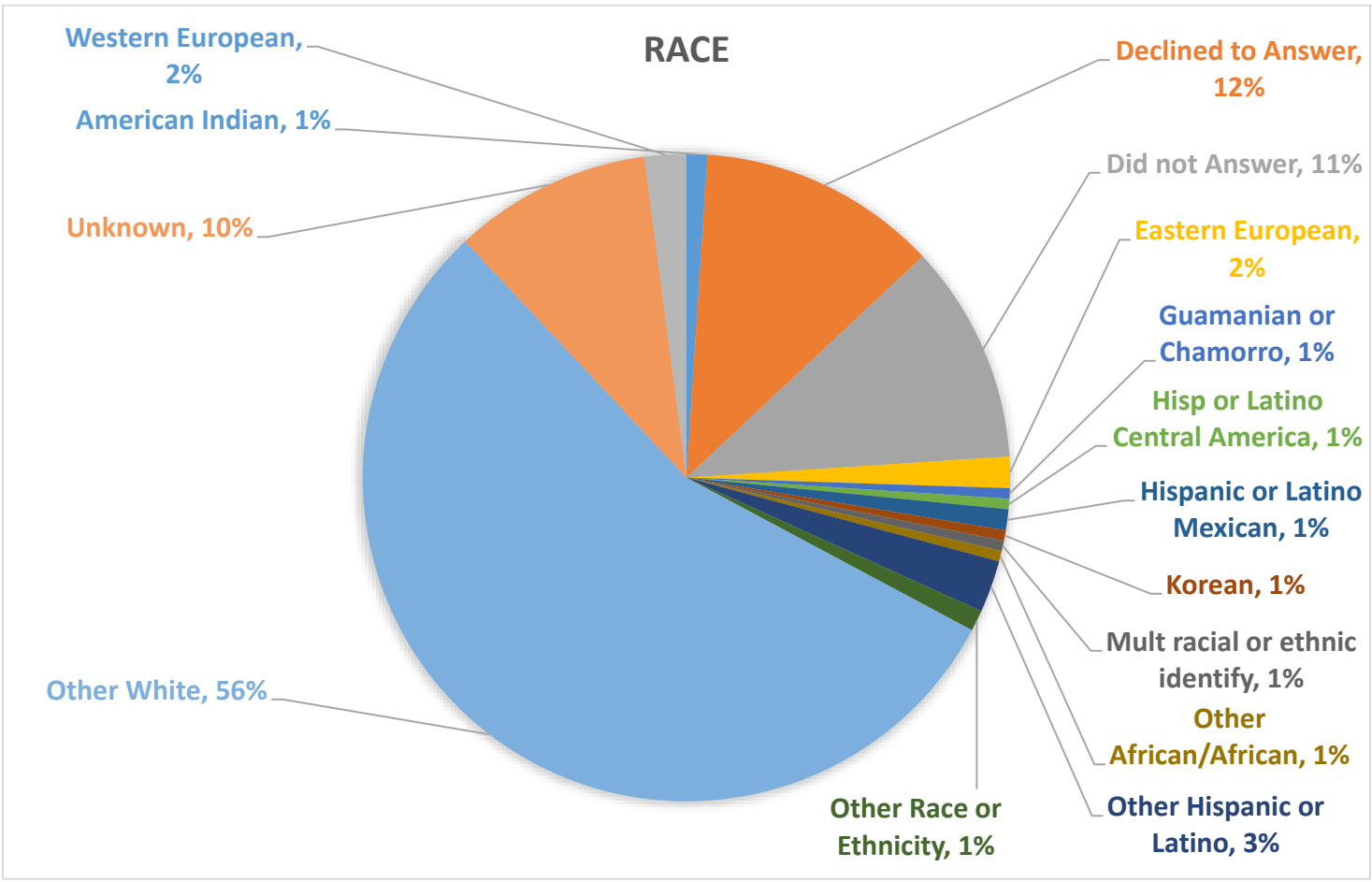
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
IHN-CCO Member experience journey map completed	Data informed journey map completed	12/31/2022	Future strategies and initiatives identified	12/31/2022
SHS Care Hub-Transitional of care after hospital discharge	Data from member survey	07/01/2023	Measuring gaps and future strategies	12/31/2023

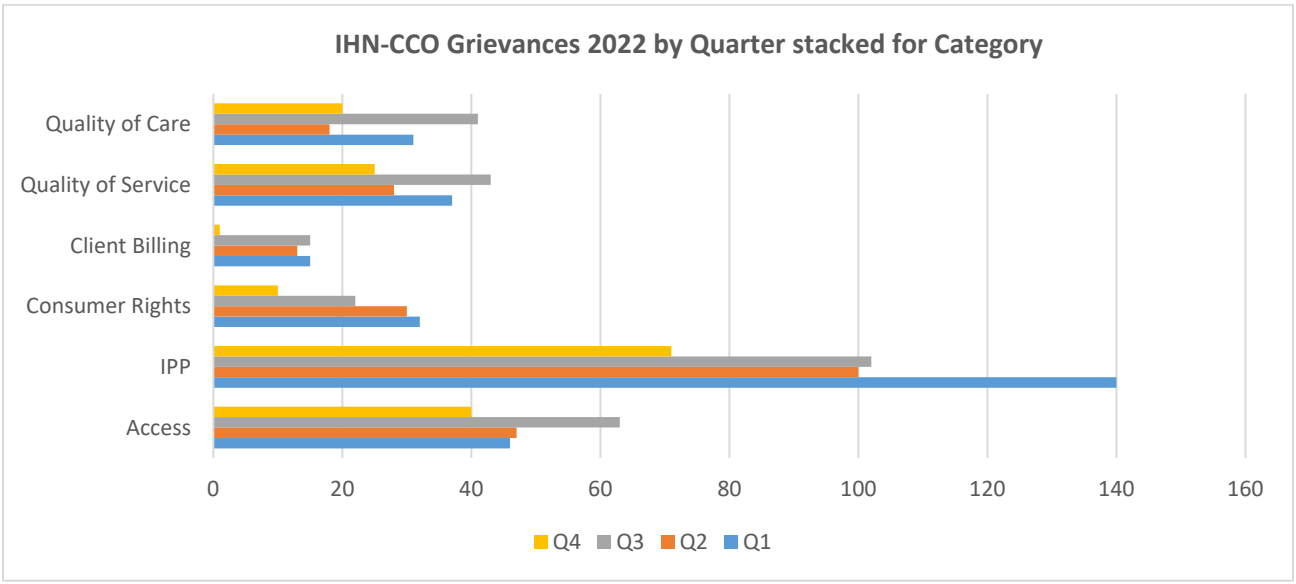
2022 Grievance Analysis



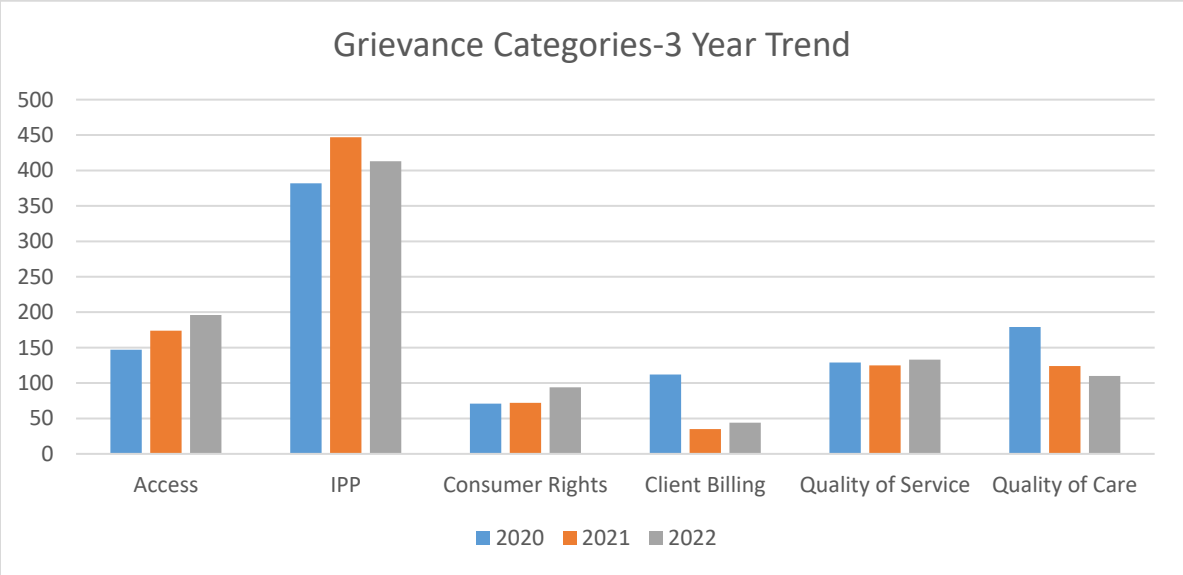





RACE
Western European, 2%
American Indian, 1%
Unknown, 10%
Declined to Answer, 12%
Did not Answer, 11%
Eastern European, 2%
Guamanian or Chamorro, 1%
Hisp or Latino Central America, 1%
Hispanic or Latino Mexican, 1%
Korean, 1%
Mult racial or ethnic identify, 1%
Other African/African, 1%
Other Hispanic or Latino, 3%
Other Race or Ethnicity, 1%
Other White, 56%


IHN-CCO Grievances 2022 by Quarter stacked for Category
Quality of Care
Quality of Service
Client Billing
Consumer Rights
IPP
Access
0
20
40
60
80
100
120
140
160
Q4
Q3
Q2
Q1

Category	Q1	Q2	Q3	Q4
Access	46	47	63	40
IPP	140	100	102	71
Consumer Rights	32	30	22	10
Client Billing	15	13	15	1
Quality of Service	37	28	43	25
Quality of Care	31	18	41	20



A. **Project short title**: Interpreter Integration with Primary Care

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**

i. Component 1: Health equity: Data
ii. Component 2 (if applicable): CLAS standards
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

The IHN-CCO community, including providers, community partners, and IHN-CCO's assigned Oregon Health Authority (OHA) Innovator Agent have provided information that interpretation services are lacking. The scenarios communicated involve lack of provider adherence to Samaritan policies, a lack of member willingness to file formal grievances when issues are experienced, and inadequacies in the delivery of these services. IHN-CCO has committed to address these deficiencies to ensure policy adherence, quality of interpretation services provided, and a less formal pathway for members to communicate related issues. IHN-CCO has a direct relationship with the Samaritan Health Services (SHS) Diversity Equity and Inclusion Director, whose role also encompasses ensuring appropriate language access. IHN-CCO has been working with the SHS Diversity Equity and Inclusion Director to understand issues in the service delivery environment and develop a path forward collaboratively.

In 2021, IHN-CCO developed a Language Access Plan (LAP) in partnership with SHS (the largest healthcare provider in the region/network accounting for over 60% of member services). The LAP promotes access and delivery of services in a culturally competent manner by providing oral interpretation guidelines, translation of materials, additional language support for providers, and requirements for attestations on policies and procedures. The LAP identifies percentages of non-English speaking patients by hospital region. See Table 1. Samaritan Health Services: Percentages of Non-English Speaking Patients.

Table 1. Samaritan Health Services: Percentages of Non-English Speaking Patients

Good Samaritan Regional Medical Center	
Spanish	53%
Unknown	25%
Arabic	6.1%
Sign Language	2.4%
Vietnamese	1.5%
Samaritan Albany General Hospital	
Spanish	82%
Unknown	9.2%

Sign Language	1.6%
Russian	1.2%
Arabic	0.8%
Samaritan Lebanon Community Hospital	
Spanish	49%
Unknown	19%
Sign Language	11%
Russian	9.8%
Ukrainian	3%
Samaritan North Lincoln Hospital	
Spanish	80%
Unknown	7%
Sign Language	2%
Korean	2%
German	1%
Samaritan Pacific Communities Hospital	
Spanish	84%
Unknown	6%
Mam	3%
Chinese, Cantonese (including Toishanese)	2%
Korean	1%

In 2022, IHN-CCO made organizational improvements to ensure CLAS Standards were being incorporated in equity trainings to ensure that members receive effective, understandable, and respectful care from all CCO staff as offered through Implicit Bias, trauma-informed, and ad hoc culturally responsive trainings, including those with a focus on African Americans in the Healthcare System and a culturally specific Grievance and Appeals training. IHN-CCO has additionally created a formalized process to review appeals and grievances employing REALD disaggregation and stratification methods.

IHN-CCO focused on the complexities and gaps identified above to improve CLAS Standard 5: Offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. 2022 activities included:

1. Ensuring language access-related policy reviews and updates:
    a. Reviewed current policies – Language Assistance Interpreter Services Policy.
    b. Obtained input from internal and external stakeholders to inform appropriate adjustments, including recommendations for appropriate interpretation mode by procedure type.
    c. Researched existing national, state, and other internal guidance.
    d. Finalized policy adjustments incorporating additional guidance parameters.
    e. Adopted new policies as necessary.
2. Enhancing provider and staff education:
    a. Ensured providers are notified of policy updates internally within SHS facilities/providers, and externally with other contracted providers via the provider newsletter.
    b. Ensured staff are notified of the policy update as necessary to perform their job functions (e.g., call center, grievances and appeals, claims, and utilization management representatives).
    c. Communicated the concepts of meaningful language access, ensuring confidentiality, and pathways for staff to easily raise issues in a nonpunitive manner.
3. Sharing best practices across IHN-CCO staff, providers, and community partners:
    a. Determined the ability to include interpreter availability in the IHN-CCO provider directory.

b. Explored the opportunity to provide technical assistance to help providers to set up/connect to proficiency training and support for OHA certification and appropriate billing practices.
c. Ensured adequate interpreter service monitoring and reporting. IHN-CCO has been participating in a statewide vendor template workgroup to ensure translation services are captured effectively and is extending this template to contract provider through the provider portal, and additionally set up a data exchange with SHS' EHR to gather reportable data on interpreter services.

4. Assessing bilingual staffing shortages across the IHN-CCO delivery system and region and identifying options to assist IHN-CCO and community partners/providers with access to bilingual staff, including the possibility of supporting a bilingual staffing pool and/or stipends.
5. Hiring an internal IHN-CCO advocate to provide a direct link to assistance with access and care issues for members. This role is intended to be a culturally appropriate resource, including from an indigenous perspective, that will focus on identifying the root cause of member issues and concerns and facilitating change across IHN-CCO's delivery system. All issue/concerns brought to this role will be tracked and evaluated collectively to further inform operational changes.
6. Hiring a dedicated Health Equity Liaison, which can assist with initiatives to improve language access.
7. Capturing interpreter data by enhancing encounter data collection in the SHS EPIC system, including individual interpreter information, language and communication preferences of the patient, mode of interpretation, and type of facility in which each interpretation service is conducted.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

The CLAS Standard impacted is to offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. While this is foundational to providing healthcare services, this project is innovative and transformational by supporting Spanish-speaking interpreter services in-house at a pediatric clinic in Albany, Oregon that serves a large portion of patients that identify Spanish as their first language. The in-house interpreter services will support members before, during, and after healthcare visits. The interpreter services being in-house supports addressing social determinants of health concerns as well as better facilitates connections to other healthcare needs such as behavioral health, lab visits, and other needed connections. These services are not currently billable or reimbursable through the Medicaid fee schedule as interpreter services can only be bill on a medical claim corresponding to a medical service for which the interpretation occurred.

After review of prior year activities including staffing shortages and a Plan Do Study Act analysis, IHN-CCO identified continued needs for Spanish-speaking members in Linn County. Note in Table #1 above, the percentage of non-English-speaking patients for Samaritan Albany General Hospital (serving Linn County, primarily in the Albany area) was 82% Spanish-speaking, which is one of the highest Spanish-speaking rates in the IHN-CCO region. The highest number of Spanish-speaking IHN-CCO members were assigned to the Mid-Valley Children's Clinic, approximately 724 members, though we feel that is a low estimate due to data collection barriers. Mid-Valley Children's Clinic handles about 50 calls per day from Spanish-speaking members and families as well. Mid-Valley Children's Clinic faced the loss of two Spanish-speaking physicians, resulting in only one Spanish-speaking physician to support of the needs of Spanish-speaking members in the clinic. While interpreters are utilized for all needed visits, a familiar and known interpreter in the clinic is innovative and transformational and can result in improved health outcomes and increased patient/member satisfaction.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

IHN-CCO will be providing funding and support for Mid-Valley Children's Clinic to establish and maintain a position for a Spanish-speaking interpreter that will reside in the clinic. The interpreter will be able to attend most (an estimated 80%) of IHN-CCO Spanish-speaking member visits to the clinic. The interpreter will also engage with

members through connecting them to resources such as community health workers and making outreach phone calls for provide appointment or follow up information. The in-house Spanish-speaking interpreter will have the ability to focus 100% on providing access to resources for Spanish-speaking IHN-CCO members. This initiative will allow for the interpreter to facilitate member communication and allow dedicated time to support the member/patient in filling out paperwork, preparing for the appointment, and assist with follow up instructions in a more in-depth, meaningful, and culturally responsive manner.

Additionally, the collection of REALD/SOGI data at these specific visits will be enabled by the in-house interpreter. Data collection for Spanish-speaking patients/members has unique barriers, for many reasons including possible fear of the establishment, unclear directions, and other cultural considerations. The in-house interpreter will help facilitate the collection of REALD/SOGI data for IHN-CCO to review in order to provide a deeper understanding of this population.

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

Activity 1 description: Hire and train Spanish-speaking interpreter in the Mid-Valley Children's Clinic

☒ Short term or ☐ Long term

Monitoring measure 1.1	Develop job description and post position			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No position open	Job description developed	03/2023	Position posted and open	06/2023
Monitoring measure 1.2	Fill position and fully train interpreter			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No interpreter hired	Hire Spanish-speaking interpreter	06/2023	Interpreter fully trained and proficiency established	09/2023

Activity 2 description: Evaluate number of visits and engagement points for Spanish-speaking members

☐ Short term or ☒ Long term

Monitoring measure 2.1	Evaluate and increase number of calls handled by in-house interpreter			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
50 calls per day handled using outside vender services	50% (25) of calls per day handled by in-house interpreter	03/2024	80% (40) of calls handled by in-house interpreter	12/2024

Monitoring measure 2.2	Collection and analysis of data related to in-house interpretation services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Incomplete data available	Data on interpretation provided to be collected and analyzed	12/2023	Number of visits to the clinic for Spanish-speaking members including resource navigation, physician and nurse visits, and drop-in informational visits	12/2024

Activity 3 description: Review efficiencies and satisfaction of members with in-house interpreter

☐ Short term or ☒ Long term

Monitoring measure 3.1	Efficiencies and cost savings to the clinic evaluated			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No interpreter to evaluate	Evaluate interpreter services for efficiency and cost savings	06/2024	Develop system recommendations based on evaluation	09/2024
Monitoring measure 3.2	Member satisfaction with interpreter services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No interpreter services to evaluate	Develop survey for interpreter services, ensure each member visit is given a survey for optional completion	09/2023	Review and evaluate six months of member visit satisfaction surveys, evaluate results, and develop recommendations	04/2024

Activity 4 description: Increase number of REALD/SOGI data collected

☐ Short term or ☒ Long term

Monitoring measure 4.1	**Include REALD/SOGI data collection at every Spanish-speaking in-house interpreter visit**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Requires evaluation, currently REALD collected annually for all patients, REALD data available, often sparsely completed by the patient/member due to the barriers mentioned above	REALD/SOGI data collected process established	09/2023	REALD/SOGI data collected at every Spanish-speaking in-house interpreter visit	04/2024
Monitoring measure 2.2	**Evaluation of REALD/SOGI data and comparison to currently collected data**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Approximately 40% of data is incomplete	Evaluation of data to determine future needs of the clinic population	09/2023	Review and evaluate six months of REALD/SOGI data collection, compare to previously collected data to establish areas of health disparities, including possible social needs for Spanish-speaking clinic members	4/2024

OHA Transformation and Quality Strategy (TQS) **CCO:** InterCommunity Health Network CCO

A. **Project short title**: Medicaid Efficiency and Performance Program (MEPP)

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

If continued, insert unique project ID from OHA: 440

B. **Components addressed**

i. Component 1: Utilization review
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☒ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and READLD data. This is broader than the specific TQS project.

The following section reports how Samaritan Health Plan (SHP) conducts a utilization review (UR) for IHN-CCO members, as well as efforts SHP conducts for assessing how over and under service utilization are directly linked to quality of care.

Utilization Review (UR)

Proper utilization management is directly linked to improving quality of care. IHN-CCO's UR is managed by the Utilization Management and Pharmacy departments. The Medical Director, Pharmacy Director and the Utilization Management Director oversee the UR program operations. UR is conducted according to department policies, procedures, clinical criteria, and clinical practice guidelines (CPGs). Medical necessity is determined, and the decision time frame and notifications align with policies and plan documents. UR decisions are made by qualified, licensed and certified healthcare professionals who have the knowledge and skills to assess clinical information, working diagnoses, and proposed treatment plans. Utilization Management is supported by board certified UR physician reviewers and behavioral health (BH) physicians and doctoral-level practitioners who hold a current license to practice without restrictions. The licensed clinicians have knowledge of coverage criteria and other plan-specific criteria to oversee UR decisions and ensure consistent and appropriate medical-necessity determinations. Inter-rater reliability (IRR) reviews are conducted to ensure consistent application of the utilization criteria.

Monitoring of the UM program includes:

- Various UM and CM reports
- Clinical performance measures
- HEDIS measures
- Over and under-utilization
- Practitioner medical, pharmacy, and utilization profiles
- Member surveys, appeals, and grievances
- Development of medical policies as needed

Medical necessity is determined, and the decision timeframe and notifications must adhere to policies and plan documents. Prospective, concurrent, and retrospective reviews are performed to provide a basis for decision-making. UM decisions are made by qualified, licensed healthcare professionals who have the knowledge and skills to assess clinical information and to evaluate working diagnoses and proposed treatment plans. Additional monitoring happens

either real time or retrospectively to identify patterns in utilization to determine if interventions with either members or providers are appropriate. Some of the real time monitoring that occurs are around drug interactions, duplicate therapy (I.e. members taking medications that are in the same class, sometimes from different providers), drugs that are considered higher risk based on a member's age, multiple drug screening (overlap) and therapeutic dose limits screening. Based on the nature of the interaction, real time alerts are sent to the member's pharmacists or provider for clinical intervention. In addition, a retrospective quarterly utilization also occurs to track prescribing patterns and member utilization around opioids. Monitoring takes into consideration patients on opioids from multiple providers and pharmacies. These members are identified for case management, and their providers are contacted to ensure non-fragmented care and agreement on treatment plans. With the provider's collaboration, members may be placed in a lock-in program limiting them to a specific provider and pharmacy. There is also a real time notification on any opioid greater than 50MME to remind the pharmacist about naloxone co-prescribing to ensure risk mitigation. For behavioral health, daily claims from the state are incorporated into the CCO's claim system so that utilization review can occur to ensure no harmful interactions, duplications, overutilization, etc. are missed, and notification/outreach provided to the prescribing provider prior to dispensing. All these monitoring and outreach efforts are performing as intended. As an example, for quarter 4 2022, there were 141,171 claims that triggered one or multiple utilization review alerts. 71.7% were deemed appropriate for member by the pharmacist/provider while the remaining 28.3% did not get filled due to clinician notification of possible detrimental interaction or waste.

Monitoring Over and Under Utilization

IHN-CCO monitors over and underutilization through utilization and case management reports. One example is monitoring the utilization (especially under-utilization) of direct acting anti-virals for the treatment of hepatitis C. Offering of case management happens at the initiation of therapy initiation, and again if underutilization is determined. Additional monitoring comes from clinical performance measures, including HEDIS which captures race, age, sex, and socioeconomic status (income, disability, and combinations). All sources of member satisfaction surveys, complaints, appeals, and grievances are also reviewed to identify potential areas of concern. Practitioner-level BH, dental, imaging, medical, pharmacy and surgical utilization profiles are also reviewed. In 2022 QPHM staff continued to analyze information to identify problematic trends, unmet member needs and any inequities in care or service authorizations. IHN-CCO has implemented a new platform, Arcadia Analytics, that includes timely cost and utilization feedback reports. The IHN-CCO Quality Committees review utilization reports and assess patterns to determine which services to monitor for over and underutilization. When available, utilization data are compared to state and national averages and benchmarks to assess health equity. Depending on the measure, our goal is to either meet or exceed the national average (see **Table 1.** for an example of IHN-CCO UR dashboard). Utilization data are analyzed by specific health equity factors to understand disparities in over and underutilization and where to focus quality improvement projects and activities.

Table 1. Example of UR dashboard for monitoring over and underutilization for IHN-CCO members

LOB	Measure	Data Source	Goal	2019 Rate (2018 data)	2020 Rate (2019 data)	MY2020 Rate (2020 data)	MY2021 Rate (2021 data)	MY2022 Summer Rate (2022 data, partial yr)		2021 Natl Avg (MY2020)	MY2021 Numerator	numerator unit of measure	MY2021 Denominator	denominator unit of measure
IHN	Adult Access to Preventive/ Ambulatory Hlth Svcs (age 20+)	HEDIS (AAP)	> Natl Avg	75.54%	78.57%	75.07%	74.00%	59.86%		77.23%	27,695	members w/ an ambulatory visit	37,426	elig pop (age 20+, contin enroll, etc)
	Follow-Up after Hospitalization for Mental Illness - 30 day follow-up	HEDIS (FUH)	> Natl Avg	65.99%	69.05%	69.85%	71.37%	64.14%		58.92%	177	members in denom w/ a follow up visit w/in 30 days	248	Mbrs age 6+ w/ I/P disch with MI prim dx
	Use of Imaging Studies for Low Back Pain *(inverted rate)*	HEDIS (LBP)	> Natl Avg	80.89%	78.98%	78.64%	78.37%	80.05%		75.63%	652	Mbrs in denom w/OUT an imaging study	832	elig pop (age 18-50 w/ low back pain dx)
	Readmission (age 18-64)	HEDIS (PCR)	< Natl Avg	11.40%	8.08%	7.90%	7.77%	6.64%		10.03%	118	readmits	1,519	indexed count of stays
	green=better than 2021 national avg (goal met) red=worse than 2021 national avg (goal NOT met)													

Data Notes: The UR monitoring dashboard utalizes annual HEDIS data. The adult access to preventative and ambulatory health services MY2021 rate includes IHN-CCO members ages 20-44.

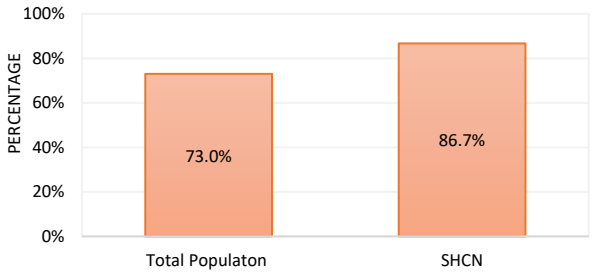
How IHN-CCO Ties Over and Under Utilizations to Quality of Care

Data in **Table 1.** show underutilization of preventive and ambulatory health services from 2019 to 2021. Annual utilization of preventive and ambulatory health services are essential to maintaining good quality of life and reducing adverse health events among our members. To fully examine how underutilization of preventive and ambulatory health services impacts the quality-of-care IHN-CCO members receive, the quality and population health management team assess complete the following analysis:

1. Assess utilization of preventive and ambulatory health services by REALD factors and place

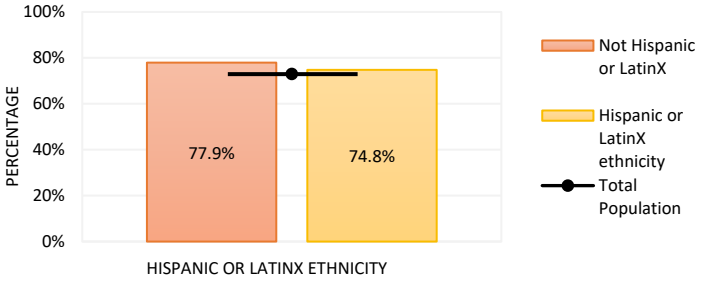
Figure 1. through **Figure 4.** show the utilization of preventive and ambulatory health services by members with Special Health Care Needs (SHCN), race, ethnicity, and preferred language. The assessment concludes there are disparities in utilizations of preventive and ambulatory health services by REALD factors. For instance, one of the disparities found is utilization rates for members who identify as Black or African American are 9.3 percent lower than the total population. **Figure 5.** includes the utilization of preventive and ambulatory health services by place. The three-county region IHN-CCO members reside all have different social, economic, and environmental factors that impact members health and access to health services. The data confirms members living in Benton and Lincoln county have lower utilization rates compared to Linn County.

