InterCommunity Health Network CCO

Transformation and Quality Strategy Report

March 2019

Stronger, healthier, together.

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

Section 1: Transformation and Quality Program Information

A. CCO governance and program structure for quality and transformation:

i. Describe your CCO's quality program structure, including your grievance and appeal system and utilization management review:

InterCommunity Health Plans serve Oregon Health Plan members in Linn, Benton and Lincoln counties under InterCommunity Health Network-Coordinated Care Organization (IHN-CCO).

Our Quality Management Program is designed to monitor the quality of healthcare provided to all IHN-CCO members to meet the Institute for Healthcare Improvement's (IHI) Triple Aim Initiative of improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care. Our Quality Management Plan and Utilization Management/Medical Management Plan are reviewed and updated annually and approved by the internal Quality Improvement Committee (QIC) and external Quality Management Council (QMC).

The goals and objectives of the program include but are not limited to:

1. Maintain an effective Quality Management Program:
   - Meet or exceed the expectations and standards of Federal, State and contractual entities regarding maintaining a quality management program including an annual evaluation of the program
2. Ensure continual high-level member satisfaction and access to appropriate healthcare services:
   - Monitor member complaints/grievances/appeals internally on an ongoing basis to identify areas for improvement
   - Monitor member satisfaction via external agencies such as through Consumer Assessment of Healthcare Providers & Systems Survey (CAHPS), etc. per Federal, State and contractual requirements to identify areas for improvement
   - Implement and monitor appropriate interventions when areas for improvement in member satisfaction or access to appropriate healthcare are identified
   - Report results of monitoring member satisfaction and access to appropriate healthcare to the Quality Management Council and to the Board of Directors as indicated but at least on a yearly basis
   - Maintain a collaborative relationship with the provider network and community entities
3. Develop programs and interventions to improve member health outcomes:
   - Promote preventive medical and dental services and early detection of disease through the member education and the case management programs
   - Promote self-management of chronic diseases through the member education and the case management programs
   - Monitor health outcomes on an individual basis through the case management program
   - Monitor health outcomes on an overall basis through various methods including Healthcare Effectiveness Data & Information Set (HEDIS) data, internal data, etc.
   - Meet or exceed expectations for all quality projects required by state contractual requirements
   - Report results from programs and intervention monitoring to the Quality Management Council and the Board of Directors on at least a yearly basis or more frequently as indicated

Our Quality Management Program monitors four key areas: utilization of services, member satisfaction, clinical services (including behavioral health/mental health, dental services, prevention, chronic care improvement, maternal/ child services, case management, member health education and quality improvement projects, etc.) and various administrative services. IHN-CCO believes that the integration, monitoring and balance of findings in these areas reflect the achievement of effective and efficient health care that is high quality and cost-effective and meets the IHI's Triple Aim Initiative.

The IHN-CCO Board of Directors retains authority and accountability for all quality activities and oversees our Quality Management Program. The Quality Management Council provides oversight to quality planning, quality monitoring and improvement activities. The Plan's Quality and Health Outcomes Manager is responsible for the daily operations of the Quality Management Program and works closely with the Chief Medical Officer, the Director of Medical Management and other managers/directors and reports indirectly to the Chief Executive Officer and directly to the Director of NCQA Accreditation.

See Attachment 01: QMC Charter. See Attachment 02: QIC Charter.

Utilization Management Program & Utilization Management Plan

The Utilization Management Program falls under the scope of our Quality Management Program. As noted above our Quality Management Council functions as the required IHN-CCO "Utilization review oversight committee" with assistance from the QIC.

We have a Utilization Management/Medical Management Plan that is reviewed and updated annually and approved by our Quality Management Committee. It reviews over/under utilization of services; documents their findings and makes recommendations for follow up actions.

Opportunities for Improvement for 2019 include:

- The Dental Health Advisory Committee (DHAC) to increase dental utilization through integration of services into medical locations
- DHAC to enhance patient case management by delivering screenings, education, and referrals from the dental office setting
- Improvement in access to preventive/ambulatory health services for adults
- Improvement in access to primary care for children and adolescents

The Behavioral Health Quality Committee (BHQC) has discussed over/under utilization of services related to the members in need of mental health services such as a lack of adult acute care.

Creation of reports specific to the needs of the BHQC were developed for discussion, planning and monitoring of compliance related to the goals that were established. The reports used for analysis included:

1. Utilization Trend Report
   - Inpatient psychiatric hospitalization claims for clients serviced in ACT
2. Behavioral Health Services Post Discharge
3. Mental Health penetration rates

ii. Describe your CCO's organizational structure for developing and managing its quality and transformation activities (please include a description of the connection between the CCO board and CAC structure):

InterCommunity Health Network CCO (Coordinated Care Organization) was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) members in Benton, Lincoln, and Linn counties.

Our organization structure has the IHN-CCO Board of Directors which consists of many community partners and stakeholders. The Board receives various updates on quality and transformation activities via the InterCommunity Health Network CCO (IHN-CCO) Chief Executive Officer, the IHN-CCO VP, Chief Operations Officer, and the IHN-CCO Medical Director. The Chief Executive Officer also presents a Board Report back to the Community Advisory Council (CAC) at regional CAC meetings.

The Board Members consist of:

- Samaritan Health Services – CEO/President – Chair of Board
- Samaritan Health Services – Hospital CEO – Vice Chair/Secretary/Treasury
- 2 Physicians
- 1 Dentist
- 1 Mental Health Provider (LCSW)
- 1 CAC Chairperson
- 2 Community Members
- 1 CPA
- 2 County Commissioners
- 1 County Administrative Officer

The Regional Planning Council (RPC) develops tools and strategies to transform and integrate the system of care; recommends funding needed for transformational activities; assures cross-system coordination and care transitions, and sponsors an effective quality improvement process to drive positive system change. The Regional Planning Council is co-chaired by the Samaritan Health Plans' (SHP) Chief Executive Officer and the Benton County Health Director. The CAC Chairperson and CAC Coordinator are members of the RPC, as are many community partners and stakeholders.

The IHN-CCO Delivery System Transformation (DST) Committee builds on current resources and partnerships in Benton, Lincoln, and Linn counties to support, sustain, and spread Transformation efforts for the Medicaid population and pursue the Triple Aim. The DST formally reports to and takes direction from the Regional Planning Council. The DST recommends transformation projects to the RPC for funding consideration. The DST is co-chaired by the SHP Chief Operations Officer and the Executive Director for the Community Health Centers of Benton and Linn counties. The Community Advisory Council Chairperson and the Community Advisory Council Coordinator are both members of the DST.

See Attachment 03: Community Relationships. See Attachment 04: RPC Charter. See Attachment 05: DST Charter.

Currently there is representation on the IHN-CCO Quality Improvement Committee (QIC) by the Transformation Department, and representation from the CAC coordinator on the Quality Management Council (QMC), of which both committees are described above in Section A.i. Additional coordination of activities will need to be developed in view of the new TQS structure.

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

The IHN-CCO Delivery System Transformation Committee, responsible for oversight of transformation pilot projects, has a history of using the Community Health Improvement Plan (CHIP) Health Impact Areas of; Access, Behavioral Health, Child Health, Chronic Disease and Prevention, and Maternal Health to inform strategic planning of transformational pilot projects.

Transformation pilot funding requests are vetted through a Request for Proposal process that includes requiring pilots to address at least one of the CHIP Health Impact Areas to be considered for funding.

Additionally, through 2018, Local Advisory Committees to the CAC and CHIP workgroup developed a proposed new CHIP to be approved this spring. The March TQS Report will be provided to this workgroup as another potential way to align our work.

The Community Health Improvement Plan also plays heavily into the CCO 2.0 Request for Application planning. This includes utilizes the CHIP while choosing Social Determinant of Health priority areas and outcomes.

iv. Describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, community mental health programs, local government, tribes, early learning hubs) to advance the TQS:

IHN-CCO builds on current resources and partnerships within Benton, Lincoln, and Linn counties to outline processes and strategies to support transformation of the delivery system for the community. IHN-CCO and community partners strive to improve community health by coordinating health initiatives, seeking efficiencies through blending services and infrastructure, and engaging all stakeholders in a regional effort to ensure all individuals have equal opportunities to be healthy where they live, work, learn and play in Benton, Lincoln, and Linn counties. IHN-CCO's breadth of partnerships is displayed in the following committees.