Figure 1. The percent of IHN-CCO members of with special health care needs (SHCN) who received a Preventive/Ambulatory health service in 2021



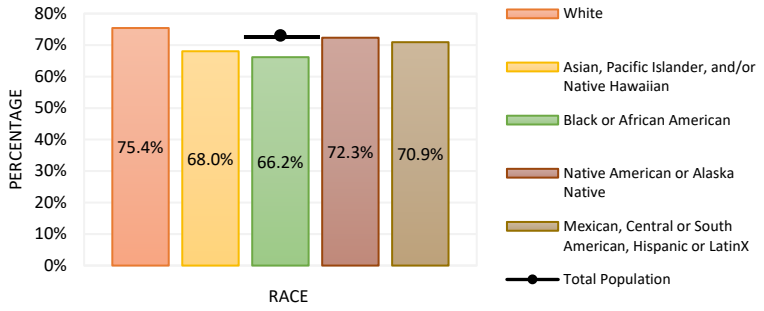
Data Notes: If a member is part of OHAs prioritied population they are categoried as having a SHCN

Figure 2. The percent of IHN-CCO members with a Preventive/Ambulatory health service in 2021 by Hispanic or LatinX ethnicity



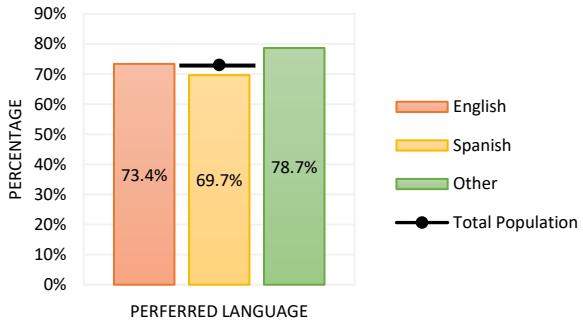
Data Notes: Approximately 20.4% of sample does not have a Hispanic or LatinX ethnicity recorded. Ethnicity data are derived from a members 834 file and electronic health record demographic data.

Figure 3. The percent of IHN-CCO members with a Preventive/Ambulatory health service in 2021 by race



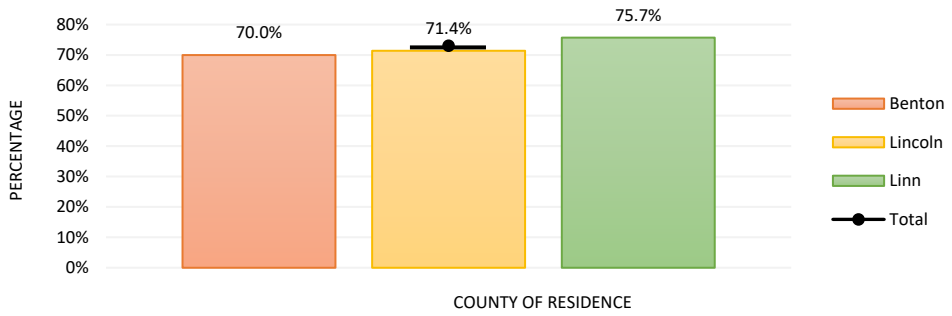
Data Notes: Approximately 14.7% of sample does not have a race recorded. Race data are derived from a members 834 file and electronic health record demographic data.

Figure 4. The percent of IHN-CCO members with a Preventive/Ambulatory health service in 2021 by preffered language



Data Notes: Approximately 10.5% of sample does not have a preferred language recorded. Language data are derived from a members 834 file and electronic health record demographic data.

Figure 5. The percent of IHN-CCO members with a Preventive/Ambulatory health service in 2021 by reported County of residence in the region



Data Notes: Approximately 94.4 percent of IHN-CCO members report living in the three-county region (Benton, Lincoln, or Linn County). <1% of IHN-CCO members do not have a County reported.

Recognizing that disparities exist for populations of color, and with a goal to eliminate these disparities, IHN-CCO is working on a few initiatives to help us better track our minority population, recognize barriers they may be facing, and work to meet them where they are, and providing culturally humble and responsive healthcare. Some of the initiatives are as follows:

- Expanding and working with additional providers and community-based partners utilizing the Unite Us platform to better understand and connect to care, members facing social determinant issues that are getting in their way of receiving the care they desire
- Working with provider groups to recognize members who identify as having limited English proficiency to ensure interpreters are available at all appointments. We have made available the interpreter services that IHN-CCOs use to our providers. In addition, training is being provided to providers about the importance of addressing health inequity, and meeting members where they are. Resources available to them have been updated in our provider manuals as well.

Work to begin this year is the tracking of no-show rates by available REALD data, so we can outreach to members that miss their primary care appointments to ensure there are no barriers preventing them from seeking care for their health in the primary care setting. Assess the differences in adverse actionable events (AAE) using OHA's MEPP Analytics platform:

AAE represents utilization that could have potentially been avoided with the right upstream interventions and clinical management, such as adequate preventive and ambulatory health care. To assess AAE, a cost analysis is conducted to determine if there are differences in AAE costs for members who utilized preventive and ambulatory health services by specific conditions. For instance, difference in AAE costs are assessed among members with hypertension who utilized preventive and ambulatory health care compared to members with hypertension who did not. If AAE costs are higher among members with hypertension who did not receive preventive and ambulatory health care, IHN-CCO can formulate quality projects around hypertension and improving members accessing preventive and ambulatory health care. IHN-CCO is currently working on improving members with poor control of their blood pressure quality of care. This includes focusing on medication management and ensuring they are seeing their primary care provider.

The assessment process allows Quality and Population Health Management staff to establish equitable strategies for improving utilization of preventive and ambulatory health services, as well as the potential impact the utilization of these services could have on the quadruple aim of improving population health outcomes, reducing the cost of care, enhancing the patient experience, and improving provider satisfaction.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

Episode 1: Diabetes: Focus on members with Diabetes and co-occurring Serious Mental Illness (SMI) and Substance Use Disorder (SUD) conditions

In 2022, Samaritan Health Plan (SHP) focused on improving comprehensive diabetes care for IHN-CCO members with co-occurring conditions of serious mental illness (SMI) and substance use disorder (SUD). The population was selected because high AAE costs were disproportionately impacting members with co-occurring conditions of diabetes, SUD, and SMI. To improve health outcomes among the cohort two monitoring measures were implemented, align systems efforts in comprehensive diabetes care and improve the percent of members with diabetes, SUD, and SMI with poor control of their HbA1c (HbA1c >9). The logic model presented in **Table 2.** was created to help track the monitoring measures in 2022 and project outcomes. **Table 2.** has the resources (inputs), activities conducted, desired results from activities (outputs), and the overall outcomes and if they were met or not met.

Table 2. Increase Comprehensive Diabetes Care for IHN-CCO members with Diabetes, SUD, and SMI

Input	Activities	Outputs	Outcomes
Diabetes Taskforce: ▪ SHS CareHub ▪ Director of SMG Value-Based Performance ▪ Pharmacy and Quality and Population Health Director ▪ SHP Pharmacy Services Staff ▪ SHP Behavioral Health Department Staff	1. Develop a diabetes dashboard for cohort (IHN-CCO members with diabetes, SUD, and SMI) 2. Review diabetes dashboard with diabetes taskforce monthly to assess cohort comprehensive diabetes needs 3. Enhance diabetes care for cohort through CareHub, Behavioral Health, and Pharmacy Services	1. Diabetes dashboard tracking the following: ▪ % of cohort with HbA1c > 9 ▪ % with HbA1c testing ▪ % with Eye Exam ▪ % with Nephropathy Visit/Rx ▪ % with Blood Pressure <140/90 2. Interventions to improve comprehensive diabetes care are established among each diabetes taskforce partner 3. Separate interventions are established and monitored by SHP behavioral health staff	Monitoring Measures 1.1 Agreed upon diabetes strategies under guidance of Chief Quality Officer **i. Not met.** 1.2 26.2% of IHN-CCO members between the ages of 18 and 85 have Poor Control of their HbA1c ii. **Not Met:** Due to inconsistencies identified within the data, and to assure the utmost integrity in data reported, this is being categorized as "not met"

		intervention, SHS CareHub, and SHS pharmacy	

In 2022 extensive barriers were experienced when monitoring measure 1.1. and 1.2. The barriers include:

1. **Data limitations:**
   - The project cohort was developed using internal population health management (PHM) platform. Which includes members' electronic health data.
   - There was limited understanding of how the data for the cohort were populated in the PHM platform. For instance, partners on the diabetes taskforce found (after conducting outreach to members) that many members in the cohort did not have diabetes. We later learned that members were included in the "condition history of diabetes" filter in the PHM platform if they are using medications for prediabetes. To overcome this barrier, the cohort was reestablished using other data sources; however, this wasn't discovered until August of 2022, making it difficult to monitor outcomes effectively.
   - The baseline data were not calculated correctly. The data did not include members without a HbA1c test, which is best practice. The PHM platform did not allow for retrospective review of A1c levels to allow us to reestablish a correct baseline.
2. **Infrastructure challenges in 2022 TQS Project Proposal:**
   - The monitoring outcome 'align system efforts' could not receive the proper infrastructure setup to ensure its success. A centralized model for aligning system efforts was not in place, which made it difficult to achieve the outcome of an 'agreed upon diabetes strategies under guidance of Chief Quality Officer'.
   - The monitoring measure outcome '26.2% of IHN-CCO members between the ages of 18 and 85 have Poor Control of their HbA1c' is a measurable outcome but challenges in study design made it difficult establishing causation – i.e., if the activities conducted impacted the decrease in poor HbA1c control.
   - Just as other health systems and organizations across the country, SHP and SHS experienced a large staff turnover in 2022 significantly impacting TQS projects and changing how work and projects are prioritized. This affected the direction of the diabetes taskforce. As **Table 2.** explains in the activity section, the diabetes dashboard was meant to be a population health management tool to aid in assessing gaps in diabetes care and prioritizing interventions. The limited capacity (especially among Behavioral Health staff) made it difficult to establish and evaluate interventions.

To overcome the barriers, the initial purpose of the project for Episode 1. was reevaluated. A complete assessment of the cohort was conducted, and disparities were assessed, including differences in AAE costs and comprehensive diabetes care.

2022 Reevaluation of Episode 1

In 2022, approximately 474 members were included in the diabetes, SUD, and SMI (< 1% of IHN-CCO members in 2022) population. This is about 13.8 percent of the IHN-CCO diabetic population. **Figure 6.** through **Figure 9.** have the population demographics for members in the cohort. Most of the members in the cohort identify as white, speak English, and are not Hispanic or LatinX.

An assessment was conducted to compare diabetes utilization that could have potentially been avoided if the correct upstream interventions and clinical management occurred. This was assessed using the differences in AAE costs among IHN-CCO members in the cohort and the total diabetes population. The data in **Figure 10.** confirms that cohort members' AAE costs are 21.3 percent higher than members who have diabetes but not co-occurring SUD and SMI. When the cohort was segmented by race, **Figure 11.** shows that AAE costs for members who are not white were 25.8 percent

higher compared to members who identify as white. When looking at comprehensive diabetes care, outcomes are more positive among IHN-CCO diabetic members without co-occurring conditions of SUD and SMI as illustrated in **Figure 12.** Data were too small to assess by race, ethnicity, and language for the cohort; however, data were able to be assessed by reported county in the region. The data are presented in **Figure 13.** and show that members with diabetes, SUD, and SMI residing in Linn County consistently have worse comprehensive diabetes care compared to the total cohort.

Population Demographics: Figures 6-9

Figure 6. The percent of IHN-CCO members with diabetes, SUD, and SMI by resported County of residence, 2022

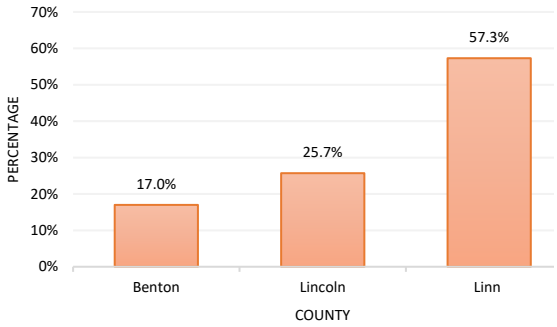
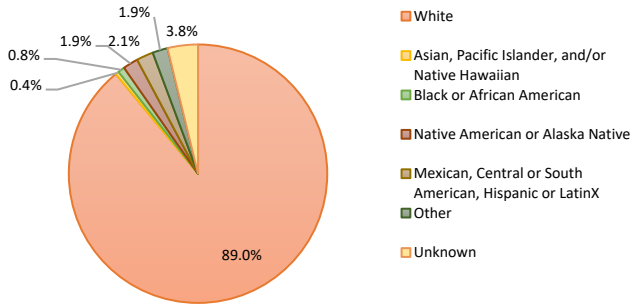


Figure 7. The percent of IHN-CCO members with diabetes, SUD, and SMI by resported race, 2022



Data Notes: Includes members who are eligible for IHN-CCO service in 2022; Approximately 96.8% of cohort members report living in Benton, Lincoln, and Linn counties; < 1% do not have a County reported.

Figure 8. The percent of IHN-CCO members with diabetes, SUD, and SMI by resported Hispanic ethnicity, 2022

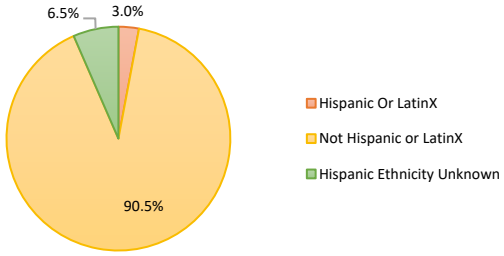
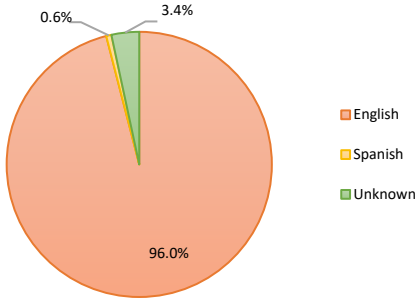


Figure 9. The percent of IHN-CCO members with diabetes, SUD, and SMI by resported preferred language, 2022



Data Notes: Includes members who are eligible for IHN-CCO service in 2022

Cost Assessment: Adverse Actionable Events (AAE): Figures 10-11

Figure 10. The percent of AAE costs for IHN-CCO members with Diabetes, SUD, and SMI from 2019 to 2022[1]

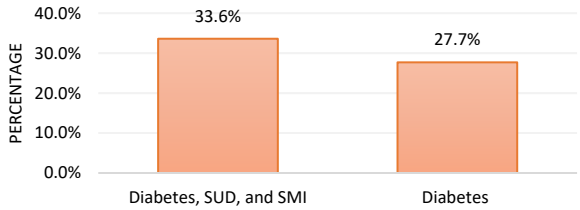
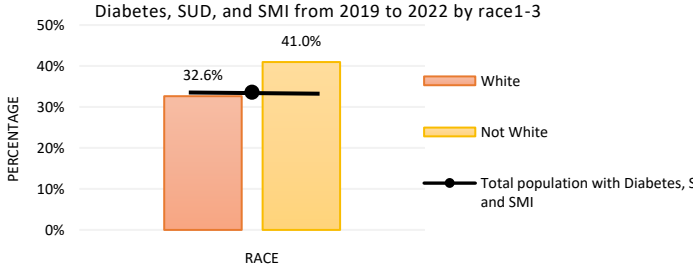


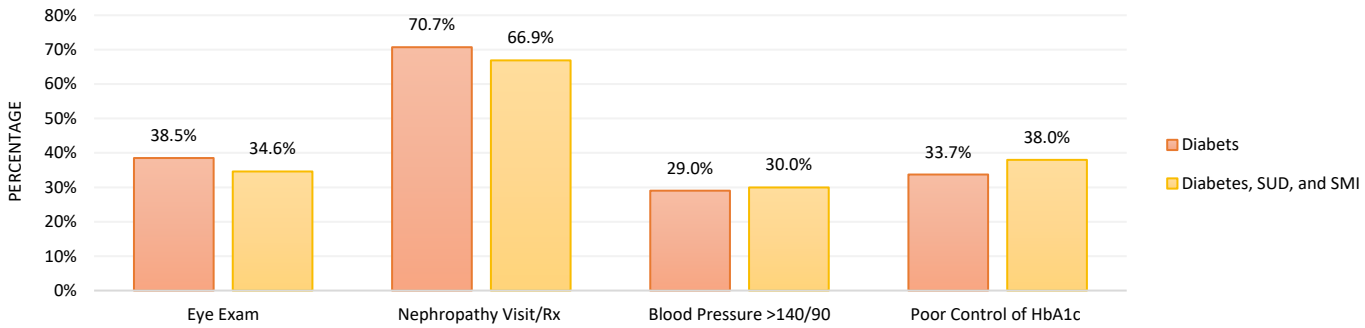
Figure 11. The percent of AAE costs for IHN-CCO members with Diabetes, SUD, and SMI from 2019 to 2022 by race1-3



Data Notes: 1) Includes members who are eligible for IHN-CCO services in 2022 with a claim for diabetes from 2019 to 2022; 2) 52 members with Diabetes, SUD, and SMI do not identify as white had a claim for Diabetes; 422 members with Diabetes, SUD, and SMI who identify as white had a diabetes claim from 2019 to 2022; 3) Members included in the 'not white' category include IHN-CCO members with diabetes, SUD, and SMI who identify as Asian, Pacific Islander, and/or Native Hawaiian, Black or African American, Native American, or Alaska Native, or Mexican, Central or South American, Hispanic or LatinX

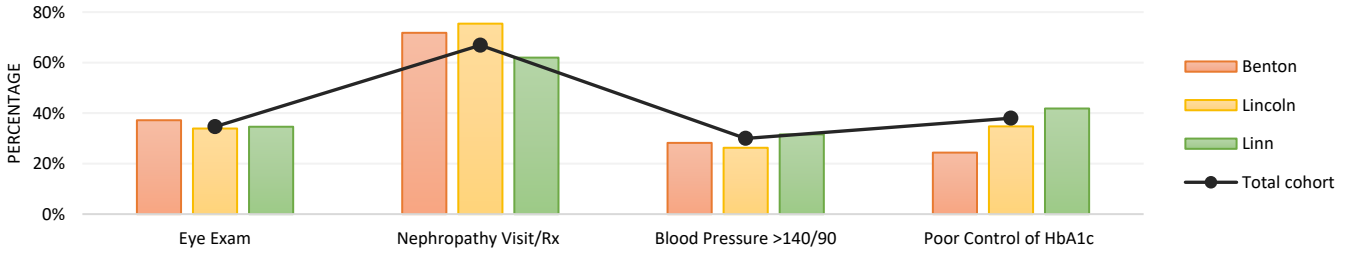
Comprehensive Diabetes Care: Figures 12-13

Figure 12. The percent of IHN-CCO members with diabetes, SUD, and SMI by comprehensive diabets care measure



Data Notes: Members are included if they had a claim for an eye exam or nephropathy visit/Rx in 2022; Poor HbA1c is defines as members with a HbA1c > 9 in 2022 and 2023 or with an HbA1c data < 1/1/2022

Figure 13. The percent of IHN-CCO members with diabetes, SUD, and SMI by comprehensive diabets care measure



Data Notes: Includes members who are eligible for IHN-CCO service in 2022; Approximately 96.8% of cohort members report living in Benton, Lincoln, and Linn counties; < 1% do not have a County reported. Members are included if they had a claim for an eye exam or nephropathy visit/Rx in 2022; Poor HbA1c is defines as members with a HbA1c > 9 in 2022 and 2023 or with an HbA1c data < 1/1/2022

Based on the 2022 assessment and the barriers associated with tracking and monitoring interventions for IHN-CCO members with Diabetes, SUD, and SMI, new strategies will be assessed in 2023 for all IHN-CCO members with diabetes. We understand members with SUD and SMI have additional barriers for managing their chronic conditions. These aspects will continue to be addressed through the diabetes taskforce, but performance outcomes will be addressed for all members with diabetes to assess gaps in comprehensive diabetes care (new initiatives for 2023 are outlined in **Section E**).

<u>Episode 2:</u> Maternal Child Health with a focus on members with high-risk pregnancy

From January 1, 2021, and October 31, 2022, approximately 47.5 percent of IHN-CCO members with a live birth were categorized as high-risk. Of the live births during this timeframe, about 11.7 percent had substance use disorder (SUD) and 33.7 percent had a known chronic condition (does not include SUD). To improve birth outcomes and reduce maternal health morbidity and mortality a heavy focus in 2022 was on our maternal and child population. The monitoring measures established in the 2022 TQS report were bold, but health systems and community partners were still recovering from COVID-19. Infrastructure needed to be rebuilt between IHN-CCO and maternal partners before understanding how IHN-CCO could support our pregnant population and community partners. **Table 3.** outlines the desired outcomes for 2022 through the established monitoring measures.

Table 3. Logic Model: Improving Maternal Health Outcomes

Input	Activities	Outputs	Outcomes
Internal Partners & Resources: ▪ Maternal Case Management Program ▪ Care Coordination ▪ Delivery System Transformation ▪ Data Analytics and Finance External Partners ▪ Benton, Lincoln, and Linn County Health Departments ▪ Early Learning Hub ▪ Smartian Medical Group	a. Educate OB/GYN clinics on SHP MCM program and how to refer IHN-CCO members who are high risk to the MCM program b. Establish monthly check-ins with Community Doula Program c. Review birth outcomes among IHN-CCO members with a community doula claim d. Establish a program description and evaluation for internal MCM program e. Attend Early Learning Hub Community Advisory Board - Health Integration Workgroup monthly meetings f. Establish Quartey check-ins with MCM+ at Benton, Lincoln, and Linn Public Health g. Partner with Care Coordination to increase referrals to Family Connects Oregon h. Partner with Data Analytics and increase live birth data for Family Connects, internal MCM program, and external MCM+ program	2.1. Monitoring Measure: a. Increase participation in MCM program among IHN-CCO members with a high-risk pregnancy. b. VBP contract discussions are initiated c. Data comparing preterm births among pregnancies with a community doula vs. pregnancies without d. Impact MCM program has on birth outcomes for high-risk IHN-CCO members e. Strengthen partnerships with maternal and child health partners f. Help maternal and child health partners combat barriers for improving IHN-CCO pregnant members to care g. Increase referrals into community maternal and child health programs	Monitoring measures: 2.1. Establish an OB/GYN engagement and referral pathway: **Not Met** 2.2 Establish VBP contract with Community Doula Program: **Not Met** 2.3. Establish quality metric for Community Doula Program: **Not Met** 2.4. Postpartum Care rates for IHN-CCO members will increase from 80.0 to 83.0: **Still in review** 2.5. Reduced AAE costs associated with CPT codes 99469, 99479, 99468 from $480,227 dollars to $432,205 dollars: **Still in review**

In 2022 many lessons were learned on improving maternal and child health outcomes and achieving the desired outcomes. There were achievements and barriers while accomplishing the monitoring measures for 2022.

Achievements:

- IHN-CCO has multiple maternal and child health partners who are eager to collaborate to improve maternal and child health outcomes. Partnerships with maternal health community partners were repaired and new partnerships were established.
- The infrastructure problems around improving maternal and child health outcomes and supporting community partners and our network providers were identified
    - Large administrative burden for establishing evaluation of MCM+ program within the counties
    - Maternal and child health data reports provided to counties are not sufficient in identifying people who are pregnant or people who recently gave birth to conduct outreach for internal and external maternal program outreach.
- SHP internal MCM program barriers were established and plans for improving barriers were identified
    - Identifying members who are high risk was solidified through Care Coordination Teams
    - Capacity problems were identified and are being addressed for the internal MCM program by the Care Coordination Team
- Data insights on pregnant members were identified through a population assessment to help IHN-CCO and community partners understand barriers and potential disparities among IHN-CCO members.

Barriers:

- The monitoring measures selected for 2022 were too broad to accomplish and effectively measure.
    - The monitoring measures were not established using the SMARTIE format making it difficult to establish causation when changes in the data occurred.
    - There were too many monitoring measures that did not have the appropriate partnerships or infrastructure built to accomplish in one-year.
- The effect of COVID-19 on maternal partnerships was severe. The infrastructure that was built prior to COVID-19 needed to be rebuilt. This was the focus in 2022, making it difficult to establish projects and interventions for improving maternal and child health outcomes and lower the AAE costs associated with CPT codes 99469, 99479, 99468.

Data Review:

An analysis of the CPT codes 99469, 99479, 99468 could not be completed to fidelity. To understand if the MCM program (the main intervention in 2022 for improving maternal and child health outcomes) was effective at saving costs, a review was completed of the difference in the average costs of members who participated in the MCM program compared to members who were identified for the MCM program but did not participate. **Table 4.** displays the average difference in newborn costs for preterm birth. There was a large difference in newborn costs for members who had a preterm birth. The cost difference in preterm birth is most likely due to the number of preterm births by non-MCM participants.

Table 4. The average difference in newborn costs for IHN-CCO members who participated in the Samaritan Health Plans Maternal Care Management (MCM) program compared to IHN-CCO members who did not

MCM participation Status	Average Newborn Costs for Preterm Birth
Participated in MCM Program	$9,590
Did not participate in MCM Program	$37,573
MCM program participant costs difference	-27,982

In 2022 IHN-CCO will be moving away from the MCM program and focusing on the Community Doula Program to help improve the health outcomes for newborns and pregnant people. The monitoring measures will focus on specific

SMARTIE goals that have the infrastructure built to help understand how innovative interventions can improve maternal and child health outcomes, reduce health care costs, improve member satisfactions, and enhance provider engagement.

Episode 3: Substance Use Disorder with a focus on timely initiation and engagement in SUD treatment services

As of January 31, 2022, approximately 29 percent of IHN-CCO members with a new SUD episode initiated SUD treatment and 16 percent engaged in treatment. The activities associated with improving our monitoring measures for Episode 3 are listed in **Table 5.** All VBP partners with a VBP measure for IET renewed their contracts in 2023; however, the engagement target was not met in 2022.