The Delivery System Transformation Committee (DST) was developed with membership to include anyone that can positively affect the health outcomes of IHN-CCO members in Benton, Lincoln, and Linn counties. Currently partners include, Education Service Districts, Mental Health, health systems, clinics, Public Health, Early Learning Hub, Department of Human Services, physical health, social service agencies, Community Advisory Council members, oral health, and other community-based organizations. The DST oversees pilot projects that must address at least one TQS area. There are currently 19 active pilots that address 1 or more TQS areas all of which are with different community, clinical, or health system partners.

The Quality Management Council (QMC) is made up of mental, physical, behavioral and dental health practicing providers or partners, health plan staff, addictions specialists, community representatives, care management personnel, and ad hoc subject matter experts as needed. QMC oversees and monitors quality improvement and performance activities of Samaritan Health Plans and Intercommunity Health Network Coordinated Care Organization.

The Quality Improvement Committee (QIC) is made up of designated Samaritan Health Plan Operations staff including the Chief Medical Officer and/or Medical Director and department representation from Quality, Appeals/Grievances, Claims, Customer Care, Customer Experience, Dental, Health Information, Medical Management, Pharmacy, Network Contracting and Strategy, Account Management, and ad hoc as applicable. The QIC's purpose is to utilize all areas of the health plan to consult, deliberate and facilitate the implementation of tactics that will lead to improved performance.

B. Review and approval of TQS

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

At IHN-CCO, Transformation and Quality are operationally managed in different departments.

Our approach for developing the TQS was to begin by leveraging what we were already doing or what was already in development and use this as our baseline.

The Transformation Department and Quality Department collaborated with various Samaritan Health Plan departments such as Medical Management, Community Solutions and Government Affairs, Compliance, Appeals and Grievances, Account Management, Reimbursement, Health Information, and Member Provider Engagement to collaborate on the development of the various TQS components.

Part of our strategy was to take advantage of the many OHA TQS webinars and office hours looking for guidance on the expectations surrounding the development of the TQS Plan. These Technical Assistance opportunities broadened our understanding and were found to be a valuable use of our time.

Communication channels included the IHN-CCO Board of Directors, Regional Planning Council, Delivery System Transformation Committee, Health Equity Workgroup, Quality Improvement Committee, Quality Management Council, Community Advisory Council Coordinator, and the Community Advisory Council.

Project management included an introductory meeting, Q & A check-ins, working sessions, and timeline development shared with the project team. The timeline included reverse engineering of internal draft due dates, review and clarification timeframes, and the planned final submission date.

A retrospective review of the process will be conducted, this along with the anticipated OHA feedback will help inform process improvements for the September progress report.

C. OPTIONAL

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

IHN-CCO currently serves approximately 72,000 members that reside in Benton, Lincoln, and Linn counties. The counties within the IHN-CCO region include a swath of area that ranges from the heart of western Oregon, through a portion of the agriculturally rich Willamette Valley and out to, and including, 60 miles of Pacific coastline, spanning 3,968 square miles. The diverse region is separated by the Coastal Mountain range which contributes to some transportation and communication challenges as a quarter of the region resides on the Oregon Pacific Coast. Over 51% of IHN-CCO members live in rural areas (36,798).

The area is predominantly white and poverty levels are high, particularly in Lincoln and Linn counties. Latinos represent the largest minority population in the region (3,488 IHN-CCO members). Over 6% (4,608) of IHN-CCO members speak a household language other than English (a 4% drop from 2018 and may indicate underreporting).

Specific demographics that are disproportionately impacted by disease and illness include those with mental illness and disabilities. Approximately 36% (25,330) of IHN-CCO members have been diagnosed with a mental illness with 17% (11,839) diagnosed with Severe and Persistent Mental Illness (SPMI). 9% (6,211) of IHN-CCO members have at least one disability that limits their ability to work.