Table 5. Logic Model: Improving Initiation and Engagement in SUD Treatment for IHN-CCO members with a new SUD event

Input	Activities	Outputs	Outcomes
Internal Partners & Resources: ▪ SHP Provider Relations Team ▪ SHP Data Analytics - Internal IET data report for IHN ▪ SHP Transformation Team External Partners & Resources ▪ OHA ▪ Value-Based Payment Partners - Samaritan Medical Group - Corvallis Clinics - Quality Care Associates - Coastal Health Practitioners - Lincoln and Benton County PCP - Valley Clinics	a. Partner with SHP provider relations team to keep in network PCP providers engaged in their VBP contract i. Conduct provider education on the IET CCO metric specifications. ii. Include education on best practices for keeping people with SUD engaged in treatment services. b. Increase quality improvement resources and support for VBP partners with an IET performance measure. c. Counselor of Alcohol and Drug position was established	a. VBP partners increase their understanding on the IET measure and are engaged to keep the IET VBP contract in 2023. b. VBP partners with low performance have additional QI support for SHP partners c. Help Samaritan Medical Group providers conduct outreach to members with a new SUD diagnosis to increase initiation and engagement in SUD treatment services.	Monitoring Measures: 3.1. VBP contacts with primary care partners: **Met** 3.2. The percent of IHN-CCO members ages 13 and older with a new SUD episode in 2021 who engaged in SUD treatment will increase from 16.69 to 18.5%: **Not met**

A lot of work was conducted in 2022 to support providers with a VBP contract to meet the IET measure. The trainings on the IET measure specifications received positive feedback from our network providers. This is a complicated measure and can be confusing. Even with the metric complications, all VBP partners renewed their contracts for 2023. Barriers were identified in 2022 which will be addressed in 2023. The main barrier for VBP providers meeting the IET measure was the data IHN-CCO gave providers to conduct outreach were based on claims which have a minimum three-month lag. This made it difficult for providers to conduct outreach and meet the measure. To combat this barriers, IHN-CCO is working to establish real-time data for providers through Collective Medical.

About 39.1 percent of IHN-CCO members with a new SUD episode were identified outside of the outpatient or telehealth setting. If a member has a new SUD episode identified in an Emergency Department (ED), Inpatient, or Treatment setting it may take a provider time to know when that event occurred. If the member is identified in the ED and the ED provider is successful at referring the member to treatment and the member initiates that treatment, the ED provider is not responsible or have the time to ensure the member is engaging in the treatment. The misconnection is creating the large gap in the percent of members who engage verse the percent of members who engage in SUD treatment. In 2023, IHN-CCO believes the Collective Medical platform will help resolve this barrier. A cohort was established and processes are being created to promote platform use among SHP network providers.

With the focus in 2022 being the utilization of SUD treatment services, we assessed if there was a difference in AAE costs for IHN-CCO members with SUD in two different phases. Phase 1 includes members with SUD from October 1, 2020-September 30, 2021, and Phase 2 includes those same members from October 1, 2021-September 30, 2022. An analysis was conducted to compare the AAE costs of SUD related claims in phase 1 to phase 2. **Table 6.** shows the percentage difference in the average AAE PMPM costs in phase 1 compared to phase 2. There was a 13.9% difference in PMPM AAE costs.

Table 6. The difference in the average PMPM AAE costs for IHN-CCO members in phase 1 (October 1, 2020-September 30, 2021) to phase 2 (October 1, 2021-September 30, 2022)	
Average AAE PMPM Phase 1	$150.56
Average AAE PMPM Phase 2	$129.64
Delta	-13.9%

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

Episode 1: Diabetes

In 2022, approximately 7.6 percent of IHN-CCO members ages 18 and older were reported to have diabetes. Diabetes continues to be one of the most prevalent and costliest conditions among IHN-CCO. The top five most costly diagnosis codes with 100% AAE costs for IHN-CCO members from 2019 to 2021 are listed in **Table 7.** Optumas Analytics reports that the top two most costly conditions with 100% AAE costs were Diabetic Ketoacidosis for Type 1 diabetes and Foot ulcers for Type 2 diabetes. Both events can be mitigated with proper blood glucose management, and engagement in additional comprehensive diabetes management activities such as routine foot examinations, improving medication adherence, blood pressure control, and HbA1c testing and management.

Figure 14. The AAE costs for IHN-CCO members with diabetes from 2019 to 2022, SHP Data Analytics

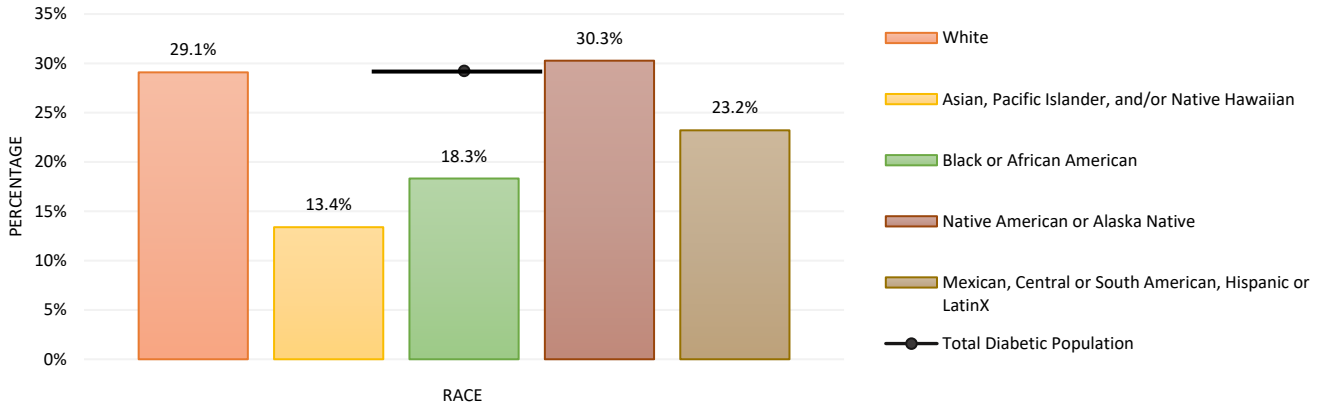
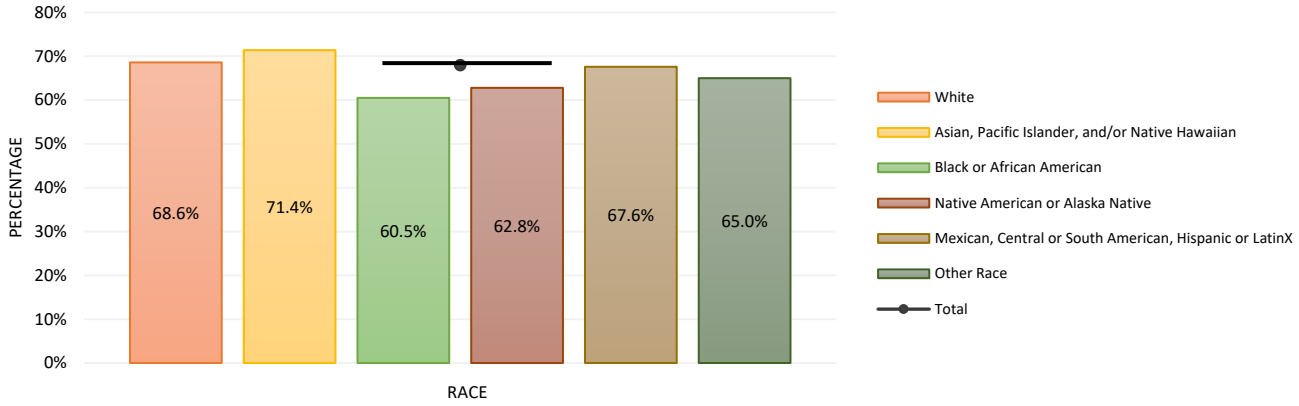


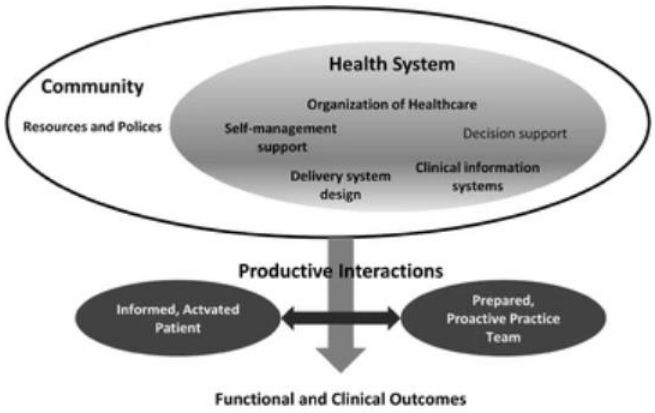
Figure 14. has the diabetes related AAE costs for IHN-CCO members with diabetes from 2019 to 2022. Members who identify American Indian and Alaska Native have the highest percent of diabetes related costs that could have been prevented if proper upstream interventions were taken, such as the proper use of medications. In 2022 approximately 71 percent of IHN-CCO members with diabetes were prescribed metformin. **Figure 15.** shows that of those members, on average, about 68.0 percent are adherent to their metformin medication and when segmented by race metformin adherence differs. Members who identify as Black or African American and American Indian and Alaska Native have the lowest adherence rates.

Figure 15. The percent of IHN-CCO members with diabetes who are adherent to their metformin medication by race, 2022



To improve health outcomes and reduce health care costs in 2023 SHP's quality and population health management team will utilize the diabetes taskforce to aligning and reducing silos in diabetes care between Samaritan Health Plans, network providers, and community-based organizations. Systematic reviews conclude the Chronic Care Model (CCM) is effective at helping health systems manage their diabetic population and suggest that merging all aspects of the CCM will improve outcomes for diabetic members.[1-2]

Figure 16. Chronic Care Model (CCM), developed in the U.S. in 1990 to help health systems manage patients with chronic disease



Source: https://dmsjournal.biomedcentral.com/articles/10.1186/s13098-015-0119-z#:~:text=The%20chronic%20care%20model%20(CCM)%20was%20developed%20to%20provide%20chronic,systems%20and%20communities%20%5B5%5D.

The diabetes taskforce will focus on SHP's use of the CCM (featured in **Figure 16.**) for managing members with diabetes and ensure the following are implemented effectively:

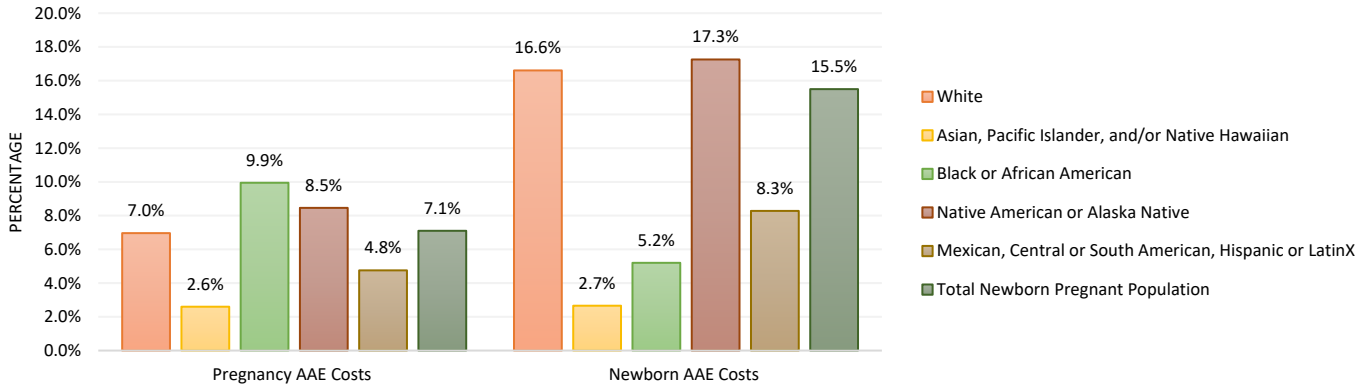
1. **Organization of health care services**: Diabetes care is a prioritized by Samaritan Health Plans, Samaritan Health System, and other network providers (i.e., included in strategic planning, focus of quality improvement projects, and highlighted in care coordination workplans).
2. **Self-care support**: IHN-CCO members have access to services that will empower them to take charge and actively engage in their diabetes care.
3. **Clinical decision support**: Samaritan Health Plans (SHP) network providers have appropriate Clinical Practice Guidelines (CPG) to support their needs. In addition, SHP provider network have avenues to give feedback regarding CPGs or other clinical decisions that impact diabetes care.
4. **Clinical information systems**: SHP has appropriate systems and processes for analyzing diabetes data, performing population health management projects, and aid health care providers in assessing gaps in comprehensive diabetes care.
5. **Design of the service delivery system**: SHP aims to implement projects and activities to improve outcomes among members with diabetes that are innovative, utilize best practices, and transform the health system.

6. **Community resources**: SHP partners with community organizations who serve our members and help improve diabetes care management (i.e., foodbanks, public health departments, housing, and transportation services).

Episode 2: Maternal and Child Health

Maternal and child health are a high priority of IHN-CCO because their health determines the health of the next generation. To improve maternal and child health outcomes, IHN-CCO aims to ensure pregnant people have culturally responsive health care, equitable access to care, are accessing community services (i.e., housing, food, dental care, and SUD treatment services), and support while navigating their health benefits during their pregnancy. In addition, IHN-CCO's goal is to decrease inequities in pregnancy and newborn health outcomes. **Figure 17.** has the AAE costs (costs that could have been prevented if upstream interventions occurred) for pregnancy and newborns from 2019 to 2021 by race.

Figure 17. The percent of pregnancy and newborn AAE costs for IHN-CCO members from 2019 to 2021, Optimus Analytics



Data Notes: AAE was calcuated by race using the member level diabetes cost data from Optumas analytics and merging it with IHN-CCO member level race data.

The data in **Figure 17.** shows that Black or African American members have the highest AAE costs related to pregnancy and Native American and Alaska Native members have the highest AAE cost for newborns. To decrease inequities in care and improve maternal and child health outcomes, in 2023 IHN-CCO will focus on increasing pregnant members participation in the community doula program. Research shows that doulas significantly improve birth outcomes, reduce birth inequities, and are cost effective.[3-5]

IHN-CCO has a contract with the community doula program (CDP). The goal is to reduce the percent of newborns who are born preterm and/or with low birth weight. About 5.0 percent of IHN-CCO members with a live birth from January 2021 to October 2022 had a claim for the CDP. Through our partnership with CDP staff, we understand not all IHN-CCO members participating in the CDP have a claim attached to their services. Detailed logic models will be established to outline how the outcome measures of lowering preterm birth rates and the percent of newborns born low weight will be achieved. **Figure 17.** presents a high-level example of the plans IHN-CCO has for accomplishing our goals in 2023.

Figure 17. 2023 high level goals and activities to increase utilization of doulas among IHN-CCO

Establish data sharing systems to evaluate birth outcomes for all IHN-CCO members with a doula service

- IHN-CCO Data Analytics team will establish a CDP claims report
- Data sharing means will be established with CDP leadership to confidently share data between organiations
- Assess equity gaps (i.e., Doula utalization by race compared to the availablity of doulas)

Improve referral pathways for CDP

- Review gaps in CDP referalls
- Partner with Samaritan Medical System to improve referrals to CDP

Identify barriers for CDP to increase the number of doula services available

- Review current barriers for building CDP capacity (i.e., funding, training, outreach, retention)

Episode 3: Substance Use Disorder: Increase engagement in SUD treatment

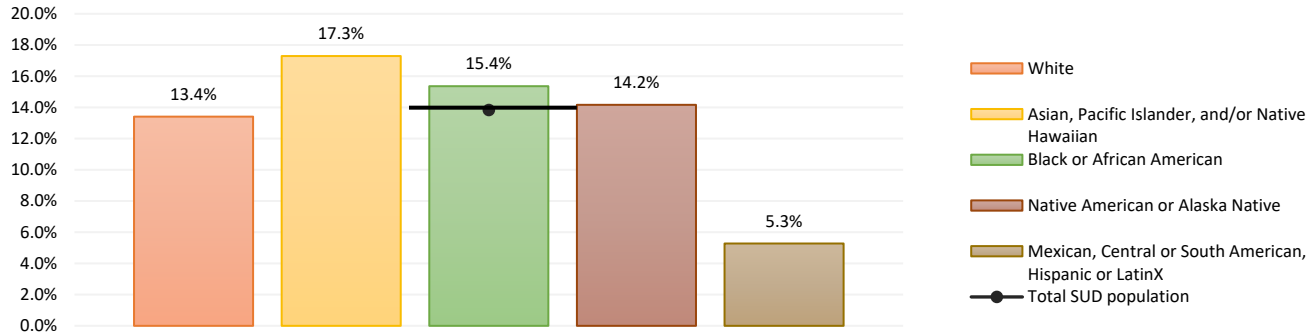
In 2022, approximately 10.2 percent of IHN-CCO members had a recorded alcohol or drug use disorder. Engaging IHN-CCO members in SUD treatment services was a major focus in 2022; however, the interventions to improve access to services focused on engaging primary care providers only. In 2023, primary care providers will continue to be involved, and engaged through the Collective Medical platform. In addition, a Counselor of Alcohol and Drug position was established and will focus on working with Primary Care to follow up initiating, and engaging treatment for members with an SUD diagnosis. With this position it will enable us to reach more patients in the time frame that is part of IET metric criteria which will benefit patients seeking treatment and in turn will increase the chances of capturing the CCO metric for the year. The position works under the direction of the Director of Samaritan Medical Group Behavioral Health Administration and Primary Care Senior Medical Director. The Key Performance Indicators are:

- Percentage of IHN patients that the position has completed the initiation portion with the patient.
- Percentage of IHN patients that followed through with the engagement portion.
- Percentage of referrals made within Samaritan Health Services (SHS) service area.

In addition, dental providers and community-based services will also be engaged to support members with SUD and evaluate how their services could potentially increase engagement in SUD treatment services.

The potentially avoidable costs associated with SUD are shown in **Figure 18.** The data shows disparities in AAE SUD costs when compared to costs for the total IHN-CCO population from 2019 to 2022. Asian, Native Hawaiian, and/or Pacific Islander (25.3% higher), Black or African American (11.6% higher), and Native American and Alaska Native (2.8% higher) members have higher AAE costs for SUD, concluding there could be inequities in SUD treatment services.

Figure 18. The percent of SUD AAE costs among IHN-CCO members from 2019-2022 by race, SHP Analytics



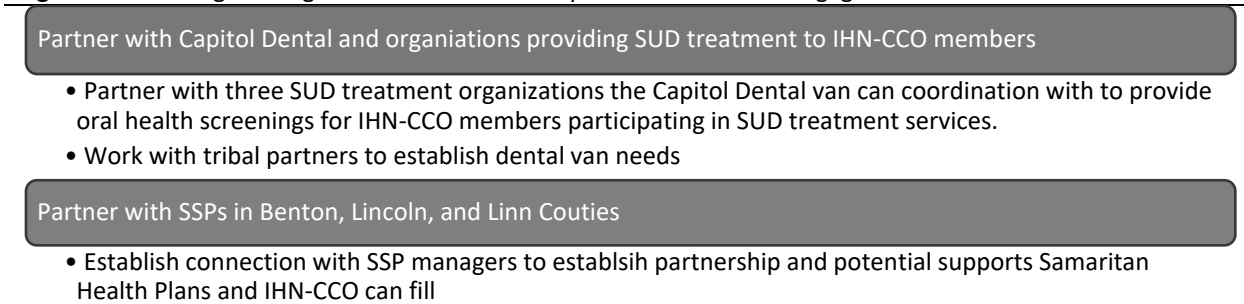
Data Notes: AAE costs were calculated using SUD AAE codes from Optimus Analytics. Members with a claim from 2019-2022 with a one of the AAE diagnosis codes were included.

The top two SUD costs with 100% AAE costs are Sepsis and alcohol induced acute pancreatitis without necrosis or infection. IV drug use can admit bacteria into the blood stream that can lead to sepsis.[6] Long-term heavy alcohol use in combination with poor diet and significant tobacco use can cause alcohol induced pancreatitis.[7] To improve health outcomes among our SUD population, lower health care costs, and help members engage in SUD treatment, IHN-CCO aims to widen the intervention scope by partnering with non-traditional providers and services, including dental providers and Syringe Service Programs. Substance use impacts physical, mental, and oral health. Heavy alcohol use, methamphetamine, cocaine, and opioid use are all connected to poor oral health outcomes. Problems with oral health are closely connected to poor physical and mental health outcomes and can greatly impact substance use.[8] Research shows that increasing oral health care among individuals with SUD improved treatment outcomes and increased how long someone maintained SUD treatment.[9] Syringe Service Programs (SSP) are an essential for all communities. SSP promote safe practices, reduces the spread of communicable disease, and reach individuals the health system has difficulty engaging with. Individuals who interact with SSP are five times more likely to participate in SUD treatment services and lower their use of injectable drugs.[8] Qualitative data from dental providers conclude that IHN-CCO members with SUD are the most difficult population reach or engage in care. They believe this occurs because of shame or embarrassment regarding their oral health. To reduce anxiety among this population and increase oral health utilization, the goal is to partner with SUD treatment facilities to perform oral examinations.

In 2023, IHN-CCO will partner with the Capitol Dental, dental van to provide oral health screenings to individuals participating in SUD treatment. Approximately 55.7% of IHN-CCO members are assigned to Capitol Dental. About 445 (1%) Capitol Dental members have an SUD indicator. Our goal is to establish partnerships between Capitol Dental and SUD treatment organizations across Benton, Lincoln, and Linn Counties because IHN-CCO members reside across all three counties.

SSPs are offered throughout the Benton, Lincoln, and Linn County region. IHN-CCO will promote partnerships between SSP and Capitol Dental, dental van. IHN-CCO will also assess the needs of the SSPs to understand gaps and potential partnerships that will aid in helping individuals utilizing SSP engage in essential health care services. Detailed logic models will be established with partners for achieving our desired outcome for improving initiation and engagement in SUD treatment by increasing oral health screenings and enhancing partnerships on SUD prevention with non-traditional agencies. **Figure 19.** presents a high-level example of the plans IHN-CCO has for accomplishing our goals in 2023.

Figure 19. 2023 high level goals and activities to improve initiation and engagement in SUD treatment services



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

Activity 1 description: Engage SHP and partners in all aspects of the Chronic Care Model

☐ Short term or ☒ Long term

Monitoring measure 1.1	Improve comprehensive diabetes care for IHN-CCO members with diabetes			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
65.7% of IHN-CCO members with diabetes are in control of their blood pressure[1]	66.5% of IHN-CCO members with diabetes are in control of their blood pressure	12/2023	67.1% of IHN-CCO members with diabetes are in control of their blood pressure	12/2024
69.5% of IHN-CCO members with diabetes are in control of their HbA1c levels[2]	70.8% of IHN-CCO members with diabetes are in control of their HbA1c levels	12/2023	72.0% of IHN-CCO members with diabetes are in control of their HbA1c levels	12/2024
Monitoring measure 1.2	Reduce inequities in medication adherence for IHN-CCO members with diabetes using metformin			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The average percent of IHN-CCO members with diabetes who are adherent to their metformin medication is 68.0%	The average percent of IHN-CCO members with diabetes who are adherent to their metformin medication is 70.0%	12/2023	The average percent of IHN-CCO members with diabetes who are adherent to their metformin medication 72.0%	12/2024

Activity 2 description: Enhance partnership with Community Doula Program

☐ Short term or ☒ Long term

Monitoring measure 2.1	Reduce preterm birth rate for IHN-CCO members

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
In 2022 the preterm birth rate for live IHN-CCO births was 6.9%[i]	6.7% of IHN-CCO live births are preterm	12/2022	6.2% of IHN-CCO live births are preterm	12/2024

Activity 3 description: Increase oral health care among IHN-CCO members with Substance Use Disorder (SUD)

☒ Short term or ☒ Long term

Monitoring measure 3.1	Increase dental utilization for IHN-CCO members with Capitol Dental coverage with SUD			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The percent of IHN-CCO members with SUD in 2022 with an oral health screening was 8.3% in 2022[ii]	11.2% of IHN-CCO members with SUD will receive an oral health screening	12/2023	15.0% of IHN-CCO members with SUD will receive an oral health screening	12/2024
Monitoring measure 3.2	Increase the percent of IHN-CCO members who engage in SUD treatment services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
16.9% of IHN-CCO members with a new SUD episode engaged in treatment services in MY2022	17.1% of IHN-CCO members with a new SUD episode engaged in treatment services	11/2023	18.1% of IHN-CCO members with a new SUD episode engaged in treatment services	11/2024

[i] Includes live births from quarter 1 to quarter 3 of 2022

[ii] Dental Procedure code D0150 was used to define if members with SUD received an oral health screening. Capitol Dental members only.

OHA Transformation and Quality Strategy (TQS) **CCO:** InterCommunity Health Network CCO

A. **Project short title**: Mental Health Home Clinic

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

If continued, insert unique project ID from OHA: 434

B. **Components addressed**

i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

IHN-CCO's Behavioral Health Strategy Plan (BHSP) is focused on developing an equitable, integrated, and person-centered behavioral health system that seamlessly and holistically integrates physical, behavioral, and oral health for members regardless of where they live in the tri-county region of Benton, Lincoln and Linn Counties. The BHSP is focused on five pillars:

- Population assessment: Design the delivery system to meet the needs of population.
- Workforce and provider network: Support provider network to achieve mental health parity and health equity for members.
- Delivery system: Provide access to full array of services, that are responsive to member needs, including focus on OHA identified special populations.
- Financing and payment models: Implementing financing models, including VBP arrangements to advance quality, evidence-based practice and integration.
- Leadership and Accountability: Establish system oversight and accountability.

The BHSP is overseen by IHN-CCO's Behavioral Health Quality Committee, and led by the Chief Medical Officer, Director of Behavioral Health, and the Director of Quality & Population Health Management. This strategy is executed through a series of projects and programs focused on designing a system to meet the unique needs of each county while simultaneously sharing best practices across the three-county region.

Through the regional population assessment and review of ED utilization, IHN-CCO found a disproportionate share of members with multiple chronic conditions, including mental illness, with high ED use reside in East Linn County, specifically in the cities of Lebanon and Sweet Home.

County	Percent of members by county
BENTON	17%
LINCOLN	25%
LINN	58%

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

East Linn County remains a difficult area to provide treatment services due to its rural location and high rates of medical co-morbidities, substance use, poverty, and mental illness. A few patients consume a large percentage of the health care dollar in this area, often through inefficient care modalities. Lebanon had one of the first Medical Home Model clinics, which serves medically complicated patients; however, this has only demonstrated the need for increased Behavioral Health services. Specifically, Samaritan Medical Group has provided Behavioral Health Consultants and psychiatry consultation through currently established Samaritan Medical Group (SMG) primary care offices; however, IHN-CCO is finding that high primary care utilization for Behavioral Health needs including, but not limited to, case management, crisis/suicidality intervention, and more intensive therapeutic intervention needs combined with high medical complexity is resulting in a high number of emergency department visits and overall cost of care. Although patients trust their current medical home primary care clinicians with their care, they often end up inappropriately seeking crisis mental health care there, making appropriate, proactive, and effective treatment difficult. Instead, care often ends up being reactionary, and ultimately, shifts crisis work to the emergency department. Wrap-around services of case management, comprehensive therapy, pharmacological intervention, peer support and crisis intervention in the mental health home model is expected to improve patient engagement in care, lead to proactive and effective intervention, and ultimately improve quality of life while decreasing both short term and long-term costs as we focus on breaking the cycle of intergenerational trauma/distress.

In 2022, system-wide barriers to implementation occurred including lack of resources and staffing. Partially due to the COVID-19 pandemic, the Mental Health Home Clinic was put on hold to address the barriers and ensure sustainability for the future. The partnerships with Linn County Mental Health and C.H.A.N.C.E. continued, but both organizations were unable to support the Mental Health Home Clinic due to the shortage of staff, increased numbers of members requiring crisis services, and the need to focus on COVID-19 strategies, especially in the case of Linn County Mental Health. Strategic planning and work has been resumed on the Mental Health Home Clinic, but targets and benchmarks are a year or more behind what was initially anticipated. Work continues as it is clear Linn County has a high need for services.

Numbers are reported in aggregate due to some too small to report. Over 12,000 members in Linn County are diagnosed with substance abuse disorder, severe & persistent mental illness, or other mental health diagnoses. At least 4% of these members speak a language other than English, with an additional 6% unreported. 711 (6%) of these members reported their ethnicity as Hispanic or Latino, while almost 5% (571) are a race other than White or Caucasian. Over 10% (1,302) have a diagnosed disability, and it is likely those that self-identify as having a disability is much higher. Gender Identity and Sexual Orientation data is not available at this time for these members.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The purpose of the Mental Health Home Clinic pilot is to bring together community partners to offer a holistic person-centered approach for individual who need more focus on their mental health/behavioral health, and crisis needs while still getting their physical and oral health care needs met. The pilot brings multi-agencies and inter-disciplinary teams to one location, providing all around comprehensive treatment and better care to members through a team-based approach. This will also increase communication between agencies for transitions of care. SMG's Mental Health and Behavioral Health departments will operate in partnership with Linn County Mental Health and C.H.A.N.C.E. recovery support service to develop a Mental Health Home clinic in Lebanon. The clinic will provide a team-based approach for adult patients that have severe persistent mental illness (SPMI) including psychotic disorders, chronic suicidality, personality disorders, and more severe forms of PTSD, in addition to chronic/complex medical issues.

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

Activity 1 description: Establish a VBP payment model for the MH Care Home & Community Memorandums of Understanding

☐ Short term or ☒ Long term

Monitoring measure 1.1	Finalize VBP contracts with SMG BH			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No Mental Health Home VBP contract established	VBP contract drafted	7/2023	VBP contract signed	9/2023
Monitoring measure 1.2	MOUs with community agencies established			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
MOUs not established	MOUs drafted for review	9/2023	MOUs finalized and signed	12/2023
Monitoring measure 1.3	Finalize Patient List			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No agreed upon patient list	Patient list finalized	9/2023	Baseline measures identified for cohort	3/2024
Monitoring measure 1.4	Finalize Provider List			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
BH Provider List Not finalized	Provider list identified	6/2023	Additional Providers Hired as need is identified	09/2024

Activity 2 description: Open Mental Health Home Clinic

☐ Short term or ☒ Long term

Monitoring measure 2.1	Epic configured for clinic program			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
EPIC not configured for clinic requirements	Configuration completed	9/2023	N/A	N/A
Monitoring measure 2.2	Workflow & Processes Mapped			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Workflows and Processes not published; staff not trained	Workflows drafted and published	9/2023	Staff trained on all workflows and processes	3/2024
Monitoring measure 2.3	Clinic open			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Clinic not open	Clinic opened and actively seeing patients	6/2024	N/A	N/A

OHA Transformation and Quality Strategy (TQS) **CCO:** InterCommunity Health Network CCO

A. **Project short title**: PCPCH: VBP & Consultant

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

If continued, insert unique project ID from OHA: 436

B. **Components addressed**

i. Component 1: PCPCH: Tier advancement
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

During and prior to 2022, IHN-CCO paid PCPCHs additional funds based on their PCPCH tier status and members assigned. Each PCPCH that has agreed to the contract receives a PMPM (Per Member Per Month) payment for each member. The PMPM is scaled up so that the higher the PCPCH tier, the greater the PMPM.

In addition, several main IHN-CCO PCPs (Primary Care Physicians) are under capitation arrangements. This puts the provider at full risk with incentives to manage the total cost and quality of the member. IHN-CCO is working to put the final main PCPs, those with >500 members, under a capitation by 2023. The PCPCH model is defined to support all aspects of a member's health. VBPs (value-based payments) support the PCPCH model by aligning reimbursement with PCPCH activity.

IHN-CCO finalized its contract with Creach Consulting Group, LLC at the beginning of 2022. By June 2022, IHN-CCO had conducted a baseline assessment its primary care network to determine areas of need for technical assistance (TA) (previous Activity 3) and prioritized clinic needs. Creach Consulting Group, LLC targeted these clinics to offer support through consultation, TA, and coaching. Approximately 6% of IHN-CCO's PCP clinics were engaged in this opportunity by the end of 2022.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

The PCPCH VBP and Consultant project provides PCPCHs with additional funds and resources to support tier maintenance and advancement. IHN-CCO's goal to improve the PCPCH tier level of all PCPCH's in our network remains unchanged. There are 103 distinct PCPs in IHN-CCO's network. Of these, 65 are PCPCHs Tier 2 or higher. IHN-CCO recognizes that a robust PCPCH network is required to fully serve community health goals. Many PCPCHs do not have the resources to achieve increases in tier level on their own. IHN-CCO offers opportunities to support them financially, educationally, and technologically to achieve PCPCH goals and tier advancement. PCP clinics in IHN-CCO's region serve the members with the following characteristics:

About 10% of the population is non-dominant culture race/ethnicity, however, this data is extremely limited with about 50% of the population's race/ethnicity being unknown. Nearly 10% of IHN-CCO members have a diagnosed disability (not including behavioral health disorders). 19% of IHN-CCO members have Severe Mental Illness (SMI), while 12% have diagnosed substance use disorders. Older people (over 65) comprise 5% of IHN-CCO's total membership. Over half of

IHN-CCO's member live in a rural area. Members with a household language not being English comprise about 5% of IHN-CCO's total membership. Children in care are over 1% of the population (1,217). Over 1% of IHN-CCO members do not have stable housing or are unhoused (this data is also severely limited due to data collection barriers). See the table below for breakdown of membership representing historically marginalized communities.

Demographic	Total Number of Members	Percentage of Total Membership
65+	4,253	5.20%
Children in Care (foster)	1,217	1.49%
Disability	7,031	9.37%
Household language other than English	4,385	5.36%
Mental Health Diagnosis	28,694	35.06%
Race/Ethnicity Non-dominant Culture	7,776	9.50%
Race/Ethnicity Unknown	40,623	49.63%
Rural	41,938	51.24%
Severe Mental Illness	15,216	18.59%
Substance Use Disorders	10,159	12.41%
Total	81,845	100.00%

IHN-CCO engaged Creach Consulting Group, LLC to provide TA in support of evidence-based PCPCH tier advancement, integrate traditional health workers, and help clinics achieve fidelity-based integrated behavioral health services. Offered to PCPs by IHN-CCO at no cost, Creach Consulting will continue to provide consultation, TA, and coaching to develop and support evidence-based PCPCH services at primary care clinics in the IHN CCO network in the following areas:

- PCPCH implementation and tier advancement.
- CCO incentive and other quality scorecard metrics.
- Behavioral health integration.
- Timely access to care.
- Traditional Health Worker integration.
- Health Information Technology (HIT), including clinical and community information exchange (e.g., Unite Us/Connect Oregon, Reliance HIE, Collective Medical/Pre-manage).
- Health-related social needs screening and effective workflows.

IHN-CCO chose Creach Consulting for its robust experience and approach to supporting PCP clinics including a focus on systems that support the most vulnerable populations including marginalized communities: LGBTQIA2S+, disabled folks, people of color, those with severe mental illness, special needs, and more. Support with Traditional Health Worker and Behavioral Health integration will improve access to appropriate care for these vulnerable populations. This support will also allow IHN-CCO's Population Heath Department to focus more on quality incentive metrics (QIM) improvement.

During 2022, six clinics or medical groups were engaged and provided TA (9% of PCP clinics, doubling the target set for September 2022, but falling short of the December 2022 benchmark set of 15%). One was provided TA to obtain Tier 5 PCPCH recognition (this is in progress) and supporting an improving timely access to care project. A new PCP office was engaged and supported to become PCPCH recognized for the first time, and others were supported in their PCPCH renewal applications, behavioral health integration, and VBP strategies. In 2023, Federally Quality Health Centers in Lincoln County engaged in this consultation opportunity to be provided TA support to restructure and enhance clinic workflows, and a PCP serving Benton County has also engaged.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The PCPCH project consists of two main components: 1) VBP Advancement and 2) PCP Consultant Support. These components include the following focus areas:

Value-Based Payment Advancement

- PCPCH tiered based payments:
  - Per Member Per Month (PMPM) payments to PCPCHs that increase by
  - tier level, offering incentive for PCPCH tier advancement.
- PCP Capitated VBPs with quality incentives:
  - PMPM based on risk of members that allows providers flexibility in managing member care, which incentivizes greater access while not compromising quality.
  - Quality based incentives to maintain quality care under a capitation agreement that includes incentives to meet selected CCO quality metrics.

PCP Consultant Support

Offered free to PCP clinics, Creach Consulting group, LLC will provide consultation, TA, and coaching to develop and support evidence-based PCPCH services at primary care clinics in the IHN-CCO network. This will consist of the following activities:

- Conducting a follow-up survey on engagement activities with PCP clinics.
- Providing additional resources and support for the process of PCPCH recognition, application renewal, and site visits.
- Providing Traditional Health Worker and Behavioral Health Integration support.
- Providing consultation on managing metrics gap lists.
- Obtaining consultation related to enhancing VBP agreements.

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

Activity 1 description: VBP Payment Advancement - PCPCHs on tiered PMPM

☐ Short term or ☒ Long term

Monitoring measure 1.1	% of members covered under tiered PCPCH PMPM			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
94%	96%	12/2022 **(96%, met)**	99%	12/2023

Activity 2 description: VBP Payment Advancement - Members in a PCP capitation or other upside/downside at risk VBP

☐ Short term or ☒ Long term

Monitoring measure 2.1	% of IHN members under an at risk PCP VBP			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
18%	85%	12/2022 **(92%, met)**	90%	12/2024

Activity 3 description: VBP Payment Advancement - PCPCH recognition, tier advancement, application renewal, and site visit preparation

☐ Short term or ☒ Long term

Monitoring measure 3.1	PCPCH Tier Advancement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
5 PCPCHs at Tier 3 or lower	4 PCPCHs at Tier 3 or lower	12/2023	2 PCPCHs at Tier 3 or lower	12/2024

Activity 4 description: PCP Consultant Support - Conduct assessment of IHN-CCO's PCP network to determine further areas of need for technical assistance (TA), evaluate past TA, and provide TA for additional PCPs

☒ Short term or ☐ Long term

Monitoring measure 4.1	PCP TA Evaluation			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No follow-up survey	Survey initiated	09/2023	Survey results completed, clinic needs prioritized, and satisfaction with past TA evaluated	01/2024

Monitoring measure 4.2	PCP Consultation Engagement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Engagement with 6% of PCP clinics	Engaged with 10% of PCP clinics	12/2023	Engaged with 15% of PCP clinics	12/2024

A. **Project short title**: Pharmacy Care Coordination for high-risk members

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

If continued, insert unique project ID from OHA: 437

B. **Components addressed**

i. Component 1: SHCN: Non-duals Medicaid
ii. Component 2 (if applicable): Serious and persistent mental illness
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

As of January 2023, over 34 thousand IHN-CCO members were on the prioritized population list. This includes members with a condition or aspect outlined in OAR 410-141-3870. The percent of IHN-CCO members within each category is displayed in **Table 1.**

Table 1. The percent of IHN-CCO members with a special health care need as outlined by OHA's prioritized population, Samaritan Health Plans Data Analytics, As of January 2023

SPMI	37.4%
Older Adults	21.7%
Chronic Condition Medication	14.3%
Chronic Condition SUD	7.4%
Chronic Condition Mental Health	4.8%
High-Risk Pregnancy	3.4%
TOC Med	2.4%
DHS Custody	2.2%
Children Serious Emotional Disorder	1.3%
TOC SUD	1.3%
IDD	< 1%
TOC MH	< 1%
MAT	< 1%
SPMI Homeless	< 1%
HIV-AIDS	< 1%
IV Drug	< 1%
Older Adults Homeless	< 1%
Chronic Condition Medical home	< 1%
Chronic Condition SUD Home	< 1%
Chronic Condition Mental Health Home	< 1%
High-risk Pregnancy: Homeless	< 1%
Neonatal Ab Syndrome	< 1%
MAT Homeless	< 1%
Tuberculosis	< 1%
IV Drug Homeless	< 1%

HIV-AIDS: Homeless	< 1%
Children with Serious Emotional Disorder: Homeless	< 1%
IDD Homeless	< 1%

Figure 1. through **Figure 4.** are demographics for IHN-CCO prioritized population. Most members identify as white and not Hispanic or LatinX. A larger percentage of members report living in in Linn County and there are more females in the prioritized population than males, most likely due to high-risk pregnancy category (Only assessed by sex assigned at birth, data for gender not available)

Figure 1. The percent of IHN-CCO members on the prioritized population list by reported race, SHP data analytics, as of January 2023

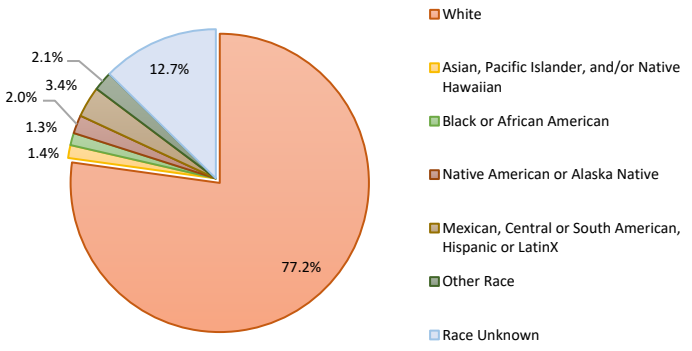


Figure 2. The percent of IHN-CCO members on the prioritized population list by reported Hispanic Ethnicity, SHP data analytics, as of January 2023

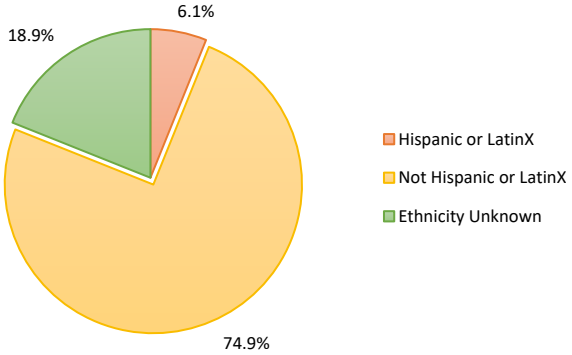


Figure 3. The percent of IHN-CCO members on the prioritized population list by sex, SHP data analytics, as of January 2023

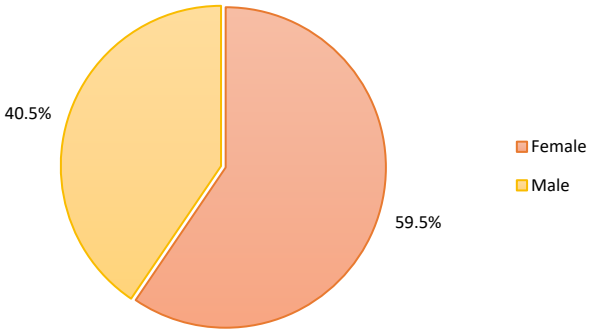
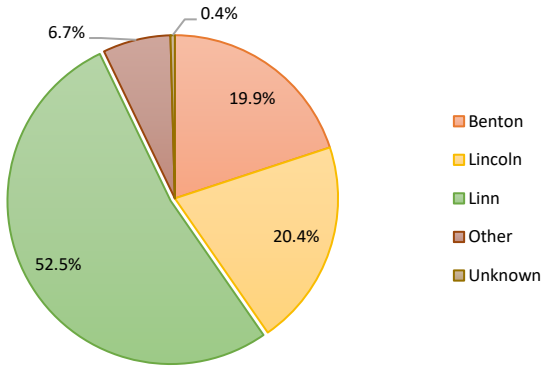


Figure 4. The percent of IHN-CCO members on the prioritized population list by reported County of residence, SHP data analytics, as of January 2023



The pharmacy therapeutic management project is one of a variety of projects focus on members with special health care needs who are not dual eligible. Other projects include:

- Improving birth outcomes for IHN-CCO members with high-risk pregnancy
- Enhancing mental health service access for members with a mental health service need
- Improving access to social-emotional health services for children ages 0-5
- Focusing on value-base payment implementation to increase initiation and engagement in treatment for members with SUD

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and READED and SOGI data.

In 2022, about 7.6% of members ages 18 years and older have diabetes. Most members with diabetes have a co-occurring condition. In 2022, multiple projects focused on improving health outcome for IHN-CCO members with co-occurring conditions of diabetes, SUD, and SMI. Research concludes that individuals with diabetes who have co-occurring SUD and/or SMI face additional challenges when managing their diabetes care and are at higher risk of adverse health outcomes.[1-2] In 2022, approximately 474 members were included in the diabetes, SUD, and SMI (< 1% of IHN-CCO members in 2022) population. This is about 13.8 percent of the IHN-CCO diabetic population. To understand the IHN-CCO member population with diabetes, SUD, and SMI, a population assessment was conducted. **Figure 5.** through **Figure 8.** have the demographics for members in the population. Most of the members in the population identify as white, speak English, are not Hispanic or LatinX, and are residing in Linn County.

Figure 5. The percent of IHN-CCO members with diabetes, SUD, and SMI by resported County of residence, 2022

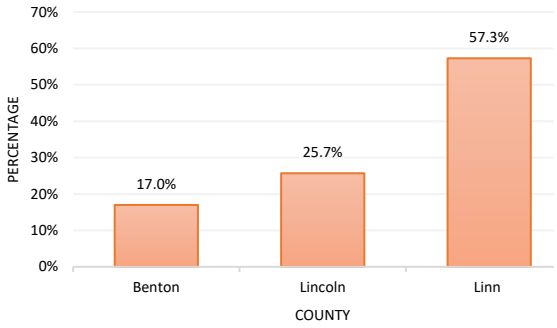
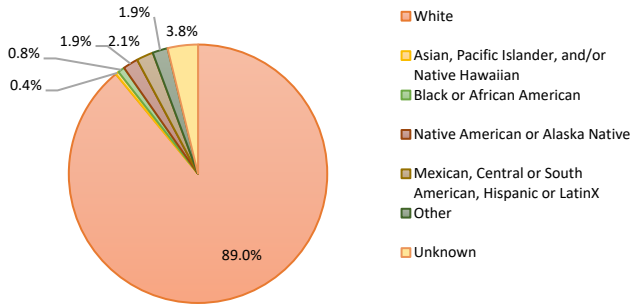


Figure 6. The percent of IHN-CCO members with diabetes, SUD, and SMI by resported race, 2022



Data Notes: Includes members who are eligible for IHN-CCO service in 2022; Approximately 96.8% of cohort members report living in Benton, Lincoln, and Linn counties; < 1% do not have a County reported.

Figure 7. The percent of IHN-CCO members with diabetes, SUD, and SMI by resported Hispanic ethnicity, 2022

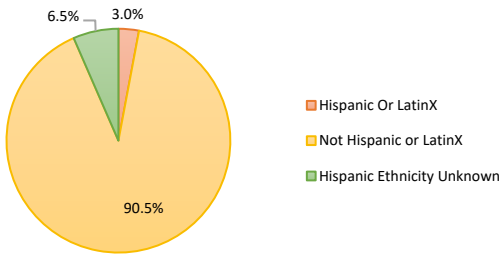
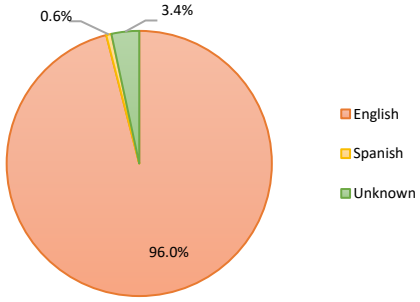


Figure 8. The percent of IHN-CCO members with diabetes, SUD, and SMI by resported preferred language, 2022



Data Notes: Includes members who are eligible for IHN-CCO service in 2022

In 2022, Samaritan Health Plan (SHP) pharmacy services department in partnerships with Samaritan Health System (SHS) pharmacy staff, focused on providing comprehensive therapeutic management to IHN-CCO members with diabetes, SUD, and SMI. The project was a small pilot. About 41 IHN-CCO members ages 18 and older with diabetes, SUD, and SMI were identified and 39 fully participated. Capacity was low among pharmacy staff which is why the pilot included a small number within the larger cohort. We believed enough evidence could be established to determine if the pilot was a success. The target population were identified by using the following parameters:

- IHN-CCO members with a diagnosis of diabetes, SUD, and SMI
- SMI diagnosis only included anxiety and or depressive disorders

- Only included members assigned to a Samaritan Medical Group clinics
- To be included members had a HbA1c greater than 9, but less than 14

The team decided to focus on anxiety and depressive disorders and not expand to other SMI conditions because of the potential to need more intensive care that the pharmacy team could not provide.

The main objectives of this interventions were to reduce medical costs for the target population by establishing appropriate medication plans, ensure the target population were established with primary care and/or mental health provider, and aid in removing barriers (i.e., food insecurity, transportation, housing problems) to ensure proper medication management and adherence. The interventions were chosen with the goal of decreasing the average HbA1c among the target population by 1 by the end of 2022 and have a decrease in costs among these members by 10 percent.

To accomplish our desired outcomes, a value-based payment contract with Samaritan Medical Group pharmacy was established. The clinical pharmacist, in partnership with a board-certified psychiatric pharmacist, reviewed medication lists of these members to see if they were clinically appropriate or if they needed to adjust their medication regimen. Pharmacy staff contact members and created a one-on-one connection in hopes of creating a positive rapport with the high-risk members. During their meetings, a pharmacist and the member reviewed their medications and confirmed they were established with a PCP or a mental health provider. Questions were also asked about other needs such as food insecurity, housing, transportation, and other aspects that made it difficult to manage their diabetes and other co-occurring conditions such as stress or limited support.

2022 Findings: Accomplishments, Barriers, and Lessons Learned:

Table 2. lists the monitoring measures selected for 2022 and if they were met or not met.

Table 2. The monitoring measures selected for the 2022 TQS submission			
Monitoring measure 1.1	Finalize VBP Contract with Pharmacy Care Coordination		
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Met or Not Met**
VBP for cohort not established.	Agreed upon cost and quality measures identified	3/2022	Met
Monitoring measure 1.2	Focus efforts on project Cohort		
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Met or Not Met**
Outreach for specialized Pharmacy Care Coordination not conducted	50% of cohort members contacted	2/2022	Met
Monitoring measure 1.3	Expand program beyond pilot cohort		
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Met or Not Met**
Pharmacy Care Coordinators focused only on a specific Cohort of members	Workflow established for identification of qualifying members and referral pathway established for member referral	1/2023	Met
Monitoring measure 2.1	Decrease Cohort Average HbA1c		
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Met or Not Met**
Baseline Average Cohort HbA1c: 11.6	Average Cohort HbA1c: 10.5	12/2022	Met

Monitoring measure 2.2	Decrease Overall Cohort Medical Spending		
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Met or Not Met**
Total 2021 cohort cost: $1,441,264	5% decrease in total cohort costs (based on 50% of 2021 total cost)	6/2022	Still in review. See Narrative for explanation.
Monitoring measure 2.3	Member experience assessed		
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Met or Not Met**
No member experience specific to the cohort exists.	50% of members receiving Pharmacy Care Coordination respond to satisfaction survey.	10/2022	In progress

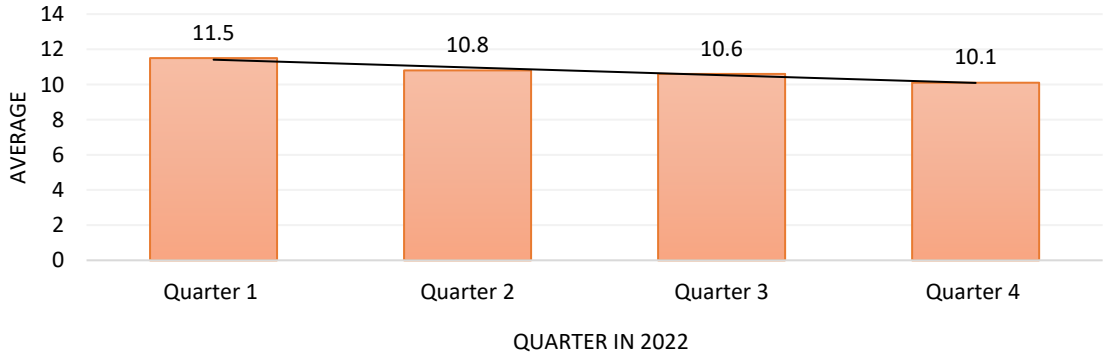
The data in **Figure 9.** and **Figure 10.** confirm the pilot was a success. **Figure 9.** has the average HbA1c for the 39 members of the target population the SHS pharmacist was able to perform outreach with. The difference in the average HbA1c from quarter 1 to quarter 4 was about a 1.4 (decrease) in HbA1c level. This exceeds the project goal of an average decrease of 1 for the target populations HbA1c levels.

Figure 10. shows the per-member per-month (PMPM) allowed dollars for the target population in 2021 compared to 2022. The goal was to have a 10% decrease in the total costs. This goal changed as the project was merged with SHP diabetes taskforce and partnered with the MEPP diabetes project. The goal changed to seeing a decrease in AAE costs for the target population. This occurred because of the large difference in AAE costs (costs that could be avoided if proper upstream interventions occurred) for members with co-occurring conditions of diabetes, SUD, and SMI compared to members with diabetes but no co-occurring SUD and SMI. As shown in **Figure 6.** the medical costs and pharmacy costs for the target population increased. We believe this is due to connect the target population to needed medical services, increase in medication adherence, and members receiving the correct medications. The AAE costs for the target population decreased from $766 dollars to $312 dollars. This is a 59.2% decrease in AAE costs for the target population from 2021 to 2022.

Qualitative data from the SHS pharmacy team was positive. The main finding was that many of these members were using the wrong medications or too many medications. Some members were also not properly diagnosed and needed to see a mental health provider or their PCP. **Table 3.** Includes quotes from the SHS pharmacy team who reached out to the target population.

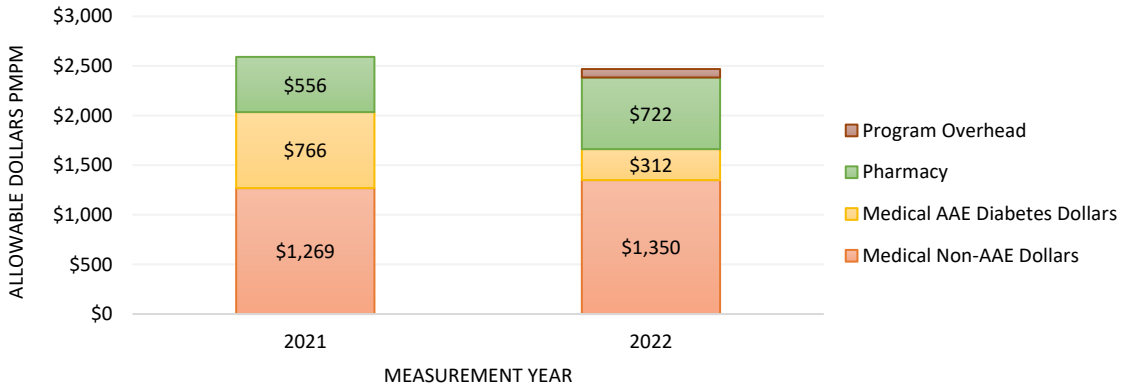
The pharmacy therapeutic management project saw a lot of achievements in 2022; however, several barriers occurred. **Table 4.** has the identified barriers and how the barriers were addressed throughout the 2022.

Figure 9. The HbA1c reported for the target population by quarter in 2022, Samaritan Health System EHR



Data notes: Includes HbA1c for 39 our of the 41 members identified for the target population.