IHN-CCO Member Demographic Source: OHA Dashboard January 2019

Section 2: Transformation and Quality Program Details

Project and Component Crosswalk					
13	1a	Access: Availability of services	09	5a	Health Information Technology: Health Information Exchange
01	1b	Access: Cultural Considerations	10	5b	Health Information Technology: Analytics
02	1c	Access: Quality and Appropriateness of Care Furnished to all Members	11	5c	Health Information Technology: Patient Engagement
03	1d	Access: Second Opinions	12	6	Integration of Care (physical, behavioral and dental health care)
05	1e	Access: Timely	11	7	Patient-Centered Primary Care Home (PCPCH)
04	2	CLAS Standards and Provider Network	13	8	Severe and Persistent Mental Illness (SPMI)
05	3	Complaints and Grievances	14	9	Social Determinants of Health (SDoH)
07	4a	Health Equity: Data	15	10	Special Health Care Needs (SHCN)
08	4b	Health Equity: Cultural Competency	16	11	Utilization Review
			17	12	Value-based Payment Models

A. #01 Access: Cultural Considerations: Care Coordination Trainings

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

B. **Primary component addressed:** Access

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

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

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

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

Members with special and complex health needs often lack ability to self-advocate or navigate the health care system and access necessary services. To address this concern, IHN-CCO provided comprehensive training to ensure care coordinators effectively engage and equip members with special and complex health care needs to access physical, dental and behavioral health care and other services. While the education and training of care coordinators is essential, we recognize a broader need for enhanced awareness and sensitivity training for community providers and staff, who serve our members with special and complex health care needs.

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

Expand training to ensure members receive culturally responsive, linguistically appropriate and trauma-informed care. Network providers and staff will receive additional cultural awareness and skills training to include, but not limited to Cultural Diversity and Inclusion, Motivational Interviewing, Trauma Informed Care and Mental Health First Aid. With enhanced training, providers will be equipped to engage members in shared decision-making, empowering members to live, work and thrive in their communities.

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

Activity 1 description: Use evidence-based materials and established training and subject matter experts to create and implement cultural awareness training curricula. Develop training modules for Trauma Informed Care, Motivational Interviewing and Mental Health First Aid. Develop education and outreach campaign in collaboration with IHN Provider

Services and community clinicians. Develop system to monitor and track feedback and compare training to national standards for evidence-based curricula.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitor using existing learning and documentation system that delivers and tracks required compliance training for direct contract clinicians.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Training and workshops exist, but there is no organized, formal training plan for Network PCPCH providers and staff.	Training modules developed. Education campaign organized.	06/2019	Training completed by 50% of Network PCPCH providers and staff.	06/2020
No organized, formal training plan exits for direct contract Network specialists.	Training modules developed.	06/2019	Training completed by 40% of specialists.	12/2020
No training evaluation exists.	Establish mechanism to provide ongoing evaluation of evidence-based training curricula and gather community provider and staff feedback and response to training.	12/2020	Training updated and modified to meet national standards and community provider and staff learning needs.	06/2021

A. #02 Access: Quality and Appropriateness: PHM Cohort Development

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

B. **Primary component addressed:** Access

i. Secondary component addressed: Utilization review
ii. Additional component(s) addressed: Health Information Technology
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

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

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

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

To ensure members have access appropriate care and resources, IHN-CCO will develop cohorts and apply utilization metrics to identify care needs, monitor care delivery and evaluate the quality and appropriateness of care provided to members with special and complex health needs.

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

IHN-CCO Care Management (CM) Program is developing population data and analytics to identify, monitor and track members with special and complex health needs to ensure they receive timely and effective care. The CM team will monitor data, and outreach to members with identified care gaps. Care mangers will engage members in decision-making, including development of care and treatment plans, coordinating with the interdisciplinary care team and community agencies, gaining access to services and supplies, and problem-solving barriers.