Figure 10. The difference in allowable PMPM dollars for the target population in 2021 compared to 2022, SHP Data Analytics



Data notes: Includes 38 of the 41 members in the target population

Table 3. Quotes from the SHS pharmacy team members conducting outreach for members of the target population	
Quote 1: Helping a member with severe PTSD	"I learned about how fearful he is to leave the house and how much time he spends avoiding people, crowded spaces etc. Gets to the hardware store as early as possible to avoid crowds, spends most his time at home… nothing in the chart from previous visits describes any of this. I don't think providers are truly aware. It affects every aspect of his life"
Quote 2: Building trust with a high-risk member	"The patient continuity is huge in this population as it seems to take a while to earn their trust, and once we are able to, they are able to open up a lot more. I saw a member in clinic, she was having a ton of anxiety about meds, new job, family issues, etc. I think I was able to make some progress with her because when we talked again, she seemed to be more calm. This member likes the week to two-week follow-ups as she said it helps keep her anxiety down when she knows the phone call is coming. Her A1C is also improving, moving in the right direction."
Quote 3: Understanding member needs	"Identified a member needed to be treated for a mood disorder. Referred member to psychiatrics and they agreed. The member was able to reduce their medications and start treatment for their unidentified disorder. Connected member to housing and utility resources – their A1C has improved"

Table 4. Identified barriers for the pharmacy therapeutic management project throughout 2022 and how they were addressed	
Barrier	**How Barrier was addressed**
Connecting with members over the phone: Most of the members in the target population were able to be reached, but it was not easy to connect with the members over the phone. Members did not answer the phone, or the phone number listed was incorrect.	To manage this barrier SHS pharmacy staff worked with SHP staff to ensure the number listed in the EHR was correct. SHS pharmacy staff also reached out to the member's pharmacy (if the pharmacy was different than SHS) to see if the other pharmacy team had a correct contact number for the member.
Capacity of SHS pharmacy staff: The number of members in the target population was small because of the pharmacy staff capacity. It takes time and effort to conduct one-on-one outreach with these members.	A value-based payment was established.
Meeting the complex needs of members: The individuals identified for the target population had a variety of physical, behavioral, and social determinant of health problems. Many of the problems the members were facing were out of scope for the pharmacy team members who were making the calls and speaking to the members.	Training was conducted on how to conduct outreach for these members and refer them to the services they need (i.e., PCP, mental health, intensive care coordination, food, and housing services). In addition, a board-certified psychiatric pharmacist was available to help with the more complex psychiatric medication needs. The psychiatric pharmacist also worked with the member's PCP to ensure they understood the change in medications (if occurred).

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In 2023, IHN-CCO will continue the value-based payment with SHS pharmacy services and expand on the 2022 pharmacy therapeutic management project. The goal is to expand the existing cohort by monitoring members with an HbA1c greater than 9 who have diabetes, SUD, and SMI. The SHS pharmacy staff will conduct outreach to the target population:

- One-on-one outreach with a pharmacist to review the current medication listed for the members, medication adherence and education.
- Medications for SUD and SMI will be reviewed with psychiatric pharmacist to confirm they are correct or if specific medications need to be added.
    - If a medication is incorrect or needs to be added the psychiatric pharmacist will reach out to the member's PCP and provide notice and education regarding the medications.
- Barriers for members will be assessed (i.e., food insecurity, houselessness or inadequate housing, proper medication storage, financial barriers, etc.)
- If needed, referrals to care coordination, primary care, mental and behavioral health, or other community-based organizations will be conducted

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

Activity 1 description: Improve HbA1c levels (< 9)

☐ Short term or ☒ Long term

Monitoring measure 1.1	IHN-CCO members assigned to an SHS clinic with diabetes, SUD, and SMI are in control of their HbA1c levels (< 9)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
45.2% percent of IHN-CCO members with diabetes, SUD, and SMI who are assigned to an SHS clinic are in control of their HbA1c[i]	54.6% (increase of 10 members) of IHN-CCO members with diabetes, SUD, and SMI who are assigned to an SHS clinic are in control of their HbA1c	12/2023	58.0% (increase of 15 members) of IHN-CCO members with diabetes, SUD, and SMI who are assigned to an SHS clinic are not in control of their HbA1c	12/2024

Activity 2 description: Decrease Emergency Department (ED) Utilization

☐ Short term or ☒ Long term

Monitoring measure 2.1	Reduce the average number of diabetes related ED visits for IHN-CCO members with diabetes, SUD, and SMI			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The average number of quarterly diabetes related ED visits is 41.6 for IHN-CCO members with diabetes, SUD, and SMI[ii]	The average number of quarterly diabetes related ED visits is 38.9% for IHN-CCO members with diabetes, SUD, and SMI	12/2023	The average number of quarterly diabetes related ED visits is 36.9% for IHN-CCO members with diabetes, SUD, and SMI	12/2024

[i] Data specification following OHA CCO metric logic, members are not listed as having poor control of their HbA1c if they have an A1c <9 and a visit with their PCP during the measurement year.

Baseline data are as of January 17, 2023. Only includes IHN-CCO members who are assigned to an SHS clinic with a value-based payment, about 119 members with diabetes, SUD, and SMI were identified for the denominator, about 26.6% of the total diabetes, SUD, and SMI population.

[ii] Includes ED claims with a primary diagnosis code related to diabetes in 2022

A. **Project short title**: Under Pressure; Managing High Blood Pressure to Decrease Morbidity and Mortality Risks

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**

i. Component 1: SHCN: Full benefit dual eligible
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

As of January 2023, 86,010 members were covered on IHN-CCO Medicaid plan and 6,731 were covered on Samaritan Advantage Health Plan (SAHP), Samaritan Health Plan's (SHP) Medicare program. Of those, approximately 1,500 members were also enrolled in the SAHP Dual Eligible Special Needs Plan (D-SNP). The dual enrollment allows for seamless coordination of Medicaid and Medicare benefits and cost-sharing protections for these members. To qualify for the D-SNP, potential and current D-SNP members must meet both the Medicaid and Medicare eligibility criteria. Samaritan Health Plan's (SHP) Enrollment Department is responsible for running and reviewing the Currently Eligible Members Report. This report includes SAHP members who have been identified as potentially eligible for the SNP. The Enrollment department verifies members who have gained full dual status in the State eligibility system, MMIS, with a current effective date.

SHP manages the D-SNP population through the SNP Model of Care (MOC). The SNP MOC established an assessment of the D-SNP populations and manages projects to improve health outcomes for D-SNP members. A full assessment of D-SNP members by sex, age, County of residence, race, ethnicity, and language is shown in **Figures 1-6.**

Figure 1. The percent of D-SNP members by sex, Empower Analytics, 2022[1]

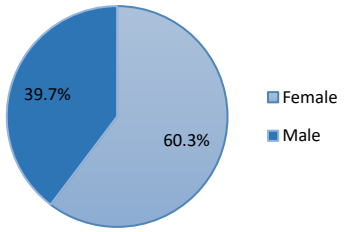


Figure 2. The percent of D-SNP members by age group, Empower Analytics, 2022[1]

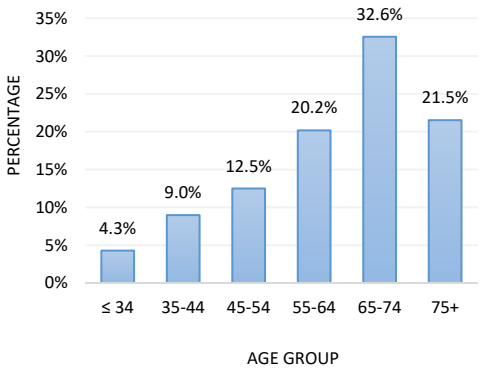


Figure 3. The percent of D-SNP members by County of residence, Empower Analytics, 2022[1-2]

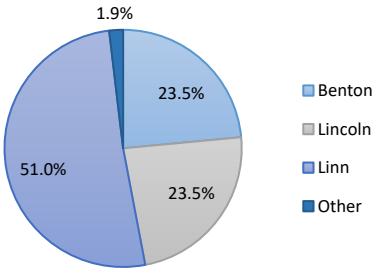


Figure 4. The percent of D-SNP members by Race, Empower Analytics, 2022[1]

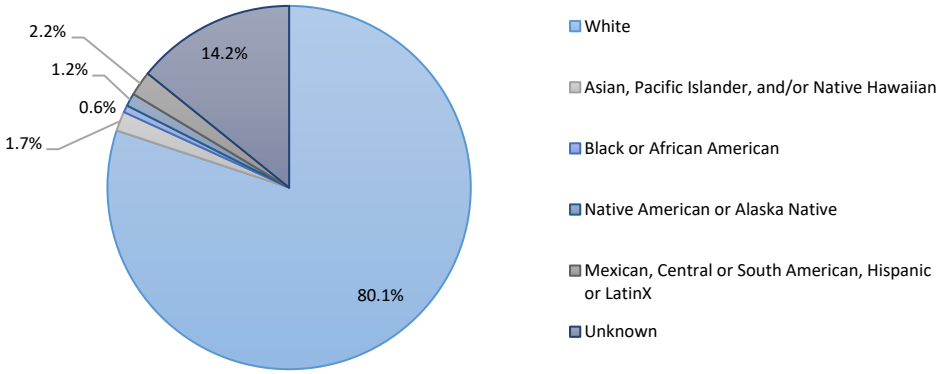
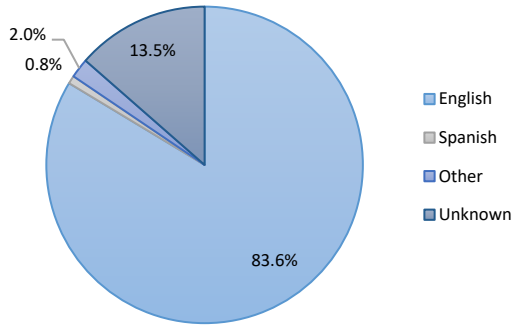
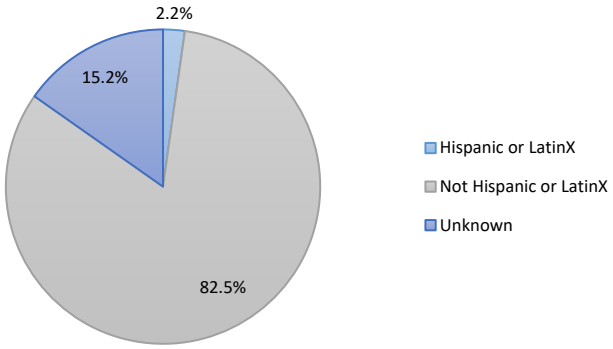


Figure 5. The percent of D-SNP members by County of residence, Empower Analytics, 2022[1,3]

Figure 6. The percent of D-SNP members by County of residence, Empower Analytics, 2022[1]





Data Notes:

1. Includes members who were eligible for D-SNP services in 2022
2. 'Other' includes members living outside of the three County region (Benton, Lincoln, Linn)
3. Other languages include: Arabic, Chinese, Cantonese (inc Toishanese), Gujarati, Hindi, Korean, Philippine (Other), Punjabi, Russian, Sign Language, Tagalog, Ukrainian, Vietnamese

The 2024 SNP MOC reports that the five most prevalent conditions, among the D-SNP population are: hypertension (30.1%), asthma (19.1%), diabetes (14.7%), chronic obstructive pulmonary disease (13.6%) and chronic pain (15.2%). Projects for D-SNP members focus on improving access to care, chronic disease and medication management, improving the quality-of-care D-SNP members receive, and reducing health care costs. From 2021 to 2022, IHN-CCO partnered with Medicare line of business (LOB), Pharmacy Services, the Provider Relations team, and Behavioral Health Department on a variety of projects associated with the following:

- Improve D-SNP members access to person-centered care through PCPCHs;
- Improve utilization of preventive and ambulatory health services;
- Ensure members with newly diagnosed substance use disorder (SUD) have immediate access to treatment services;
- Keep D-SNP members adherent to their medications; and
- Establishing processes for improving the completion of Health Risk Assessments (HRA), Individualized Care Plans (ICP) and Interdisciplinary Care Teams (ICT) among D-SNP members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

The American Heart Association refers to hypertension as the "silent killer"[1]. In 2020 more than 670,000 deaths were contributed to hypertension, a condition that can be managed through appropriate lifestyle changes and proper

medication management.[1-2] Among SHP D-SNP population, approximately 30.1 percent (441 members) of members have a hypertension diagnosis. Of those with hypertension, 26.8 percent have a comorbidity, with the average number of comorbidities for the D-SNP hypertensive population being seven. The goal of the, *Under Pressure; Managing High Blood Pressure to Decrease Morbidity and Mortality Risks,* TQS project is to help patients collaborate with a pharmacist to aid in blood pressure control, prevent adverse health events, additional comorbidities, and improve D-SNP members' quality of life.

The integration of pharmacists into medical care is proven effective by a variety of peer-review literature. One study, *Pharmacist involvement in primary care improves hypertensive patient clinical outcomes,* conducted by Sookaneknun and Richards placed pharmacist in primary care settings to aid in monthly check-ins with hypertensive patients. They reviewed their medications and provided pharmaceutical care and counseling. The results were that the hypertensive patients who worked with a pharmacist had a statistically significant reduction in poor blood pressure control, improvements in medication adherence rates and lifestyle modifications when compared to the control group.[3] Nemerovski, Younge, and Mariani's, *Project ImPACT: Hypertension Outcomes of a Pharmacist-Provided Hypertension Service,* project focused one-on-one care of pharmacists to help patients control their blood pressure, improve lifestyle, adhere to antihypertensive therapy, improve patient knowledge and satisfaction, and modify cardiovascular risk factors. The evaluation concluded that patients who collaborated with a pharmacist had significant improvements in blood pressure control and achieving their blood pressure control goals.[4] Another study found that pharmacy-physician partnerships to help patients control their blood pressure were cost-effective. In Polgreen, Han, and Carter's study, *Cost Effectiveness of a Physician-Pharmacist Collaboration Intervention to Improve Blood Pressure Control,* patients in the intervention group had a decrease in medical costs and had better control of their blood pressure. The level of outreach conducted among pharmacist was approximately two-hours over a 9-month period, making intervention costs moderately low.

Research concludes that partnerships between pharmacists and medical care helps manage hypertensive members. The TQS project will provide one-on-one pharmacy support, education, and resources to D-SNP members with a condition history of hypertension who are not in control of their blood pressure. D-SNP members are generally more high-risk, have extensive health care costs, and are top health care utilizers. Given the evidence, the TQS project has the potential of greatly improving D-SNP population health outcomes, enhancing D-SNP member experience, and reduce health care spending.

Sources:

1. American Heart Association (2017). The facts about high blood pressure. Retrieved from https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure
2. Centers for Disease Control and Prevention (2023). Facts about hypertension. Retrieved from https://www.cdc.gov/bloodpressure/facts.htm
3. Sookaneknun, P., Richards, R., Sanguansermsri, J. (2004). Pharmacist involvement in primary care improves hypertensive patient clinical outcomes. *Ann Pharmacother, 38*(12) 2023-8. https://pubmed.ncbi.nlm.nih.gov/15522983/
4. Nemerovski, C.W., Young, M., Mariani, N. (2013). Project ImPACT: Hypertension
5. Outcomes of a Pharmacist-Provided Hypertension Service. *Innovations in Pharmacy, 4*(3). https://www.aphafoundation.org/sites/default/files/ckeditor/files/hypertension_article_459152.pdf
6. Polgreen, L.A., Han, J., Carter, B.L. (2015). Effectiveness of a physician-pharmacist collaboration intervention to improve blood pressure control. *Hypertension, 66*(6), 1145-51. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4644092/

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The purpose of the intervention is to reduce risk of morbidity and mortality for D-SNP members with poor control of their hypertension. The intervention includes positive coordination and communication between the following entities: Samaritan Health Plans (SHP) Quality and Population Health Management team; SHP Medicare and Medicaid Programs; SHP Pharmacy; Samaritan Health System (SHS) pharmacy team; SHS Primary Care and Behavioral Health providers; and

SHP Care coordination team. The D-SNP members who are identified as having hypertension and have a blood pressure reading greater than 140/90 will be assigned to a cohort and connected to the intervention. Members of the cohort will be invited to meet with a pharmacist to support medication reconciliation, medication review, disease state and lifestyle education. To meet approved collaboration protocols and ensure members of the cohort are receiving high quality care, members who agree to participate will receive a referral to their PCP to initiate medication management.

The pharmacist assigned to members in the cohort will initiate the following:

- Educate members on home blood pressure monitoring (home meters will be checked against clinic monitors to ensure accuracy).
- Medication plans and education will be established. Medications will be adjusted for optimal dosing and side effect profiles. Diabetes is included in the protocols because optimization of diabetes medications may, in some cases, help with blood pressure control as well (e.g., SGLT2 inhibitors).
- Appropriate labs will be ordered for the member and follow up will occur as needed.
- Assessment of medication will be established to ensure no medication issues are identified (e.g., other medications worsening blood pressure control).
    - If medications are identified that are impacting a member's blood pressure control, the pharmacist will conduct a consultation with the ordering provider.
- Referrals to care coordination teams and other resources when additional social, economic, or environmental barriers surface (i.e., food insecurity, transportation issues, houselessness, SUD)

Pharmacists will track interventions, time spent with members and blood pressure control to evaluate if the D-SNP one-on-one mentorship with the clinical pharmacist was successful.

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

Activity 1 description: Hypertension Management

☐ Short term or ☒ Long term

Monitoring measure 1.1	DSNP cohort members ages 18-85 with hypertension are adherent to their RAS antagonist medication			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
As of quarter 3 of 2022, 88.0% of DSNP members with hypertension are adherent to their RAS antagonist medication[i]	90.0% of DSNP members ages 18-85 with hypertension are adherent to their RAS antagonist medication	12/2023	92.0% of SNP members ages 18-85 with hypertension are adherent to their RAS antagonist medication	12/2024
Monitoring measure 1.2	DSNP cohort members with a condition history of hypertension are in-control of their blood pressure (<140/90)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
100% of DSNP members with a condition history of hypertension are not in control of their blood pressure[ii]	80.0% of DSNP members with a condition history of hypertension are in control of their blood pressure	12/2023	90.0%of DSNP members with a condition history of hypertension are in control of their blood pressure	12/2024

Activity 2 description: Completion of Care Coordination Assessments and Services

☐ Short term or ☒ Long term

Monitoring measure 2.1	DSNP cohort members with a condition history of hypertension have a completed Heath Risk Assessment (HRA)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
95.3% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA)[iii]	97% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA)	12/2023	100% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA)	12/2024
Monitoring measure 2.2	DSNP cohort members with a condition history of hypertension have a completed Individualized Care Plan (ICP) and an Interdisciplinary Care Team (ICT)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
81.5% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team[iv]	83% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team	12/2022	87% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team	12/2024

[i] CMS technical specifications are utilized for determining RASA adherence

[ii] BP poor control numerator includes SNP members ages 18-85 with a condition history of hypertension - Members with a BP reading date <1/1/2022, do not have a BP recorded, and/or with a BP value of >140/90 with a BP test date between the dates of 1/1/2022 and 1/31/2023

The cohort includes D-SNP members identified through SHP PHM platform with a history of hypertension

[iii] Includes DSNP members between the ages of 18-85 with condition history of hypertension with a recorded HRA as of December 2022

[iv] Includes DSNP members between the ages of 18-85 with condition history of hypertension with a recorded ICT and ICP as of December 2022

The cohort includes D-SNP members identified through SHP PHM platform with a history of hypertension

Section 2: Discontinued Projects Closeout

ID	Project Name
433	Improving Access to Social and Emotional Health Services
432	Improving Meaningful Access to Interpreter Services
439	Pathfinder Clubhouse
376	Timely Hospital Follow-Up

OHA Transformation and Quality Strategy (TQS) CCO: InterCommunity Health Network CCO

A. Project short title: Improving Access to Social and Emotional Health Services
B. Project unique ID (as provided by OHA): 433
C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): IHN-CCO is discontinuing the TQS project, *Improving Access to Social and Emotional Health Services*, to reprioritize and shift to other bodies of work. Improving access to quality Social-Emotional (SE) health services for children ages 0-5 is being addressed in other projects, including Performance Improvement Projects and internal CCO metric improvement projects. The following monitoring measures for this project are completed:

- Develop a CCO led workgroup for building SE health infrastructure for children ages 0-5 and their families.
- The social-emotional health Reach metric data provided by OHA are shared with community partners.
- Conduct a qualitative analysis on social-emotional health services and access barriers with community partners and internal Samaritan Health Plans (SHP) staff.
- Establish a foundation for sustaining an accurate and comprehensive regional map of social-emotional health services and resources for children ages 0-5 and their families.
- Create an action plan to improve social-emotional health service capacity and access for children ages 0-5 and their families.

IHN-CCO is moving forward with the following activities to address the SE health needs for children ages zero to five:

1. Address access barriers for families (e.g., improve language access supports, provide childcare supports, provide transportation supports, expand hours or offer flexible scheduling).
2. Improve care coordination for families, including providing support navigating Social Emotional health services and improving referral pathways.
3. Address contract or payment barriers for existing providers who provide Social-Emotional health services.
4. Pursue new contract and payment options for community-based providers to enhance provision of Social-Emotional health services.

A. Project short title: Improving Meaningful Access to Interpreter Services
B. Project unique ID (as provided by OHA): 432
C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):

Improving Meaningful Access to Interpreter Services met the project targets and benchmarks through the following activities:

1. Ensured language access-related policy reviews and updates by reviewing current policies, obtaining input from stakeholders, and research.
2. Enhanced provider and staff education through increased and meaningful communication.
3. Ensured adequate interpreter service monitoring and reporting. IHN-CCO has been participating in a statewide vendor template workgroup to ensure translation services are captured effectively.
4. Assessed bilingual staffing shortages across the IHN-CCO delivery system and region and identified options to assist IHN-CCO and community partners/providers with access to bilingual staff.
5. Hired an internal IHN-CCO advocate to provide a direct link to assistance with access and care issues for members.
6. Hired a Health Equity Liaison, which can assist with initiatives to improve language access.
7. Captured interpreter data by enhancing encounter data collection in the SHS EPIC system, including individual interpreter information, language and communication preferences of the patient, mode of interpretation, and type of facility in which each interpretation service is conducted.

While the components of the project will carry on, the bulk of the transformational and innovative aspects are set up and on track to be operationalized. Hence the discontinuation of this project under the Transformation & Quality Strategy.

A. Project short title: Pathfinder Clubhouse
B. Project unique ID (as provided by OHA): 432
C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):

Pathfinder Clubhouse provides a nontraditional behavioral health alternative to treatment through a psychosocial rehabilitation model of intervention. The expected outcomes for the Pathfinder Clubhouse Project included: Improved discharge planning from Good Samaritan Regional Medical Center (GSRMC) psychiatric inpatient and partial hospitalization, reduced inpatient hospitalizations and emergency department utilization for active members, and increased services using Traditional Health Workers (THWs).

The project was meant to continue for two years; however, Pathfinders exceeded their goals for the first year and in many cases met their goals for the second year. This includes increasing THWs from two to five including staff reflective of the individuals served, serving 172 Members throughout the year, and supporting: 13 Members in gaining or maintaining housing, 9 Members in educational achievement, and 34 Members becoming or remaining employed by the end of 2022.

Pathfinders now has a formal relationship with the Psychiatric Inpatient and Partial Hospitalization programs at GSRMC. They are able to support transition planning meeting the Members while they are at GSRMC and enrolling them in Pathfinders to meet their defined goals. Although our preliminary data was limited, it did show reduced Emergency Department and Psychiatric Inpatient admissions following Member engagement.

Pathfinder Clubhouse has become a model for Clubhouses and because of their success presented at a National Conference. We have no reason to believe that numbers of individuals served or outcomes achieved will decrease in the second year and so intend to sunset this project while focusing on other promising interventions.

OHA Transformation and Quality Strategy (TQS) CCO: InterCommunity Health Network CCO

A. Project short title: Timely Hospital Follow-Up for D-SNP
B. Project unique ID (as provided by OHA): 376
C. Criteria for project discontinuation: Project has failed to meet its expected outcomes and cannot be adapted to meet the outcomes
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):
The TQS project, *Timely Hospital Follow-Up for D-SNP,* began in 2021. The focus of this project was to build on enhanced care management workflow and work with hospital discharge planners and PCPCH clinic staff to increase timely follow-up of PCP after discharge. The scope of this project was limited to evaluation of Samaritan hospital discharge and 30-days post discharge follow-up for a cohort of members who are eligible for Medicare and Medicaid, the D-SNP members assigned to Samaritan PCPs.

The monitoring measures focused on building the infrastructure needed to improve the percent of D-SNP members who receive a 30-day follow up from their PCP after a hospitalization. The monitoring measures were established with the partnership from AxisPoint Health (APH) to provide data and help with provider coordination. SHP is no longer contracting with APH and is partnering with the CareHub to coordinate with providers and D-SNP members to ensure timely follow up after a hospitalization. The partnerships is currently being established and all new monitoring measures will need to be established. Due to these outcomes, the current TQS project will be discontinued and a new TQS project will be established focusing on our D-SNP population. The timely hospital follow-up work is being conducted through the D-SNP Model of Care and will be a priority for Medicare Programs and SHP Quality and Population Health Management teams for 2023-2024.