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

Activity 1 description: 1) Develop data set 2) develop processes and tools to accurately segment and risk stratify population to identify members with special and complex health care needs. Develop workflow and processes to apply criteria and access benchmarks to population. Establish consensus on data use with stakeholders. 3) Data and tools are used effectively to monitor access, quality, and appropriateness of care.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Apply much of the work done on the SNP population assessment to the rest of the IHN population.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Multiple reports and disparate sources of data are utilized without standardization.	Creation of standardized sets of criteria to assess the IHN population for risk and utilization.	09/2019	Reports are used to identify care gaps and evaluate appropriate access to services for members with complex and special health needs.	12/2019

Monitoring activity 2 for improvement: Benchmarks and metrics are identified and aligned for this population for creation of baseline and future interventions

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Many different metrics and benchmarks exist for the population but are not aligned or coordinated across the CCO.	Metrics are aligned across the CCO for interventions and efforts towards the population.	09/2019	Standard data sets and metrics are systematically updated, validated and monitored for accuracy and consistency. Standard data sets are used all departments within the CCO. Decisions are based on accurate data. Metrics are used to monitor performance and align efforts to improve health outcomes for members with special and complex health needs.	12/2019

A. #03 Access: Second Opinions: Second Opinions

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

B. **Primary component addressed:** Access

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

C. **Primary subcomponent addressed:** Access: Second opinions

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

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

IHN-CCO contracts with a large network of physical, behavioral health and dental providers to ensure that members can easily access a second opinion for their health and well-being. Second opinions are available for all health plan service types at no cost to members. Care coordinators are available to assist members with arranging a second opinion from a qualified health care provider within or outside the network. Providers and members are educated on this policy through outreach education and provider and member manuals. Issues and concerns around access to second opinions are tracked through our grievance and appeals system. With exception of DCOs, that track second options through the care coordination and UM process, physical and behavioral health authorizations are only tracked for out-of-network providers. IHN would like to develop comprehensive tracking of second opinions to include tracking of in-network physical and behavioral health referrals.

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

IHN-CCO will create a field in our new utilization management software platform to identify and track second opinions for physical and behavioral health. Until this field is created, tracking will continue through Appeals and Grievance.

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

Activity 1 description: Establish comprehensive tracking through new utilization management system.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Develop utilization tracking of second opinions to include in-network services.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Referrals are not required for in-network physician and behavioral health second opinion evaluations. Second opinions are only tracked for out-of-network requests.	Second opinion referral tracking established through new utilization management software platform.	12/2019	Comprehensive reports of second opinion services developed to identify issues, trends and potential access and or quality of care concerns.	03/2020

Activity 2 description: Once tracking is established, benchmarks can be set to ensure timeliness of requests, and to determine the average length of time it takes from referral to second opinion being completed. Historical review of

claims data is required to determine baseline and establish performance targets. Utilization management platform can be queried to identify and monitor second opinion requests.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Establishing benchmarks and performance monitoring to identify trends.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Comprehensive trending reports of second opinions are not available.	Reports established, review of past 6 m of data to identify trends, patterns and establish benchmarks.	06/2020	Reports are used to evaluate performance and to identify issues around access and quality of services.	01/2021

A. #04 CLAS standards and provider network: Health Equity in the Workforce

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

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

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

C. **Primary subcomponent addressed:** Health Equity: Cultural competence

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

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

A person's overall health and well-being is affected by a combination of factors. With an increased awareness of how culture and language affect overall health, it is crucial that trainings and supports are in place and the workforce reflects the diversity of the region. Having a culturally responsive workforce increases member engagement and health literacy, and in turn, leads to better health outcomes. Cultural diversity is more than knowing the values, beliefs, practices and customs of racial classification and national origins. It also includes religious affiliation, language, physical state, gender, sexual orientation, age, disability (both physical and mental), political orientation, socio-economic status, occupational status, geographical location and more. Through education and training, the Health Equity Strategic Plan will assist IHN-CCO staff and providers in delivering care that is:

- Culturally and linguistically appropriate;
- Communicated clearly and effectively; and
- Using a health equity lens for better health outcomes.

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

The IHN-CCO Delivery System Transformation Committee Health Equity Workgroup supports delivery system transformation that identifies and reduces health disparities and advances health equity. The Workgroup supports the culturally diverse needs of members (cultural competence training, provider composition reflects member diversity, Certified Traditional Health Workers composition reflect member diversity). Quality improvement focused on eliminating racial, ethnic, linguistic, and other disparities in access, quality of care, experience of care, and outcomes is a large part of the Strategic Plan as well as supporting IHN-CCO's Community Health Needs Assessment and Community Health Improvement Plan. The National Standards for Culturally and Linguistically Appropriate Services (CLAS) are accepted as a base standard for the work of the workgroup.

The Healthy Equity Workgroup developed a five-year Strategic Plan to assist IHN-CCO in meeting the culturally diverse needs of members and eliminating health disparities, including promoting a diverse workforce with an overall vision of a community where all members of IHN-CCO can meet their potential for optimum health and well-being. See Attachment 06: Health Equity Strategic Plan.

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

Activity 1 description: Develop training plan for IHN-CCO Health Equity Workgroup, IHN-CCO staff, IHN-CCO providers, and other community stakeholders based on the CLAS framework.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Development, approval, and adoption of training plan.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Plan is developed	Plan is developed	12/2018	Plan is developed	12/2018
Plan pending approval and adoption	Plan is approved and adopted	03/2019	Plan is approved and developed	03/2019

Activity 2 description: Research whether demographic data is collected on IHN-CCO provider workforce and determine plan for data collection.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Research whether demographic data is collected on IHN-CCO provider workforce and determine plan for data collection.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Unknown	Determination is in progress	04/2018	Determination is made	03/2019
No current plan	Plan is developed	06/2019	Plan is developed	06/2019

Activity 3 description: Evaluate and establish baseline regarding provider diversity. Dependent on available data, may include physicians, THWs, physician assistants, nurses, management, and/or other providers.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Establish baseline percentage of providers by race/ethnicity and language.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Unknown	Baseline established	12/2019	Baseline established	12/2019

A. #05 Grievance and appeal system: Grievances and Appeals

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

B. **Primary component addressed:** Grievance and appeal system

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

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

i. Additional subcomponent(s) addressed: Timely access and cultural considerations

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

The analysis is part of the deliverable that IHN-CCO provides to OHA on a quarterly basis through the submission of Exhibit I. Also, an internal analysis is completed and reported to internal committees of IHN-CCO each quarter. An internal year-end analysis is also completed by IHN. The analysis details the top three grievance categories as well as rates per thousand for both grievances and appeals. The top three grievance categories for 2018 were Interaction with Provider or Plan, Quality of Care, and Access. See Attachment 07: IHN-CCO Appeals and Grievances Analysis.

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

Appeals and Grievances Department tracks and trends the issues that our members face when receiving health services or the lack of services from providers. Grievance categories tracked are access, interaction with providers of IHN-CCO, consumer rights, quality of care, quality of service, and client billing issues. Reports are evaluated quarterly and presented to various internal committees, as well as our external Quality Management Council, which is comprised of providers and key IHN-CCO management staff. IHN-CCO continues to explore opportunities for improvement to ensure the three top categories are trending downward. We also continue to reach out for more providers to become contracted with IHN-CCO. IHN-CCO has a Provider Engagement department that provides training and education to our contracted providers to improve quality of service and care to all IHN-CCO members. All grievances and appeals are processed according to Attachment 08: GA-02 Grievance/Complaint Policy for IHN and Attachment 09: AT-02 Policy and Procedure-Appeals-IHN.

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

Activity 1 description: Track, trend, and analyze grievances according to OHA categories.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monthly workgroup meeting to review plan status.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
IHN-CCO continues to monitor grievance data for the top three categories: Interaction with Provider or Plan, Quality of Care, and Access.	Develop plans to address the top three categories.	07/2019	Implementing process improvement plans for the top three categories.	12/2019

A. #07 Health Equity: Data: SNP Population Assessment

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

B. **Primary component addressed:** Health equity

i. Secondary component addressed: Social determinants of health
ii. Additional component(s) addressed: Health Information Technology
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed:** Health Equity: Data

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

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

IHN-CCO developed population health management (PHM) reporting for Special Needs Plan (SNP) members who are dually enrolled in IHN-CCO as well as our Medicare Advantage Plan. The PHM data aggregation includes claims data and relevant characteristics such as access to health care, food supply, housing, location of residence, age, race, language, gender, as well as disabilities, chronic conditions and comorbidities. Through PHM data and reports, we can segment subpopulations and stratify our members into high, medium and low risk categories to address care gaps and barriers to ensure resources and interventions are targeted to individuals who will benefit most.