Section 3: Required Quality Attachments

Attachment Name
Quality Assurance and Performance Improvement Workplan
Quality Assurance and Performance Improvement Impact Analysis called *Quality Improvement Program*

2023 QI Workplan

Topic/Element	Deliverable	Due Date
2022 Annual Evaluation	Complete annual evaluation of QI activities.	8/31/2023
	Annual Evaluation reviewed and approved by QIC	10/25/2023
	Annual Evaluation reviewed and approved by QMC	11/14/2023
2023 KPIs	Determine 2023 KPIs	3/31/2023
2023 Quality Improvement Program	Update QI Program annually.	1/31/2023
	QI Program reviewed by QIC	2/22/2023
	QI Program reviewed and approved by QMC	3/14/2023
Appeals and Grievances	Report appeals and grievance data to QIC Q1	6/28/2023
	Report appeals and grievance data to QIC Q2	8/23/2023
	Report appeals and grievance data to QIC Q3	10/25/2023
	Report appeals and grievance data to QIC Q4	2/28/2024
Behavioral Health Program	Annual Behavioral Health Report	7/31/2023
	Mental Health Parity Report	6/1/2023
	Annual Behavioral Health Plan update and progress report	7/31/2023
Care Coordination Program	2023 Care Coordination Program	4/1/2023
	Care Coordination Program reviewed/approved by QIC	2/22/2023
	Care Coordination Program presented to QMC (via QIC update report out)	3/14/2023
	Submit Care Coordination Activities Report (July 1 - Dec. 31, 2022)	3/1/2023
	Care Coordination Activities Report (July 1 - Dec. 31, 2022) to QIC for review of summary recommendations.	4/26/2023
	Submit Care Coordination Activities Report (Jan 1 - June 30, 2023)	8/29/2023
	Care Coordination Activities Report (Jan 1 - June 30, 2023) to QIC for review of summary recommendations	10/25/2023
Care Transitions Program Evaluation	Complete annual program evaluation	
	Evaluation reviewed and approved by QIC	
	Presented to QMC	
Utilization Management (UM)	Utilization Management Program	
	Utilization Management Program reviewed/approved by QIC	
	Presented to QMC	
	Review and update Quality Assurance program document with detailed requirements and oversight and monitoring activities	
	Submit Part C Organization Determinations & Reconsiderations Data	2/27/2023

2023 QI Workplan

Topic/Element	Deliverable	Due Date
	Conduct IRR testing annually.	
	Update Utilization and Service Authorization Handbook annually	3/1/2023
	Utilization and Service Authorization Handbook reviewed/approved by QIC	4/26/2023
	Utilization and Service Authorization Handbook presented to QMC (via QIC update report out)	5/9/2023
Chronic Care Improvement Program (CCIP)	Complete CCIP annual documentation requirements.	1/31/2023
	Sign CCIP attestation annually.	12/30/2023
	Summary level CCIP report to QMC annually	
	Report CCIPs to QIC annually.	
DCBS reporting	Complete DCBS Patient Protection form for Commercial LOB	6/30/2023
DSN Narrative	Update DSN Narrative annually and submit to OHA	7/31/2023
Evidence-Based Clinical Practice Guidelines (CPG)	Annually review and update the Hypertension Guideline. Obtain adoption by QMC.	3/14/2023
	Disseminate Hypertension Guideline to CPG webpage.	3/31/2023
	Provider Newsletter article Re: Hypertension Guideline	4/27/2023
	Annually review and update the ADA Clinical Practice Guidelines. Obtain adoption by QMC.	7/11/2023
	Annually review and update the Diabetes Guideline. Obtain adoption by QMC.	7/11/2023
	Annually review and update the Adult Immunizations Guideline. Obtain adoption by QMC.	7/11/2023
	Annually review and update the Childhood Immunizations Guideline. Obtain adoption by QMC.	7/11/2023
	Annually review and update the Adult and Child Preventive Screenings Guideline. Obtain adoption by QMC.	7/11/2023
	Disseminate ADA, Diabetes, Adult Immunizations, Child Immunizations, Adult and Child Preventive Screenings Guidelines to CPG webpage.	7/31/2023
	Provider Newsletter article Re: ADA, Diabetes, Adult Immunizations, Child Immunizations, Adult and Child Preventive Screenings Guidelines	7/27/2023
	Annually review and update the Osteoporosis Guidelines. Obtain adoption by QMC.	9/12/2023
	Annually review and update the Pediatric Preventive Screenings Guidelines. Obtain adoption by QMC.	9/12/2023
	Annually review and update the Tobacco Cessation Guidelines. Obtain adoption by QMC.	9/12/2023
	Disseminate Osteoporosis, Pediatric Preventive Screenings, and Tobacco Cessation Guidelines to CPG webpage.	9/30/2023

2023 QI Workplan

Topic/Element	Deliverable	Due Date
	Provider Newsletter article Re: Osteoporosis, Pediatric Preventive Screenings, and Tobacco Cessation Guidelines	10/26/2023
	Annually review and update the Heart Disease Guideline. Obtain adoption by QMC	11/14/2023
	Annually review and update the Congestive Heart Failure Guideline. Obtain adoption by QMC	11/14/2023
	Disseminate Heart Disease and Congestive Heart Failure Guidelines to CPG webpage.	11/30/2023
	Provider Newsletter article Re: Heart Disease and Congestive Heart Failure Guidelines.	1/26/2024
	Update Immunization charts on member and Health Resources website.	7/31/2023
	Annually inform QMC of MCG Care Guidelines	11/14/2023
	Provider Newsletter article Re: MCG Care Guidelines	3/1/2024
	Review APA and ASAM Guidelines. Obtain adoption by QMC.	11/14/2023
	Disseminate APA and ASAM Guidelines to CPG webpage.	11/31/2023
	Provider Newsletter article Re: APA and ASAM Guidelines	3/1/2024
External Quality Review (EQR)	Document submission Standard III - Coordination and Continuity of Care (done in 2020; next 2023)	4/20/2023
	Document submission: Standard XI - Clinical Practice Guidelines (done in 2021; next 2024)	na
	Document submission: Standard XII Quality Assessment and Performance Improvement (done in 2022; next 2025)	na
Health Equity: Member Race, Language, Culture and Linguistics	Health Equity Plan	
	Annual Updated HIT Roadmap	
Health Outcomes Survey (HOS)	Complete 2022 HOS (via vendor)	
	Notify NCQA HOS Project Team of Survey Vendor Selection.	
	Analyze 2021 SAHP HOS survey data.	
	Present SAHP HOS survey results to QIC	
	Present summary level SAHP HOS survey results to QMC	1/9/2024
Healthcare Effectiveness Data and Information Set (HEDIS)	SAHP/SNP: Complete 100% of auditing and reporting requirements.	
	IHN-CCO: Run administrative HEDIS measures, including utilization measures. Not externally reported.	
	Commercial: Run administrative HEDIS measures and oversee completion of CBP and CDC hybrid measures. Not externally reported.	
Long-Term Services and Supports (LTSS)	MOU report on coordination activities and required domain metrics	3/15/2023
	Updates or revisions to MOU	1/31/2023
	Submit new MOU	3/1/2023
MCM Program Evaluation	Complete annual program evaluation	
	Evaluation reviewed and approved by QIC	
	Presented to QMC	
Medicaid Efficiency and Performance	MEPP updated annually and submitted with TQS	
	MEPP to QIC	

2023 QI Workplan

Topic/Element	Deliverable	Due Date
Medical Coverage Policies (MCP)	Annually review and update Coverage of Routine Care for Members Enrolled in Qualifying Clinical Trials MCP. Receive approval through PolicyTech.	2/7/2023
	Coverage of Routine Care for Members enrolled in Qualifying Clinical Trials MCP to QMC for approval	3/14/2023
	Annually review and update Cosmetic and Reconstructive Procedures MCP. Receive approval through PolicyTech.	2/7/2023
	Cosmetic and Reconstructive Procedures MCP to QMC for approval	3/14/2023
	Annually review and update psychiatric Sub-Acute Admission MCP. Receive approval through PolicyTech.	2/16/2023
	Psychiatric Sub-Acute Admission MCP to QMC for approval.	3/14/2023
	Annually review and update Drug Testing in the Outpatient Setting MCP. Receive approval through PolicyTech.	6/30/2023
	Drug Testing in the Outpatient Setting MCP to QMC for approval	7/11/2023
	Annually review and update Applied Behavioral Analysis MCP. Receive approval through PolicyTech.	4/13/2023
	Applied Behavioral Analysis MCP to QMC for approval	5/9/2023
	Annually review and update Gender Dysphoria Medical Necessity Criteria MCP. Receive approval through PolicyTech.	2/16/2023
	Gender Dysphoria Medical Necessity Criteria MCP to QMC for approval	3/14/2023
	Annually review and update Genetic Testing MCP. Receive approval through PolicyTech.	2/16/2023
	Genetic Testing MCP to QMC for approval	3/14/2023
	Annually review and update Advanced Care Planning MCP. Receive approval through PolicyTech.	2/16/2023
	Advanced Care Planning MCP to QMC for approval	3/14/2023
	Annually review and update Proprietary Laboratory Analyses MCP. Receive approval through PolicyTech.	2/16/2023
	Proprietary Laboratory Analyses MCP to QMC for approval	3/14/2023
	Annually review and update Evaluation of New and Existing Technologies MCP. Receive approval through PolicyTech.	1/12/2024
	Evaluation of New and Existing Technologies MCP to QMC for approval	3/14/2023
	Annually review and update Computer Assisted Surgical Navigational Procedure MCP. Receive approval through PolicyTech.	1/12/2024
	Computer Assisted Surgical Navigational Procedure MCP to QMC for approval	3/14/2023
	Annually review and update Wireless Gastrointestinal Monitoring System MCP. Receive approval through PolicyTech.	1/12/2024
	Wireless Gastrointestinal Monitoring System MCP to QMC for approval	3/14/2023

2023 QI Workplan

Topic/Element	Deliverable	Due Date
	Annually review and update Botulinum Toxin MCP. Receive approval through PolicyTech.	7/7/2023
	Botulinum Toxin MCP to QMC for approval	9/12/2023
Medicare Stars	Complete First Plan Preview	
	Complete Second Plan Preview for assigned measures	
	Complete Display measure Plan Preview for assigned measures	
	Analyze star rating results and present to QIC.	
	Analyze star rating results and present to QMC.	11/14/2023
	Provider Newsletter: Star article	Q4 or Q1
Member Health Education and Promotion	SAHP Member Newsletter - January Edition	
	SAHP Member Newsletter - April Edition	
	SAHP Member Newsletter - July Edition	
	SAHP Member Newsletter - October Edition	
	SAHP Member Newsletter - January 2024 Edition	
	IHN-CCO Member Newsletter - March, Spring issue	4/1/2023
	IHN-CCO Member Newsletter - June, Summary Issue	7/1/2023
	IHN-CCO Member Newsletter - September, Fall Issue	9/1/2023
	IHN-CCO Member Newsletter - December, Winter Issue	12/1/2023
	SAHP Member Incentive Program	7/1/2023
	IHN-CCO Member Incentive Program	7/1/2023
	Create: SharePoint material request workflow page/button	12/31/2023
	Update brochure: Your Sam Adv Diabetes Benefit	
	Update flyer: Diabetes Education and Support	
	Create flyer: Where to go for Care (appropriate ED use)	4/30/2023
	Create flyer and magnet: Nurse Advice Line	TBD
	Revive brochure: Would you like to become pregnant?	5/21/2023
	Update brochure: Medications Matter	
	Update brochure: Advance Directives	6/1/2023
	Update brochure:	
	Monthly Growth Chart mailing: January	1/31/2023
	Monthly Growth Chart mailing: February	2/28/2023
	Monthly Growth Chart mailing: March	3/31/2023
	Monthly Growth Chart mailing: April	4/30/2023
	Monthly Growth Chart mailing: May	5/31/2023
	Monthly Growth Chart mailing: June	6/30/2023
	Monthly Growth Chart mailing: July	7/31/2023
	Monthly Growth Chart mailing: August	8/31/2023
	Monthly Growth Chart mailing: September	9/30/2023
	Monthly Growth Chart mailing: October	10/31/2023
	Monthly Growth Chart mailing: November	11/30/2023
	Monthly Growth Chart mailing: December	12/31/2023
	Monthly Pregnancy/Oral Health mailing: January	1/15/2023
	Monthly Pregnancy/Oral Health mailing: February	2/15/2023
	Monthly Pregnancy/Oral Health mailing: March	3/15/2023

2023 QI Workplan

Topic/Element	Deliverable	Due Date
	Monthly Pregnancy/Oral Health mailing: April	4/15/2023
	Monthly Pregnancy/Oral Health mailing: May	5/15/2023
	Monthly Pregnancy/Oral Health mailing: June	6/15/2023
	Monthly Pregnancy/Oral Health mailing: July	7/15/2023
	Monthly Pregnancy/Oral Health mailing: August	8/15/2023
	Monthly Pregnancy/Oral Health mailing: September	9/15/2023
	Monthly Pregnancy/Oral Health mailing: October	10/15/2023
	Monthly Pregnancy/Oral Health mailing: November	11/15/2023
	Monthly Pregnancy/Oral Health mailing: December	12/15/2023
	Care Gap letter: Breast Cancer Screening	7/1/2023
	Care Gap letter: Colorectal Cancer Screening	7/1/2023
	Care Gap letter: Diabetes Eye Exam	7/1/2023
	Osteoporosis initial mailing-January	
	Osteoporosis initial mailing-February	
	Osteoporosis initial mailing-March	
	Osteoporosis initial mailing-April	
	Osteoporosis initial mailing-May	
	Osteoporosis initial mailing-June	
	Osteoporosis initial mailing-July	
	Osteoporosis initial mailing-August	
	Osteoporosis initial mailing-September	
	Osteoporosis initial mailing-October	
	Osteoporosis initial mailing-November	
	Osteoporosis initial mailing-December	
	Diabetes initial mailing-February	
	Diabetes initial mailing-March	
	Diabetes initial mailing-April	
	Diabetes initial mailing-May	
	Diabetes initial mailing-June	
	Diabetes initial mailing-July	
	Diabetes initial mailing-August	
	Diabetes initial mailing-September	
	Diabetes initial mailing-October	
	Diabetes initial mailing-November	
	Diabetes initial mailing-December	
	Hypertension CCIP initial mailing-March	
	Hypertension CCIP initial mailing-April	
	Hypertension CCIP initial mailing-May	
	Hypertension CCIP initial mailing-June	
	Hypertension CCIP initial mailing-July	
	Hypertension CCIP initial mailing-August	
	Hypertension CCIP initial mailing-September	
	Hypertension CCIP initial mailing-October	
	Hypertension CCIP initial mailing-November	
	Hypertension CCIP initial mailing-December	

2023 QI Workplan

Topic/Element	Deliverable	Due Date
	Hypertension CCIP follow up mailing-Q2	
	Hypertension CCIP follow up mailing-Q3	
	Hypertension CCIP follow up mailing-Q4	
	Q1 APH Print Campaign	2/15/2023
	Q1 APH Text Campaign	2/15/2023
	HOS Falls Mailing	
	Health Education website maintenance	12/31/2023
Member Satisfaction Surveys	Analyze annual IHN-CCO CAHPS survey results.	
	Present IHN-CCO CAHPS survey data to QIC	
	Present IHN-CCO CAHPS survey data to QMC	
	Administer SAHP CAHPS survey to members (via vendor)	
	Submit SAHP 2022 CAHPS append file	
	Analyze annual CMS SAHP CAHPS survey results.	
	Present SAHP CAHPS survey data to QIC	
	Present SAHP CAHPS survey data to QMC	
	Use MA &PDP CAHPS Vendor Authorization and Oversample Request Tool to authorize vendor and request oversample.	
	Complete Project Details and Client Service Center sections in SPH Nexus Portal	
	Request any needed changes to the 2023 CAHPS append file report	
	Analyze CM survey data to evaluate satisfaction with case manager and overall effectiveness of program and report to QIC annually as part of the QI Program Eval.	
	Evaluate 2022 Mental Health Statistics Improvement Program (MHSIP) survey results	
Non-Emergent Medical Transport (NEMT)	NEMT QI Program in place	
Over and under utilization	Quality & Pharmacy to determine what types of data will be included for review of over and under utilization of services	
	Over and under utilization reporting to QMC	
	Over and under utilization reporting to QIC	
Performance Improvement Projects (PIP) - four PIPs	Submit Q4 2022 PIP Reports to OHA	1/31/2023
	Submit Q1 2023 PIP Reports to OHA	4/30/2023
	Submit Q2 PIP Reports to OHA	7/31/2023
	Submit Q3 PIP Reports to OHA	10/31/2023
	Submit Q4 PIP Reports to OHA	1/31/2024
	PIP progress report to QIC	
	Summary level PIP progress report to QMC	7/11/2023
Pharmacy Services	Submit Part D Coverage Determinations & Reconsiderations, Reopenings Data	2/13/2023
	Submit Part D Improving Drug Utilization Review Controls Data	2/13/2023

2023 QI Workplan

Topic/Element	Deliverable	Due Date
	Submit Part D Medication Therapy Management Programs Data	2/13/2023
	Preferred Drug List and Prior Authorization Criteria for all Drug classes	1/15/2023
	CMS Annual Drug Utilization Review Survey	
	Findings from PBM Market Check	7/1/2023
Policies & Procedures	All CSD P&Ps reviewed and revised annually.	12/31/2023
Population Health Management (PHM)	Annual Population Assessment	
	Identification of prioritized population and screening	2nd Thursday
	Annually evaluate CCM program to determine effectiveness, identify areas of improvement, and plan interventions for following year.	
	Intensive Care Coordination: Complete annual evaluation	
	Maternity Case Management: Tracking per APM metric	
Provider Manual	Review/revise Quality section of Provider Manual: Q1 - 3/31/2023	2/22/2023
	Review/revise Quality section of Provider Manual: Q2 - 6/30/2023	6/19/2023
	Review/revise Quality section of Provider Manual: Q3 - 9/30/2023	9/18/2023
	Review/revise Quality section of Provider Manual: Q4 - 12/31/2023	12/18/2023
Provider Newsletter	Provider Newsletter March Edition	1/26/2023
	Provider Newsletter June Edition	4/27/2023
	Provider Newsletter September Edition	7/27/2023
	Provider Newsletter December Edition	10/26/2023
Provider Webinars	Provider Webinar content for March webinar	1/27/2023
	Provider Webinar content for June webinar	4/28/2023
	Provider Webinar content for September webinar	7/28/2023
	Provider Webinar content for December webinar	10/27/2023
QIC Taskforces	Member Experience Taskforce annual SMART goals semi annual report to QIC	
	Member Experience Taskforce annual SMART goals semi annual report to QIC	
	Population Health Taskforce annual SMART goals semi annual report to QIC	
	Population Health Taskforce annual SMART goals semi annual report to QIC	
	Provider Network Taskforce annual SMART goals semi annual report to QIC	
	Provider Network Taskforce annual SMART goals semi annual report to QIC	

2023 QI Workplan

Topic/Element	Deliverable	Due Date
	SNP MOC Taskforce annual SMART goals semi annual report to QIC	
	SNP MOC Taskforce annual SMART goals semi annual report to QIC	
	TQS Taskforce annual SMART goals semi annual report to QIC	
	TQS Taskforce annual SMART goals semi annual report to QIC	
	Complete annual SNP MOC Program evaluation	
	SNP MOC Eval reviewed by QIC	
SNP MOC Program & Eval	SNP MOC Eval reviewed and approved by QMC	7/11/2023
	Write 2024 SNP Program (for 2023 submission)	
	Submit Part C Special Needs Plan Care Management Data	
	Submit required measure rates for DSNP reporting to OHA	
	Update projects for OHA submission	11/1/2023
	Submit TQS Report	11/15/2023
Transformation and Quality Strategy (TQS)	TQS reviewed and approved by QIC	2/22/2023
	TQS reviewed by QMC - informed	3/15/2023
	Enhance TOC program description and requirements	
	Build TOC Monitoring Program	
Transitions of Care	1. Prioritize and align QI metric management: Prioritize QI and strengthen the organization through the alignment of resources for metric performance and projects. Prioritize and align QI with organizational governance structure, goals, priorities, and strategic plan when available.	
	2. Build IS capacity: Continue to build capacity and IS infrastructure and data management tools and analytics. Improve data analytics and reporting through industry standard data validation processes and integration of SDoH and REALD data. Ensure sufficient staffing to maintain data and reporting for comprehensive population assessment, metric management, and performance improvement.	
2021 QI Program Evaluation Recommendations	3. Enhance QI performance: Enhance the existing quality department staffing, strengthen governance, and organizational structures to deliver improved results for performance improvement. Set and monitor performance improvement targets. Ensure tracking and monitoring reports are available and accurate.	
	4. Engage network providers in QI activities: Strengthen quality committees with deeper engagement of the provider network. Engage providers in QI project work. From these efforts, identify and cultivate quality champions. Develop glidepath to support providers in achieving success under value-based care and alternative payment models.	

2023 QI Workplan

Topic/Element	Deliverable	Due Date
	5. Strengthen HEDIS operations: Develop infrastructure and internal staffing to manage year-round HEDIS auditing, supplemental data sources, monitoring and reporting, including providing consistent and timely education, feedback and performance reports to providers.	

2023 Quality Improvement Program

Prepared by Samaritan Health Plans Quality and Population Health Management Department with contributions from:

- Associate vice president, Clinical Services Division
- Associate vice president, Health Plans compliance officer
- Director, Behavioral Health
- Director, Integrated Care Coordination
- Director, Pharmacy Services, Quality and Population Health Management
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Revision history

Version	Date	Approved by
2020	Nov. 12, 2019	Quality Management Council
2021	Jan. 12, 2021	Quality Management Council
2022	Jan. 11, 2022	Quality Management Council
2023	March 14, 2023	Quality Management Council

Samaritan Health Plans

InterCommunity Health Network CCO

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Executive summary

Samaritan Health Plans is an integrated nonprofit healthcare organization that includes InterCommunity Health Network-Coordinated Care Organization. IHN-CCO serves Oregon Health Plan members in Benton, Lincoln and Linn counties. SHP serves Medicare members through the Samaritan Advantage Health Plan, HMO and Special Needs Plan members in Benton, Lincoln and Linn counties. SHP also serves Samaritan Health Services employees through a self-funded plan Samaritan Choice Plans. SHP also offers large, small, and association Employer Group (commercial) Plans.

As of December 2022, SHP serves approximately 101,535 members under these lines of business.

The Quality Improvement (QI) Program encompasses Population Health Management and describes organizational framework, scope, and objectives for improving the safety, quality, experience, and affordability of healthcare for our members. The QI Program provides an overview of the objectives, structure, responsibilities, and program components, and activities in place to monitor and improve the quality of health care services and the outcomes of care. The QI Program is updated annually to respond to the changing needs of members, clinical standards, and regulatory and accrediting standards.

MISSION Building healthier communities together
VISION Serving communities with PRIDE
VALUES **P**assion * **R**espect * **I**ntegrity * **D**edication * **E**xcellence

Program overview

The Samaritan Health Plans and IHN-CCO Board of Directors govern the QI Program, which integrates network providers, social service agencies and community-based organizations, members, health plan departments and staff at all levels. The QI Program ensures members receive compassionate and effective care that is easily accessible, safe, equitable and affordable.

Purpose

The QI Program provides a formal process to monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and services objectively and systematically. This approach enables SHP to focus on opportunities for improving operational processes and health outcomes, ensuring cultural and linguistically appropriate

services and high levels of member, clinician, and care team satisfaction. The QI Program promotes accountability of all staff and affiliated health professionals and community-based organizations for the quality of care and services provided to our members.

Quality improvement goals

The SHP QI Program goals aim to improve the quality of health care while advancing health care transformation through the quadruple aim of healthcare by optimizing health and wellbeing with a focus on safety, disparities in health care delivery, cultural humility, care teams and partners, and the member the care experience.

- **Deliver quality care and services that set community standards.** Maintaining processes to ensure evidence-based clinical practice guidelines are adopted, regularly reviewed, approved, and disseminated to network providers. Systematically evaluate delivery of services in accordance with approved guidelines and clinical performance indicators.
- **Give members care that is compassionate and effective.** Integrating behavioral health, addressing the whole person including social determinants of health and health equity, individualizing care, engaging in health promotion and education of preventive services and active self-management.
- **Make equity part of practice, process, action, innovation and organizational performance.** Actively monitoring member perception of network providers and their health outcomes to identify trends and opportunities for quality improvement through member experience feedback and CAHPS (Consumer Assessments of Healthcare Providers and Systems) and HOS (Health Outcomes Survey).
- **Engaged and aligned provider network to deliver care that promotes healthy outcomes via value-based care and other innovative payment and relationship model.** Building relationships and engaging clinicians in quality improvement work that is physician-led, evidence-based, and data driven.

Objectives

- Design and maintain the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement.
- Meet the cultural and linguistic needs of the membership.
- Comply and coordinate with all governmental agency requirements.
- Support clinicians with participation in quality improvement initiatives of SHP and all governing regulatory agencies.
- Establish clinical and service indicators that reflect the demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and or periodic monitoring and evaluation.
- Measure the availability and accessibility to clinical care and services.

- Collaborate with stakeholders and partners to measure member satisfaction to identify and address areas of dissatisfaction in a timely manner through quarterly analysis of trended member compliant data, member satisfaction surveys, and member suggestions to improve care and services.
- Continue to review, adopt, and adapt practice guidelines reflective of the membership.
- Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improved performance and/or validate a problem or measure conformance to standards.
- Collaborate with stakeholders and partners to evaluate over and underutilization, continuity, and coordination of care through a variety of methods and frequencies based on member needs.
- Coordinate all QI activities with all other activities, including the identification and reporting of risk situations, the identification and reporting of adverse events from UM activities, and the identification and reporting of quality-of-care concerns through monitoring reports, and complaints and grievances.
- Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities may include identification of high-risk and/or chronically ill members, education of clinicians, and outreach programs to members.
- Create and maintain infrastructure to achieve accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting bodies as appropriate.

Evaluation of the QI Program

The QI Program is evaluated on an annual basis. Findings from the annual evaluation are used to make modifications to the QI Program and QI workplan, as necessary.

Scope of the QI Program

The QI Program provides for review and evaluation of all aspects of health care, encompassing both clinical care and services provided to members. All departments participate in the quality improvement process. The Chief Medical Officer integrates review and evaluation components to demonstrate the process is effective in improving health care. Measurement of clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process. The scope of the quality review will be reflective of the health care delivery systems, including quality of clinical care and services. All activities when instituted, will reflect the member population in terms of age groups, disease categories, special needs, risk status, including those members with complex needs.

The scope of services includes services provided in institutional settings, such as acute inpatient, outpatient, long term care, skilled nursing, ambulatory care, home care, and

behavioral health, and services provided by primary care, specialty care and other practitioners.

QI Program structure

Oversight of the QI Program is provided through a committee structure, which allows for the flow of information to and from the SHP and IHN-CCO boards of directors.

QI Program functional area and responsibility

The Quality and Population Health Department is responsible for implementing a multidisciplinary QI Program that effectively and systematically monitors and evaluates the quality and safety of clinical care and services rendered to members.

QI Program functions

- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services in primary care delivery sites.
- Ensure effectiveness of continuous quality improvement activities across the organization.
- Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes annual evaluation of the QI Program.
- Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- Conduct oversight of delegated providers in collaboration with the director of delegation and auditing.
- Ensure strong collaboration between QI and other SHP departments, such as Care Coordination, Pharmacy and Provider Services, as needed, to ensure the most effective action plan is being taken on various QI initiatives.

Quality and Population Health Department

The Quality and Population Health Department reports to the chief medical officer. Responsibilities of the department include:

- Provide staff support to the Quality Management Council, the Quality Improvement Committee, and the Quality-of-Care Review Committee.
- Develop initial drafts of QI Program documents for committee review and approval.
- Develop a workplan identifying the responsibilities of the operations that support the QI Program implementation.
- Review and evaluate the workplans and reports of committees and taskforces.
- Assist in the review and evaluation of delegate reports.
- Assist in the data collection for selected components of contractual reporting requirements for external review agencies.
- Assist and implement systematic data collection methodologies.

- Lead in the development of project design and methodologies for disease management and health promotion programs.
- Monitor the QI Program to assure compliance with regulatory and accrediting requirements.
- Lead the development of organizational policies related to Quality Improvement.

The QI Program is comprised of three core sections:

- **Clinical care and patient safety**
  Clinical care refers to all clinical care and services provided to members as well as the clinical programs to manage populations. In the context of clinical care, patient safety refers to the efforts of clinical providers to reduce or avoid preventable harm to the patient during treatment, as well as strategies to keep patient health risk as low as possible.
- **Quality and service improvement**
  The Quality and Service Improvement section includes quality improvement initiatives to improve care and services.
- **Quality governance and systems**
  The Quality Governance and Systems section includes committee structures, roles and responsibilities, quality information systems and quality data reporting, Health Equity, Delegation and Oversight, Program Audits, the QI workplan and confidentiality and security of information.

The QI Program provides the organizational objectives, structure, program components, processes, and quality improvement tools to carry out the quality management and population health goals for the membership. Regulatory requirements for the QI Program are reviewed annually to ensure compliance.

The QI Program is available to members and providers upon request.

Quality definition

At SHP healthcare quality is defined by the Institute of Medicine's six aims: care that is safe; effective; patient-centered; timely; efficient; and equitable.

Quality improvement focus areas

The QI Program includes the following:

- Accreditation and Standards:
  - Planning and implementation of policies, procedures, and requirements.
  - Quality assurance and monitoring to ensure adherence to standards.
  - Evaluation of adherence to NCQA standards.
  - Regulatory, accreditation, and external reporting.
  - Reportable events.

    - Ethics.
- Population insights:
    - Population Assessment
    - Data management systems, data collection plans, data validation, data display
    - Maintaining data security and confidentiality
    - Statistics for data description
    - Interpreting data to support decision making
    - Epidemiology theory and surveillance
    - Measures, metrics, and scorecards
- Continuous Quality Improvement
    - Establishing priorities
    - Developing action plans
    - Performance improvement methods, tools, and technical resources
    - Change management
    - Process improvement teams
    - Performance improvement plans
    - Project management, closure, and program handoff
    - Evaluation
- Patient Safety
    - Culture of Safety
    - High Reliability Organization, Just Culture, and Patient Safety Principles
    - Program Implementation
    - Developing corrective action plans
    - Technology and resources
    - Audits and evaluation
    - Risk management
    - Cultural Humility

Clinical care and patient safety

The Clinical Care and Patient Safety section of the QI Program encompasses all clinical care and programs, including population health management, health education and promotion, clinical practice guidelines, Behavioral Health Program, Care Management Program, Pharmacy Services, utilization management, Continuity and Coordination of Care, and Patient Safety.

Population health management

Population health management definition

Figure X. NCQA PHM Framework

The National Committee for Quality Assurance (NCQA) defines population health management (PHM) as:

"A model of care that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.".

The QI program utilizes NCQA's PHM framework (shown in **Figure X**.) to gain meaningful insights on members through data integration, population assessment, and targeted interventions that are stratified to improve population health outcomes, enhance member experience, and support our provider network**.** The framework includes:

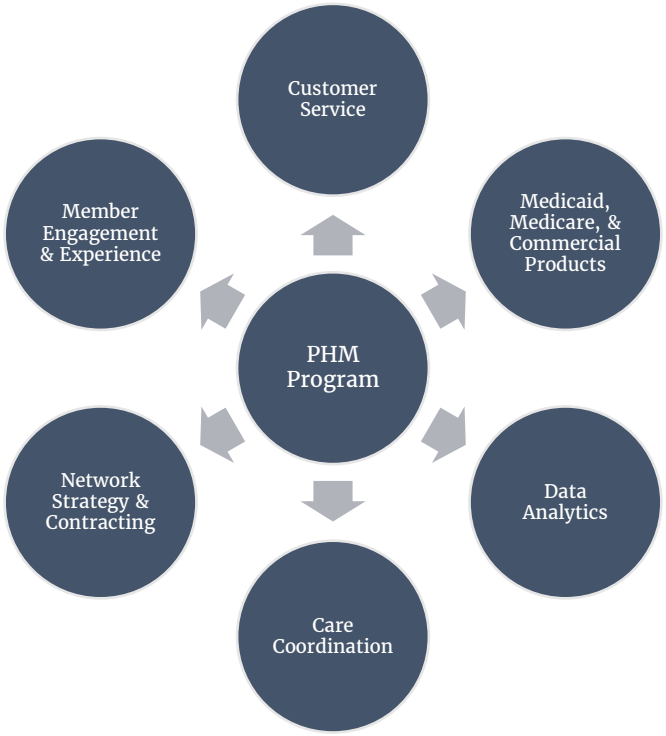
1. **Data Integration:** Combining data from several source – pharmacy, medical, behavioral, dental, laboratory, etc.
2. **Population Identification:** Using the integrated data to assess member needs and create interventionsthat are better informed and tailored to member needs.
3. **Stratification/Segmentation:** Sorts members based on similar traits, chronic conditions, and risk. Members receive targeted intervention or targeted resources based on stratification or segmentation.
4. **Community:** Community Based Oregonizations are serving our members in a variety of ways and have the social, economic, and environmental resrouces members need.
5. **Care Delivery System:** Providers and care teams are delivering the care essential to meeting the person-centered interventions established in steps one through three.
6. **Measurement:** Evaluate effectiveness of tailored interventions, members experience, and overall processes.

In 2023 the PHM program will expand its scope to build on the work being accomplished by the partners outlined in **Figure X.**

- **Customer Service and Member Engagement:** Partner with customer service and member engagement to meet members where they are and listen to their need. This will be accomplished by increasing insights on members, including quantitative and qualitative survey dissemination and program evaluation.

- **SHP Product Lines:** Collaborate with SHP product lines (Smartian Choice, Medicaid and Medicare, and Commercial) to support and translate clinical and medical data to the individual member needs, address assess internal and external barriers for engaging and improving member health outcomes, and aid in partnering with community-based organizations or understand and management members' Social Determinant of Health needs.
- **Data Analytics:** Data analytics teams are essential to PHM. The PHM team will partner with SHP data analytics to ensure quality data integration, population identification, and risk stratification and segmentation.
- **Care Coordination:** Care Coordination is directly connected to SHP members and can implement the tailored interventions established by PHM for the segmented and stratified populations.
- **Network Strategy and Contracting:** The provider network and community-based organizations directly impact SHP members. They provide the services to keep members health and improve their quality of life. The PHM program will partner with Network Strategy and Contracting to support providers with their value-based payment contracts, including data insights, program development and implementation, workforce support, and education and engagement.

Figure X. PHM partnerships outline



In 2022, the Quality and Population Health Department conducted a population assessment and, considering member characteristics, social factors, disease prevalence, and the unique regional environments, identified three priority areas: diabetes, hypertension, and high-risk pregnancy. The QI Program is not limited to these focus areas; however, they are prioritized to improve health care outcomes and while doing so, also reduce costs.

Population insights

The population assessment is key to both defining the population and measuring member health outcomes. The objective of the population assessment is to understand our population and population needs, and evaluate the care and services provided to our members. The SHP Population Insights Program includes a data management plan to ensure quality control of data collection and processes, data security, integrity of data and analysis and confidentiality of data. The PI Program is focused on the ongoing tracking of clinical quality and performance and developing actionable data to improve health outcomes. The PI Program initiatives and program activities allow SHP to determine the quality of care and identify areas for improvement.

SHP is contracted with the population health management platform Arcadia Analytics. With the addition of this information system SHP is able to aggregate disparate health data to drill down on the unique complexities of its membership and populations. The Arcadia platform will drive quality improvement and the SHP value-based care strategy by surfacing actionable opportunities to leverage comprehensive change through improved care coordination and further informed provider contracting and relationships.

Health education and promotion

SHP health education and promotion activities and materials are developed and maintained to ensure alignment with best practice, clinical guidelines, and contractual and regulatory requirements, and to ensure the program is tailored to specific age groups and population health needs.

Health education and promotional materials are developed through various means keeping the needs of the member population in mind. They are provided in English and Spanish as requested or required. Health education and promotional materials are often created in support of the various quality projects and initiatives. The quality team continues to develop, or contribute to member and provider newsletters, brochures and flyers, targeted letter and postcard mailings, virtual member events, member incentives, and provider CCO metrics trainings. The SHP health resources webpage is maintained and includes links to the SHS library and external resources to expand member access to health-related materials and education.

Evidence-based medicine and clinical practice guidelines

SHP evaluates practice guidelines, standards and policies for dental care, medical and behavioral health practice to ensure alignment with evidence-based practice, community standards and relevant law. The QMC reviews, adopts, and disseminates evidence-based clinical practice guidelines that encompass acute, chronic, and preventive care relevant to the SHP membership. Clinical practice guidelines are reviewed and updated at least every two years or as needed to reflect current standards and scientific knowledge. CPGs are available to community clinicians, network providers and members. To evaluate delivery of services in accordance with approved guidelines, annual performance measurements are analyzed using claims data, lab data, and electronic health record data.

Accreditation and Standards

SHP Quality and PHM programs, including the Special Needs Plan Model of Care, ensure compliance with NCQA accreditation and regulatory standards through "audit readiness" activities. Policies and procedures and reporting guidance are reviewed and updated no less than annually to maintain compliance with current regulatory requirements and address identified gaps in procedures. Performance of internal programs and external programs and services across the continuum of care and provider network are measured against CMS and OHA contract requirements, as well as federal and state regulations. Mock-audits with delegated entities are completed as a means of evaluating performance and compliance in accordance with applicable state and federal requirements and NCQA standards. Integrity of the patient safety program is monitored through the review of clinical practice guidelines, reportable events, and ethics.

Behavioral Health Program

Behavioral health services are provided by an extensive network of behavioral health providers and facilities. This includes inpatient psychiatric and substance abuse units as well as free-standing psychiatric and substance abuse facilities. Outpatient care is provided by psychologists, psychiatrists, psychiatric nurse practitioners, social workers, and licensed mental health counselors and traditional health workers (THW). Treatment is also provided in community mental health clinics and substance abuse programs. In addition to standard inpatient and outpatient behavioral health services, SHP has contracted with providers to develop both telephonic and mobile crisis intervention. All providers meet state requirements for licensure as well as SHP credentialing standards.

The Behavioral Health Director provides oversight of the Behavioral Health program and is involved in implementing and evaluating behavioral health services. SHP assesses population needs to identify gaps in community behavioral health services. By partnering with local behavioral health providers and developing innovative programs these gaps can be addressed.

The Director of Integrated Care Coordination oversees the triage and referral processes for behavioral health services, coordinated through qualified behavioral health care managers.

Referrals to intensive levels of care are facilitated through contracted community mental health crisis response teams and qualified licensed practitioners. The program oversees services such as Assertive Community Treatment (ACT), Wraparound, intensive care coordination, and care management for adults, youth, and children.

Care Management Program

Care management

The Care Management (CM) program offers support and assists members who are experiencing immediate and ongoing medical conditions or injuries that may require complex, high-intensity, long-term and/or a high utilization of health care services. Members may be identified for care management through referrals, diagnosis of specific conditions, risk stratification and/or quality improvement initiatives. The CM program uses data and analytics to assess member needs and develop strategies and approaches to engage members to achieve their health care goals. The objective of care management is to ensure appropriate, timely, effective, and continuous person-centered care that improves health outcomes and maintains the highest level of function. Care management includes working with hospitals, facilities, community partners and any member of the Interdisciplinary Care Team, to meet the individual member's care needs. Care management staff perform services in a trauma-informed manner, understanding the impact of trauma on an individual's ability to function, interact with others, and request and accept help.

Complex case management

Complex case management is a process designed for members with chronic and/or complex medical/behavioral health conditions to promote independence, optimal health, and continuity of care at the lowest cost appropriate to the member's needs. The CCM program is voluntary and is provided at no cost to the member. A member must give verbal and/or written consent for enrollment in this program. The program is most successful with participation of the member's family, caregivers and/or other support systems. The CCM program is a delegated service provided through Sagility and is available to any individual enrolled into IHN-CCO and Samaritan Advantage health plans, including the Special Needs Plan.

The following conditions are examples of conditions that are commonly identified for case management:

- Complex medical and behavioral and social health needs.
- Chronic condition management (Congestive Heart Failure, Diabetes, COPD, Asthma, Depression, CAD).
- IHN-CCO priority populations.
- High-risk pregnancy.
- Physical and/or behavioral trauma.

Maternity case management

SHP offers a case management program specifically tailored to the needs of a member identified as having a high-risk pregnancy. SHP case management and public health departments are working collaboratively to include data to identify high-risk pregnant members in the first trimester of pregnancy.

Intensive care coordination for members with complex and special health needs

Intensive care coordination is a process to coordinate multiple services and supports available to members who have complex medical, dental and/or behavioral health needs that may include multiple chronic conditions and/or severe and persistent behavioral health challenges. ICC facilitates communication between members, providers, and community partners through interdisciplinary care teams to address health disparities, assist in accessing appropriate preventive, remedial and supportive care, and services, and manage transitions and gaps in care to improve outcomes.

IHN-CCO currently serves more than 80,300 Medicaid managed care enrollees. While many of these members are healthy and require only access to primary care practitioners to obtain episodic and preventive health care, the Medicaid program also serves several population groups who have complex medical, behavioral, and long-term care needs that have poorer health outcomes and drive high-cost services, including inpatient and long-term institutional care. Navigating the current health care system can be difficult for these members. Encouraging the appropriate utilization of services, through ICC and service integration, is essential for controlling future health care costs and improving health outcomes for this population.

Continuity and coordination of care

Delegation oversight activities

SHP may delegate call center, claims, credentialing, case management, disease management, pharmacy benefit administration, and utilization management activities to entities and provider groups that meet delegation requirements. SHP conducts delegation assessments to determine compliance with regulatory and accrediting requirements. The health plan monitors ongoing compliance with review of policies and procedures, monthly reports, and annual assessments.

SHP maintains a Delegation Oversight Committee, a sub-committee of the Internal Compliance Committee, that meets monthly to review pre-delegation and ongoing monitoring activities.

Dental Plan Partners

IHN-CCO ensures members have access to comprehensive dental services and oral health care by delegating the adjudication of these benefits to four dental plan partners. The dental partners include Advantage Dental, Capitol Dental Care, ODS Community Dental, and Willamette Dental Group. The dental plans subcontract and employ dental providers to

establish a delivery system network that can determine medically necessary dental needs and provide comprehensive oral health care. IHN-CCO ensures member care is comprehensive and coordinated through the interdisciplinary care team process and delegates dental care coordination to dental subject matter experts within each partnered dental plan.

Dental plans also ensure members are provided oral health covered services within the scope of the member's benefit package of dental coverage. This is done through an auto-adjudication process with claims to ensure equitable and appropriate treatment of membership related to access to benefits. In addition, members may request coverage of non-covered dental treatment and it will receive a multi-layer review of multiple qualified dentists prior to a decision of extra coverage.

Dental plans maintain a Quality Assurance and Quality Improvement Program in addition to the IHN-CCO executed oversight audit to ensure compliance with regulatory guidelines and contractual obligations. Elements of oversight include:

- Clinical practice guidelines (bi-annually).
- Grievance analysis (annually).
- Delivery system network monitoring (quarterly).
- Provider directory review (quarterly).
- Workflow of provider directory maintenance.
- Timely access monitoring (monthly).
- Dental access review based on member urgency (annually).
- Ease of referrals for long term specialty care (annually).
- Prior authorization review and Inter-Rater Reliability process review (annually).
- Chart review for special health care needs membership (annually).
- Business continuity and disaster recovery (annually).
- Benefit adjudication process (annually).
- Utilization management (annually).
- Electronic health record provider education and tracking (annually).
- Health information and data integration (annually).
- OIG (Office of the Inspector General) exclusion review (annually).
- Encounter validation (quarterly).
- Miscellaneous policy and workflow review after implementation of a new process (ex. transition of care) (ad hoc).

In addition, IHN-CCO leads the effort to integrate a Caries risk assessment internal to the Samaritan Health Services hospital system. Referrals are then generated on an individual basis determined by the level of risk a patient has related to developing cavities. Dental partners and SHP are working together to develop a referral pathway through the Unite Us platform.

Long-term services and supports

IHN-CCO maintains a care coordination agreement with Oregon Cascades West Council of Governments Senior and Disability Services for members who require long-term services and supports. To improve person-centered care, SHP maintains a memorandum of understanding with both Oregon Cascades West Council and Senior and Disability Services. This MOU includes:

- Individualized care teams.
- Transitional care practices.
- Member engagement.

The purpose of the agreement is to clarify roles and responsibilities of each entity to ensure coordination between the two systems to provide quality care, and to produce the best health and functional outcomes for individuals to prevent escalation or duplication of services. The objective is to improve person-centered care, align care and service delivery and provide the right care at the right time in the right place for members who require long-term services and supports.

Non-emergent medical transport

IHN-CCO ensures members have access to safe, reliable, timely and appropriate non-emergent medical transportation to and from covered appointments. NEMT services are contracted as participating providers and have been delegated to Oregon Cascade West Council of Governments through their Ride Line program. NEMT services are accessed through a toll-free call center and available to members 24 hours a day, 365 days per year. The NEMT services are covered at no cost to the member. NEMT transportation providers must comply with local, state, and federal safety standards and ensure appropriate qualifications and training for drivers.

IHN-CCO conducts an annual oversight audit for this delegated partner to ensure quality assurance of these benefits and services. The following elements are reviewed:

- Approved rides universe (annually).
- Encounter validation (quarterly).
- Denied rides universe (annually).
- Quarterly NEMT report (quarterly – OHA template).
- Driver level review (annually).
- Vehicle level review (annually).
- Grievance analysis (annually).
- Call center review (annually and quarterly).
- Policy and procedure review (bi-annually).
- Business continuity and disaster recovery (annually).
- Accidents and incidents (ad hoc and annually).

In addition, Ride Line hosts a Transportation Brokerage Advisory Committee. During these meetings agenda topics include operational improvements, provider trending barriers to provide safe and appropriate care to members, as well as member level grievance trends.

Special Needs Plan Model of Care

The Special Needs Plan Model of Care (MOC) provides a framework for quality improvement and methods to ensure the unique needs of members enrolled in our Special Needs Plan are identified and addressed. The Centers for Medicare and Medicaid Services (CMS) sets guidelines for Medicare Advantage plans' MOC and requires approval by the National Committee for Quality Assurance (NCQA). SHP is also required to have a contract with the Oregon Health Authority (OHA) to operate a Medicare Advantage Dual Special Needs Plan (D-SNP) for members dually eligible for Medicare and Medicaid. The goal is to ensure coordination of care and payment to effectively support the special health care needs of this vulnerable population.

Patient safety

Patient safety is a health priority and health care discipline that has emerged in response to the rise of patient harm in health care facilities. Marked by an emphasis on continuous improvement, patient safety is focused on preventing errors and harm and reducing risks associated with the provision of care. Safe and high-quality care are fundamental to achieving the Quadruple Aim of Healthcare (optimizing health and wellbeing with a focus on safety, increasing affordability, engaging care teams and partners, and enhancing the care experience). Through our Member Safety Program once established, SHP aims to create a more collaborative and secure healthcare system for our communities. Toward this objective, SHP is promoting High Reliability Organization (HRO) methodology as an essential component in improving patient safety and quality of care.

High Reliability Organization

The foundation of safety is high reliability and zero-harm is our overarching goal. SHS has engaged Press Ganey to implement Health Care Performance Improvement (HPI) training and methodologies to transform our organization into an HRO. There are five high-reliability principles that enable HROs to achieve and maintain safety.

- **Sensitivity to operations** – large threats typically appear as slight changes in the organization's operations and reporting any deviation from expected performance.
- **Reluctance to simplify** – acceptance that healthcare is complex with potential to fail in new and unexpected ways.
- **Preoccupation with failure** – never satisfied.
- **Deference to expertise** – HROs have mechanisms in place to identify the individuals with the greatest expertise relevant to managing the new situation or place decision-making authority with the individual or group with the greatest expertise.

- **Commitment to resilience** – despite best efforts and past success, errors will occur, but those errors do not disable the system by becoming larger problems.

Adopting a zero-harm goal is commitment to developing a new high-reliability culture in which our improvement efforts are focused squarely on eliminating harm, injury and failure.

Safety culture

The overarching goal of our patient safety program is to create a culture of safety and high reliability within the care delivery system. The Agency for Healthcare Research and Quality defines the safety culture of an organization as the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, and organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. In creating a culture of safety, we are concerned with provider and care team burnout and multiple dimensions of safety.

With a focus on safety culture, we are convening stakeholders to apply high-reliability science to healthcare and develop strategies to improve care coordination and member experience across the continuum of care.

The following oversight initiatives help assure SHP members receive safe, high-quality on a continuous basis. Health care safety is assessed using readily available administrative data i.e., survey and claims, grievance data, and medical record data.

Preventable/Never Events

Preventable/Never Events include both Hospital-Acquired Conditions and Serious Reportable Events as defined by CMS. Hospital-acquired conditions originate in any inpatient hospital setting and are identified as: (a) excessive cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group that has a higher payment when present as a secondary diagnosis, and (c) could have been prevented through the application of evidence-based guidelines. Serious reportable events are errors in medical care which are clearly identifiable, preventable, serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.

Preventable/Never Events are grouped into seven categories:

- Care management events.
- Criminal events.
- Environmental events.
- Patient protection events.
- Product or device events.
- Radiological events.
- Surgical or procedural events.

Preventable and Never Events are evaluated according to SHP policy.

Quality of care concerns

SHP has established a Clinical Quality of Care Concern committee to address potential quality of care concerns. Cases may be referrals from providers or identified through health plan processes such as claims, utilization review, complaints, and grievances.

Examples may include:

- Treatment in an emergency department within seven days of discharge of an inpatient facility for the same diagnosis.
- Readmission to the hospital within seven days of discharge.
- Post-surgical infections.
- ED treatment or inpatient admission for hypertensive crisis/malignant hypertension.
- Inappropriate Level of Care determinations.
- Member safety such as abuse, neglect, or exploitation.

Clinical reviewers evaluate trends and individual cases for quality-of-care concerns. When a clinical quality of care concern is confirmed, a corrective action plan is developed and implemented with stakeholders. SHP may also refer cases to the Credentialing Committee for peer review.

Drug utilization review

The standard prospective and concurrent drug utilization review programs are delegated to the designated pharmacy benefit manager, OptumRx, utilizing the standards, criteria, protocols, and procedures established by agreement of the SHP Pharmacy Department and Optum, in accordance with applicable state and federal requirements and NCQA standards. The DUR program also functions to identify opportunities to improve the quality of care for members by evaluating patient adherence to prescribed therapy and improvements in the medication regimen as appropriate for the patient's diagnoses or conditions. The results of retrospective review may also be used to initiate additional claims review and analysis. Follow-up studies may be performed to assess the impact and outcomes of DUR program interventions. The SHP Pharmacy Department uses information identified through the DUR program to develop education and outreach to pharmacies, prescribers, and members. The DUR program is submitted for review and approval to the Pharmacy and Therapeutics Committee annually.

Medication Therapy Management

The Medication Therapy Management program offers a comprehensive approach to improve medication use and reduce the risk of adverse events and improve medication adherence. The program follows Medicare Part D requirements. The MTM program aims to identify an additional group of at-risk Medicare beneficiaries following the CMS' requirements, taking a multidisciplinary approach to MTM, coordinating engagement with beneficiaries with

outreach and interventions by case management as appropriate. Pharmacists working under SHP's MTM vendor collaborate with our primary care providers to promote MTM services to our members. The goal of the MTM program is to improve the safety and effectiveness of pharmacotherapy for members, leading to improved medical outcomes and efficiencies. Improvement will be achieved through pharmacist or pharmacist-directed interventions with members, physicians, or provider pharmacies regarding the pharmacy co-therapeutic management of chronic conditions. A comprehensive medication review is offered at least annually to all targeted members enrolled in the plan's MTM program.

Utilization Management

Utilization Management is integrated within the Care Coordination Care Management program. The chief medical officer and the medical director oversee the program operations. Utilization review is conducted according to department policies, procedures, and clinical criteria. Medical necessity is determined, and the decision period and notifications must adhere to policies and plan documents. Prospective, concurrent, and retrospective reviews are performed to provide a basis for decision-making. UM decisions are made by qualified, licensed healthcare professionals who have the knowledge and skills to assess clinical information and to evaluate working diagnoses and proposed treatment plans. Care Coordination is supported by board certified UM physician reviewers and behavioral health physicians and doctoral-level practitioners who hold a current license to practice without restrictions. These licensed physicians oversee UM decisions to ensure consistent and appropriate medical-necessity determinations. Inter-rater reliability reviews are conducted to ensure consistent application of the utilization criteria.

Monitoring for over-utilization and under-utilization occurs through utilization and case management reports. Additional monitoring comes from clinical performance measures, including HEDIS which captures race, age, sex, and socioeconomic status (income, disability and combinations). Along with these sources, new reports are in development that will aggregate household language and apply it to other reports to approximate a linguistic and ethnic view into utilization patterns. This may indicate inequitable needs to be addressed in the resultant sub-populations. All sources of member satisfaction surveys, complaints, appeals, and grievances are reviewed to identify potential areas of concern. Practitioner medical, pharmacy and utilization profiles are also reviewed.

Transitions of care

The SHP Care Management team ensures member care is coordinated and continuous for members who are experiencing a transition of care from one setting to another or between health care practitioners or episode of care through established care management processes. SHP care managers convene and participate in Interdisciplinary Care Team meetings and develop individualized care plans which are shared with the member. This ensures care plans are adapted to members' needs and understood by all using the teach back method. SHP care managers coordinate with providers and community agency partners to manage care between settings including hospitals, and Oregon State Hospital, acute care nursing and

rehabilitative facilities, hospice, home health and home. Care coordination practices integrated cross-system education, timely information sharing, and coordination to avoid duplication of effort and to ensure effective deployment of integrated interdisciplinary nursing, behavioral and psycho-social resources.

IHN-CCO provides seamless continuity of care and services during a member's transition between CCO's or fee-for-service Medicaid. IHN-CCO provides integrated care coordination to ensure members have continued access to care for members identified as within the prioritized population or who have special needs. Whether members are newly enrolled in IHN-CCO or transferring to another CCO, IHN-CCO works collaboratively with other CCO's providers, and social agencies to ensure a successful transition. Member centered elements of transition of care activities are monitored to verify regulatory compliance and identify any areas of concern where corrective action may be needed.

Quality and Service Improvement

SHP Quality and Service Improvement initiatives are identified through QI Program activities. QI projects are selected and designed to achieve quadruple aim goals and leverage QI tools and resources to achieve the best outcomes to benefit the member population. SHP fosters a robust QI Program focused on transforming the delivery system and driving value-based care.

Quality Improvement projects

Quality Improvement methodologies such as Lean Six Sigma, Root Cause Analysis and Plan, Do, Study, Act cycle are used to improve processes. QI process methodologies are structured to identify and analyze significant opportunities for improvement in care and service. The development of improvement strategies and systematic tracking determine whether these strategies result in progress toward established benchmarks or goals. Focused QI activities are carried out on an ongoing basis to promote efforts to identify and correct quality of care issues.

Chronic Care Improvement Program

The Chronic Care Improvement Program for Samaritan Advantage Health Plans members ensures members with chronic conditions are effectively managed. CCIPs run for a minimum of three years. The current SAHP CCIP focuses on the implementation of a Hypertension Control Program for members identified as having a diagnosis of hypertension. The Special Needs Plan CCIP focuses on improving the treatment engagement rate for members identified with a substance use disorder.

Each CCIP is made up of two components:

- **The plan section** describes the criteria for the CCIP, including the methodology used for identifying participants, mechanisms for monitoring participants, and performance assessments.
- **The annual update** describes the Medicare Advantage Organization's progress in implementing the CCIP, including systematic and ongoing follow-up. The MAO must also report status and updates to CMS as requested.

IHN-CCO Performance Improvement Projects

SHP conducts Performance Improvement Projects to examine and improve care and health outcomes in areas identified for improvement. This is in accordance with the OHA 1115 demonstration waiver, the CCO contract and federal requirements. SHP has four PIPs, including two statewide PIPs for which all CCO's in Oregon are required to address the same topic or problem. Topics and interventions for the remaining PIPs are chosen from eight focus areas outlined in the CCO contract and determined by SHP, relevant to IHN-CCO's unique population and member needs. In support of our PHM strategy, SHP's four PIPs include:

- Addressing high-risk pregnancies to reduce pre-term births.
- Improving comprehensive care for members with diabetes and co-occurring substance use disorder and serious mental illness.
- Mental health service access monitoring (statewide PIP).
- Initiation, engagement and treatment of alcohol and other drugs use disorders (Statewide PIP).

PIPs typically run for three years and are subject to change based on the current Quality and PHM strategy and feedback from OHA. IHN-CCO reports PIP progress to OHA on a quarterly basis.

Transformation and Quality Strategy

The Transformation and Quality Strategy is an OHA initiative required for CCOs. The objective is to move health transformation forward to meet the triple aim of better health, better care, and lower costs. The programs and projects included within the TQS aim to make significant movement in health system transformation and to coordinate internal CCO transformation and quality initiatives. IHN-CCO conducts an annual evaluation of progress toward goals for each section of the TQS. This evaluation informs the updates to the TQS program, which are made during October through January under the guidance of the TQS Taskforce.

The TQS is comprised of three sections:

- **Section 1: Transformation and Quality Program details** is a comprehensive overview of initiatives that IHN-CCO undertakes to meet OHA's 13 prioritized components.
    - Behavioral health integration — development and implementation of an equitable, integrated, person-centered behavioral health system that seamlessly and holistically integrates physical, behavioral and oral health and

supports all integration models from communication to coordination to co-management to co-location to the fully integrated patient-centered primary care home and behavioral health home.

- CLAS (Culturally and Linguistically Appropriate Services) standards — implementing activities to support the National Culturally and Linguistically Appropriate Services standards. The National CLAS standards establish a blueprint (CLAS Standards Blueprint) and provides specific recommendations for addressing inequities at every point where the member has contact with the health care system.
- Grievance and appeal system — assessment and analysis of the quality of the grievance and appeal system (inclusive of complaints, notice of actions, appeals and hearings), including aggregate data to indicate IHN-CCO's quality improvement activities.
- Health equity: data — adopt processes that allow stratification of quality data by patient race, ethnicity, and language in every area of the organization as a tool for providing culturally and linguistically appropriate services to advance health equity and for uncovering and responding to health care disparities.
- Health equity: cultural responsiveness — IHN-CCO ensures members receive effective, understandable and respectful care from all CCO staff and the provider network. IHN-CCO ensures that health and health care services (including physical health, behavioral health, substance use disorder and oral health services) are provided in a manner compatible with members' cultural health beliefs, practices, preferred language, and communication needs.
- Oral health integration — development and implementation of an equitable health care delivery model that seamlessly and holistically integrates physical, behavioral, and oral health.
- PCPCH: member enrollment — IHN-CCO ensures that a significant percentage of members are enrolled in PCPCHs recognized as Tier 1 or higher according to Oregon's PCPCH recognition standards.
- PCPCH: tier advancement — a comprehensive plan to support PCPCH practices in upward tier recognition that include targets and benchmarks supporting PCPCHs to advance from Tier 1 toward Tier 5 (5 Star) in Oregon's PCPCH recognition standards.
- Serious and persistent mental illness (SPMI) — demonstrate improvement in an area of poor performance in care coordination for members with SPMI, even if this population overlaps with other designations such as civil commitment, aid and assist and the psychiatric security review board.
- Social determinants of health and equity (SDOH-E) - development and implementation of initiatives to address the community-level social, economic, and environmental conditions that impact health, or the social determinants of health.

  - Special health care needs (SHCN): full benefit dual eligible population — identify the target population and align the rationale, improvement objectives and monitoring activities to demonstrate how IHN-CCO expects members with special health care needs will benefit and see improvement from the project.
  - SHCN: non-duals Medicaid population — identify the target population and align the rationale, improvement objectives and monitoring activities to demonstrate how IHN-CCO expects members with special health care needs will benefit and see improvement from the project.
  - Utilization review — reviewing, evaluating, and ensuring appropriate use of medical resources and services encompassing quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services. Utilization review must be aligned with the Medicaid Efficiency and Performance Program (MEPP).
- **Section 2: Discontinued Project(s) closeout** informs OHA of any previous TQS initiatives that are no longer being pursued by IHN-CCO, what the outcomes of the projects are, and the reason(s) that IHN-CCO is discontinuing the projects.
- **Section 3: Required Quality Program attachments** informs OHA how IHN-CCO meets the Quality management and structure following state regulatory requirements:

The development and management of IHN-CCO's TQS program is overseen by the TQS Taskforce, who then reports progress and findings up to the Quality Improvement Committee. The QIC reviews and approves TQS documentation, as developed by the Taskforce, prior to the TQS submission to the Oregon Health Authority for scoring and feedback.

IHN-CCO's 2022 TQS Program efforts include:

Project Name	Component
Equitable Access to Traditional Health Workers	Health Equity: Cultural Responsiveness; Social Determinants of Health & Equity
Expanded Dental Health Delivery Model	Oral Health Integration
Grievances and Appeals	Grievance and Appeal System
Improving Access to Social and Emotional Health Services	Access: Quality and Adequacy of Services
Improving Meaningful Access to Interpreter Services	Access: Cultural Considerations; CLAS Standards; Health Equity: Data
Pathfinder Clubhouse	Serious and Persistent Mental Illness (SPMI)
Medicaid Efficiency and Performance Program	Utilization Review
Mental Health Home Clinic	Behavioral Health Integration

Project Name	Component
PCPCH: Clinic Collaboration	PCPCH: Member Enrollment
PCPCH: VBP & Consultant	PCPCH: Tier Advancement
Pharmacy Care Coordination for High-risk Members	Serious and Persistent Mental Illness (SPMI); SHCN: Non-Duals Medicaid Population
Timely Hospital Follow-up for D-SNP	Access: Timely; SHCN: Full benefit dual eligible (FBDE) population

Service improvement projects

Appeals and grievances

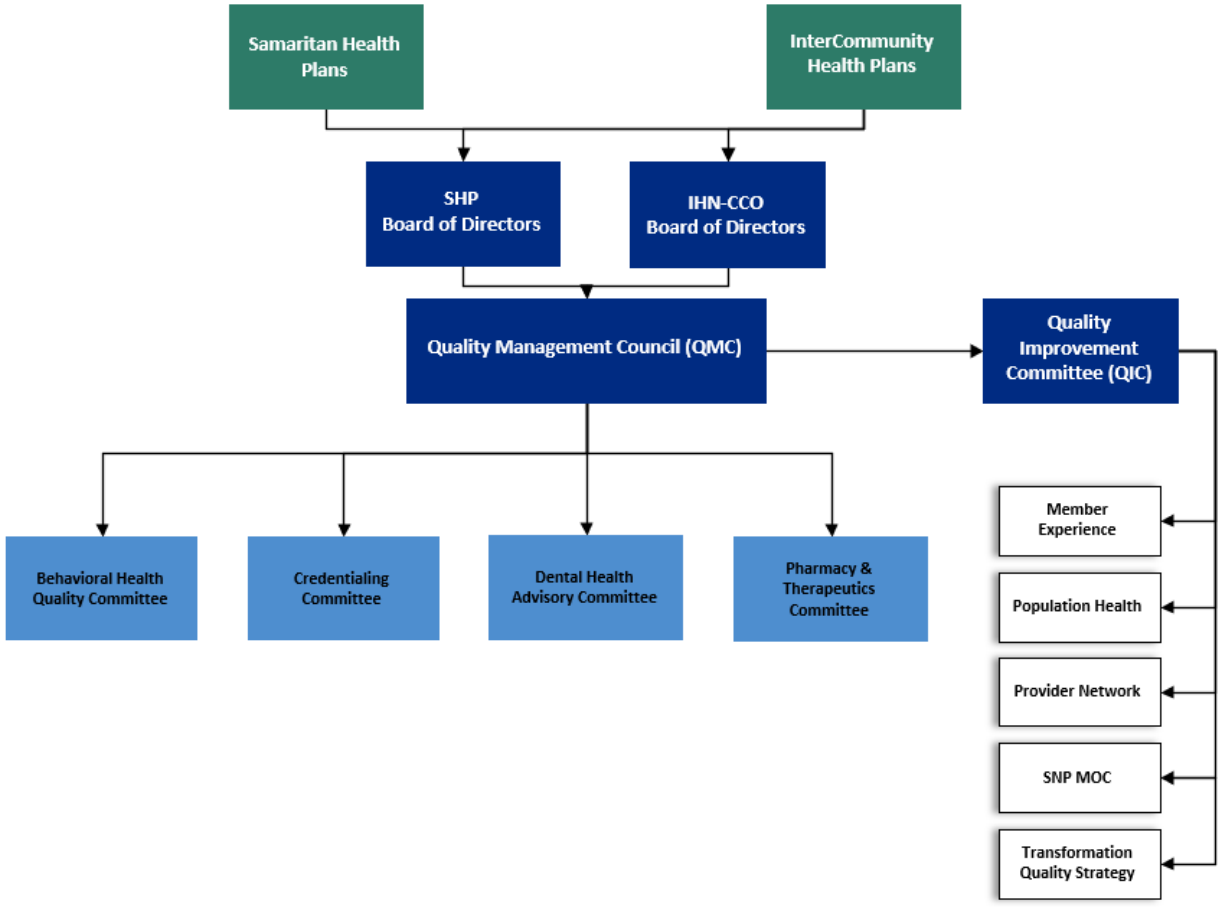
SHP continuously evaluates complaints, appeals and grievances to determine trends and improvement initiatives. Multi-disciplinary teams are engaged to address identified areas for process improvement. In 2021 the SHP Strategy Division implemented a workgroup solely dedicated to reviewing and analyzing complaints and grievances specific to IHN-CCO. The QIC reviews, analyzes, and monitors complaints, appeals and grievances quarterly.

Quality governance and systems

The Quality governance and systems section includes committee structures, roles and responsibilities, quality information systems and quality data reporting, health equity, delegation and oversight, program audits, the QI workplan and confidentiality and security of information.

Committee structure: roles and responsibilities

Samaritan Health Plans' board of directors, as governing body, maintains overall accountability of the QI Program.



Board of directors

Samaritan Health Plans' board of directors oversees all Advantage and Commercial health plans. IHN-CCO BOD oversees InterCommunity Health Network. These governing bodies maintain overall accountability and responsibility of the QI Program. The BOD communicates any recommendations to the chief medical officer.

Quality Management Council

The SHP boards have designated the Quality Management Council as the entity responsible for the oversight and management of all quality and performance improvement activities. The QMC serves as the clinical advisory panel for IHN-CCO. The QMC is chaired by the chief medical officer and is comprised of community partners and network clinicians representing primary care, behavioral health, oral health, and specialties. SHP functional area directors and health plan staff participate as required. QMC meets every other month.

Responsibilities of the QMC include:

- Endorse and support strategies to optimize member safety, health, and well-being, enhancing the care experience, engaging care teams and partners, and improving the affordability of health care.

- Inform direction for quality improvement activities and sharing between entities of Benton, Lincoln and Linn counties.
- Oversee quality efforts and activities performed by reporting committees, including effectiveness of corrective action plan recommendations.
- Guide health plan clinical quality and service performance through monitoring of IHN-CCO metrics, Medicare Stars, HEDIS, HOS and CAHPS measures.
- Review summary reports of identified over and underutilization of services, gaps in care, and mitigation of health equity issues.
- Inform and adopt utilization management criteria and clinical practice guidelines.
- Coordinate and disseminate best practices and policies, clinical practice guidelines and UM guidelines.
- Review and approve the annual QI Program and Program Evaluation, and Special Needs Plan Model of Care (SNP MOC) Annual Evaluation.

Quality Improvement Committee

The Quality Improvement Committee is chaired by the chief medical officer. QIC includes cross-functional areas, leadership and staff. The committee is responsible for leading and overseeing the quality and service improvement activities for the organization. The goals of this committee are focused on improving member health outcomes, improving member and clinician experience, and reducing health care costs. QIC activities are to monitor, evaluate and analyze data to identify gaps and develop interventions as indicated on our annual QI workplan.

Responsibilities of the QIC include:

- Design and maintain the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention and re-measurement.
- Support clinicians with participation in quality improvement initiatives of SHP and all governing regulatory agencies.
- Analyze and evaluate the results of Quality Improvement activities and reporting — including: CCO metrics, CAHPS, CMS Stars, HEDIS, HOS and quality measures used for the value-based payment program.
- Establish clinical and service indicators that reflect the demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and or periodic monitoring and evaluation.
- Oversee member satisfaction to identify and address areas of dissatisfaction in a timely manner through quarterly analysis of trended member grievances and appeals data, member satisfaction surveys, and member suggestions to improve care and services.
- Oversee quality and population health initiatives for member population using demographic data.

- Oversee delegated activities by establishing standards, monitoring performance, and evaluating performance, including effectiveness of corrective action plan recommendations.
- Review and evaluate utilization data to identify over and underutilization, gaps in service delivery and mitigate health equity issues.
- Oversight of QIC taskforces and workgroups
- Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance.
- Create and maintain infrastructure to achieve accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting bodies as appropriate.
- Oversee and approve the Transformation and Quality Strategy to align transformation and quality work.
- Oversees recommendations and revisions to policies for effective operation of the QI Program and achievement of QI Program objectives.

Taskforces

- **Member Experience:** Assesses data, develops solutions and implements interventions to improve member communications and overall experience; and identifies opportunities for benefit optimization. Acting as the voice of the member to the QIC, the taskforce is vital to driving the organization's pursuit of quality and service excellence.
- **Provider Network:** Drives change in the provider network by addressing network adequacy and member needs. This taskforce places a focused effort on alleviating the burden of administrative tasks placed on the providers, improving provider satisfaction, and further developing and improving network relationships.
- **Special Needs Model of Care (SNP MOC):** Guides the organization in the development, coordination, and implementation of the SNP MOC program, continually informing and collaborating with the Quality Improvement Committee. This collaboration of cross-departmental efforts will ensure our most vulnerable members have the best possible coordination of care and health outcomes.
- **Population Health:** Guide the organization on metric and measure status. Prioritizes, develops and implements plans focused on improving measure outcomes and achieving organizational goals.
- **Transformation and Quality Strategy:** Oversees, monitors and executes the IHN-CCO Transformation and Quality Strategy program and subsequent projects to ensure alignment with organization priorities and transformation strategy as required through the OHA CCO 2.0 Healthcare Services Contract.

Behavioral Health Quality Committee

The Behavioral Health Quality Committee includes behavioral health providers, community partners and health plan leadership and staff. The committee meets quarterly. BHQC

oversees planning for and evaluation of the behavioral health needs of members, the behavioral health delivery system, capacity, and treatment programs for substance use disorder, and mental health. The BHQC evaluates care coordination, integration with larger care delivery system, and the utilization and quality outcomes of behavioral health services provided to members. BHQC promotes coordination of care and resources with community partners and jurisdictional stakeholders.

Credentialing Committee

Samaritan Health Services (SHS) credentialing committee is comprised of the Samaritan Health Plans chief medical officer, participating physicians and other health care professionals. The committee meets monthly via Teams meeting, face-to-face or via phone conferences. The credentialing committee reviews credentialing applications and either approves, denies or terminates participation of physicians, clinicians, adjunct, and organizational providers. The Credentialing Committee is responsible for assuring network providers meet SHS's requirements for initial credentialing and recredentialing. The committee is responsible for developing the credentialing criteria, quality review and ensures all physicians and providers' qualifications meet the criteria. The credentialing services policies and procedures are reviewed at least annually.

Dental Health Advisory Committee

The Dental Health Advisory Committee is chaired by a dentist elected from the dental partner community. The DHAC provides oversight and monitoring of dental plan activities. The DHAC evaluates the integration of IHN-CCO members' dental health services with physical and mental health services in Benton, Lincoln and Linn counties, to advance the improvement of member experience and health outcomes. The DHAC maintains an understanding of dental health metric requirements, identifies elevated risk barriers for access, evaluates utilization data to identify gaps in service, and creates strategies to ensure an achievable dental health outcome. The committee disseminates best practices and ensures collaboration and sharing between entities of Benton, Lincoln and Linn counties. DHAC's membership is comprised of contracted ad hoc subject matter experts, IHN-CCO staff, and Dental Care Organization staff. DHAC will resume meeting quarterly in 2023.

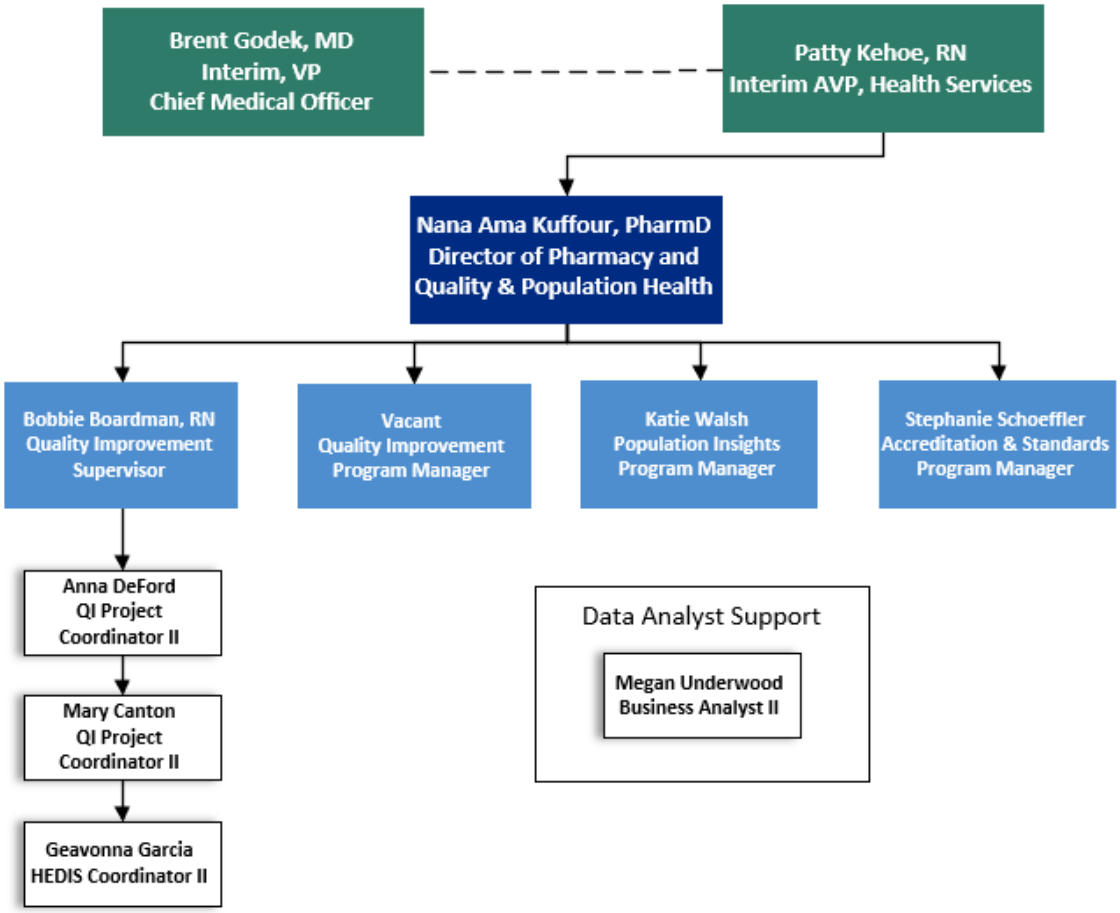
Pharmacy and Therapeutics Committee

The role and function of the Pharmacy and Therapeutics committee is to ensure that the most clinically appropriate and cost-effective drugs are available for members. The committee recommends the adoption of policies regarding evaluation, selection, and therapeutic use of drugs; recommends or assists in the formulation of programs to meet the pharmaceutical needs of practitioners and recommends and maintains the plan's formularies in accordance with pharmacy policies and procedures.

The P&T committee is composed of network physicians, pharmacists, and other health care professionals and staff who represent a cross-section of primary care and specialties. Membership includes at least one practicing physician and one practicing pharmacist who

are experts in the care of the elderly or disabled persons. At least one practicing physician and pharmacist will be free of conflicts of interest with respect to SHP. The P&T committee meets at least quarterly to review and vote on SHP Drug Review Board's formulary recommendations.

Quality personnel and organizational chart



Quality and Information Systems

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance. It is one of the most widely used sets of health care performance measures in the United States, which allows SHP to benchmark and compare performance with similar health plans across the nation.

HEDIS measures focus on:

- Prevention, screenings, and medication use.

- Care provided for numerous conditions across all body systems.
- Members' access to various health care services.
- Overuse or receipt of inappropriate care.
- Health care utilization for services and procedures in different care settings.

HEDIS reporting is required for SHP's Samaritan Advantage and Special Needs Plan lines of business. Measures are calculated by NCQA certified software using data from claims, supplemental data collected from electronic health records and/or manual chart review. Reported HEDIS results are also audited annually by certified auditors using a rigorous process designed by NCQA including an onsite visit focused on information and reporting systems. HEDIS measure results are a key component in the Medicare Star ratings and are used to target specific opportunities for improvement.

In 2023, SHP seeks to strengthen HEDIS performance and operations by:

- Reinforcing the importance of preventive screenings, and chronic disease care through various member communications.
- Identification and outreach to members with care gaps.
- Investigating additional supplemental data sources to enhance reporting including year-round chart review activities.
- Analyzing rates and recommending measures for value-based payment programs.

Oregon Health Authority CCO metrics

OHA uses outcome and quality measures to demonstrate performance among Coordinated Care Organizations (CCOs) to improve the quality of care, eliminate health disparities and reduce costs. Measures fall into one of two categories: CCO incentive measures, for which CCO's are eligible to receive payments based on their performance each year; and state quality measures, which OHA has agreed to report to CMS as part of Oregon's 1115 Medicaid waiver. IHN-CCO maintains a dashboard of performance metrics to evaluate performance and engages network providers in quality improvement initiatives to improve performance.

Medicare Stars program

The Medicare Part C & D Star ratings were developed by CMS to help beneficiaries compare health plans and providers based on quality and performance and to reward top-performing health plans. Star ratings include quality measures designed to evaluate success in providing preventive services, managing chronic illness, access to care, HEDIS measures, the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey and responsiveness. Both medical (Part C) and pharmacy (Part D) measures are included in the Star rating. Health plans are assigned a Star rate for each measure (one through five with five being the highest) as well as an overall summary Star rating.

SHP's goal for SAHP is to continue to improve performance across SHP and the provider network and advance to a 5 Star rating. Select Star measures are included each year in provider value-based payments.

Consumer Assessment of Healthcare Providers and Systems

The CAHPS Health Plan survey is a tool for collecting standardized information on members' experiences that cannot be assessed by other means.

The CAHPS survey gives members the chance to review SHP and their providers as well as rate the quality of care they have received and includes questions from the following domains:

- Your healthcare in the last 6 months.
- Your personal doctor.
- Getting health care from specialists.
- Your health plan.
- Your prescription drug plan.
- About you.

The survey is conducted every year and SHP uses the survey results to identify opportunities to improve the overall member experience.

CAHPS survey results are analyzed and reported to the Medicare Stars Program Performance Committee, QMC and QIC annually.

CAHPS IHN-CCO (Medicaid)

The CAHPS survey is conducted in the spring of each year (for the previous reporting year). A mixed mail and telephone survey administration methodology is used. OHA conducts this survey for the Medicaid adult and child populations on SHP's behalf.

CAHPS SAHP (Medicare)

Symphony Performance Health (SPH) Analytics, an NCQA certified survey vendor, conducts the annual CAHPS survey for our adult Medicare members. A mixed mail and telephone survey administration methodology is used. The results of this survey are a key part of the Medicare Stars rating.

Health Outcomes Survey

The Health Outcomes Survey, also called HOS measures the physical and mental well-being of Medicare members over time. It is administered annually to a random sample of SAHP members who receive the survey again at the end of a two-year period. The two survey results are compared to determine if the care received is keeping the member as healthy as possible.

The HOS is comprised of several components including questions:

- To evaluate the members' physical and mental health.
- To address important problems associated with poor physical and mental functioning such as urinary incontinence, lack of physical activity and fall risk.

- Related to chronic conditions, activities of daily living and sociodemographic information.

HOS results from questions related to bladder control, physical activity and fall risk are used in the health plans Medicare Star rating.

Medicaid Efficiency and Performance Program

CCOs are required to participate in the OHA Medicaid Efficiency and Performance Program (MEPP), which is administered through the OHA Actuarial department to focus upstream on initiatives to improve quality and reduce the overall cost of care. The OHA Actuarial department introduced Prometheus Analytics, a tool provided by Optumas to analyze episodes of medical care and identify population risk and potentially avoidable costs in the CCO program. Prometheus Analytics uses encounter data to identify cost drivers and potentially avoidable complications, also known as PACs. Prometheus Analytics separates episode costs between "typical" and "PACs." This tool allows IHN-CCO to review and summarize episode costs by multiple dimensions to impact quality improvement through the lens of efficiency and quality. This is in keeping with the SHP goal of achieving the triple aim by developing projects to improve quality and reduce costs by focusing on upstream factors that drive costly conditions and procedures. SHP has developed three initiatives for IHN-CCO to reduce costs and improve care. The three initiatives are designed for members with diabetes and co-occurring behavioral health conditions; maternal and child health with a focus on reducing unnecessary costs; and initiation and engagement in substance use disorder treatment services.

Key performance indicator tracking

Quality improvement is a data driven process and used to monitor performance through established benchmarks and performance goals. To inform on the progress of quality improvement initiatives, and focus prioritization, SHP has historically defined a set of industry aligned outcome measures centered around 3 domains: preventive health, safe and effective care, and member experience. These measures serve as key performance indicators, or KPIs.

In 2023, KPIs will be selected based on the results of the 2023 population assessment. After the data are evaluated KPIs will be selected no later than September 2023. Evaluation plans will be implemented to assess the selected KPIs through 2023 and 2024.

Value-based payment methods

Financial stability is key to the sustainability of any organization. It is important that SHP's provider network is compensated in a manner that enables them to drive innovation and a culture of patient-centered care based on quality. SHP is promoting the shift from a fee-for-service system that reimburses only on volume, to a system that holds providers accountable for quality and health outcomes and allows innovation to cultivate transformation on the front lines of care delivery. In accordance with CMS, SHP recognizes the definition of value-

based care as "paying for health care services in a manner that directly links performance on cost, quality, and the patient's experience of care."

Health equity: member race, language, and culture

IHN-CCO is developing and implementing strategies for promoting health equity throughout the organization. This includes training for the board of directors, leadership, and staff (including staff that work with other lines of business). IHN-CCO will improve the quality of care for members by ensuring employees and members feel safe and are always treated with respect and dignity. IHN-CCO will hold its provider network to the same standards of safety and respect.

Quality Improvement annual workplan

The QI workplan governs the program structure and activities for the period of one calendar year. The QI workplan includes quality improvement initiatives, targets, measures, and metrics, activities, and methods of performance tracking throughout the year to advance quality goals and meet regulatory requirements for each line of business.

The QI workplan is focused on delivering the QI Program goals.

- Quarterly project implementation plans, data management, and monitoring processes to achieve SHP quality and population health goals and meet regulatory requirements.
- Identifies specific measurements for quality and population health program goals and objectives and compliance activities.
- Includes key milestones, improvement targets and measurements (KPIs).

Quality Improvement Program evaluation

At least annually, the Quality Department will facilitate a formal evaluation of the QI Program. The program evaluation informs the development of the QI workplan for the coming year. The evaluation includes:

- An evaluation of the results of each QI activity implemented during the year and identifies quantifiable improvements in care and service.
- Evaluates resources, training, scope, and content of the program and practitioner participation.
- Evaluates the overall effectiveness of the QI Program.
- Identifies limitations and barriers and makes recommendations for the upcoming year, including the identification of activities that will carry over into next year.
- Identifies opportunities to strengthen member safety activities.
- Trended indicator report and brief analysis of changes in trends and improvement actions taken because of the trends.

Confidentiality

The QI program follows all Samaritan Health System and Samaritan Health Plans HIPAA, also known as the Health Insurance Portability and Accountability Act policies related to procedures, access, safeguards, and security of protected health information. All SHP personnel and committee members receive privacy and confidentiality training. HIPAA policies are reviewed with all staff upon hire and annually. SHP is authorized by regulatory agencies and by members to obtain and review medical records, including member and practitioner identities. Authorization is subject to all state and federal laws and regulations including Title 42 Code of Federal Regulations. Use of protected health information is outlined in the SHS HIPAA policy and a privacy notice is distributed to all members.

Annual review and revision of the Quality Improvement Program

The Quality Improvement Program is reviewed at least annually and updated more frequently as appropriate. The Quality Management Council is accountable for approving the Quality Improvement Program.

Brent Godek, MD

Interim VP, Chief Medical Officer, Samaritan Health Plans

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