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

IHN-CCO will expand PHM tools and reports to analyze health status of subpopulations to identify the unique needs of our members and prevent consequences of health inequity.

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

Activity 1 description: PHM data and reports will be evaluated on a quarterly basis to determine approaches and interventions needed to assist IHN membership.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Quarterly updates and presentations to the PHM workgroup with updated information from the report and any newly available information that may be added to it. Newly available information may consist of HRA information from new vendor, new SDOH information, participation in Care Coordination or Case Management related programs available, etc.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Report has been developed and presented showing population demographics, chronic conditions, and comorbidities.	Report further includes statistical analysis of comorbidities, other SDOH in claims, SDOH not in claims, results from HRA, participating in programs, and risk scores.	01/2020	PHM workgroup and SNP MOC Subcommittee have discussed and implemented approaches to best coordinate care of the IHN-CCO population.	01/2020

Monitoring activity 2 for improvement: Implementation of identified care coordination tactics and any interventions identified through the data and with new Care Management vendor

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Care Coordination is taking place, but we are going live with new Care Management vendor 03/01/2019.	New pathways to close gaps and best coordinate care will need to be implemented and aligned between SHP's and our vender's analytics.	01/2020	Targeted approaches are occurring for our members identified through the report.	03/2020

A. #08 Health equity: Cultural competence: Interpreter Services

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

B. **Primary component addressed:** Health equity

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

C. **Primary subcomponent addressed:** Health Equity: Cultural competence

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

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

The plan has a very low number of interpreter requests and the service has been monitored through the grievance process. One grievance was received regarding the transferring of the call to an interpreter during the entire year 2017. The plan received zero grievances regarding interpreter services for 2018.

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

Samaritan Health Plans and IHN-CCO ensure members' linguistic needs are met to support the management and comprehension of their health care. Samaritan Health Plans/IHN-CCO contracts with certified and/or qualified interpreter services providers to deliver the largest variety of language options available, including but not limited to: spoken language other than English and sign language for the hearing or speech impaired. All interpreters are capable of translating clinical information effectively in English and in the members' primary language.

Samaritan Health Plans/IHN-CCO provides information on linguistic interpreter and translation service options and how to obtain services via member materials, provider manual, and public plan website. Materials are provided to and available for all members and providers.

Samaritan Health Plans/IHN-CCO makes linguistic interpreter services available to its members and works with providers to ensure that services are delivered when needed. Plan provides interpretation to members when they identify that they have a need for the service.

Samaritan Health Plans requires its contracted providers to meet the requirements of the Affordable Care Act (ACA) regarding linguistic interpretation, 45 CFR 92.201.

For specific information regarding translation and interpretation services available to plan members please see Attachment 10: Linguistic Interpreter Services Policy and page 13 of the member handbook located at https://www.ihntogether.org/-/media/ihn/documents/benefits/2019-ihn-cco-member-handbook.pdf?la=en&hash=BBB6619826894EC2F66E938C10958F42B5C5273F.

Samaritan Health Plans/ IHN-CCO Provider Engagement will monitor grievances filed on interpreter and translation services and will provide education to providers through on-site visits and Quarterly Provider Meetings

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

Activity 1 description: The plan monitors interpreter and translation services through the grievance process.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Provider Engagement will monitor Interpreter and Translation Services on a quarterly basis.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)

Establish monitoring program.	Develop a calendar or schedule.	03/2019	Meet quarterly	06/2019

A. #09 Health Information Technology: HIE: RHIC HIT Data Partners

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

B. **Primary component addressed:** Health information technology

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

C. **Primary subcomponent addressed:** HIT: Health information exchange

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

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

An incomplete patient health record leads to gaps in care and disruptions in continuity of care. Currently, there are several gaps in the Health Information Exchange (HIE) landscape that are being addressed through Regional Health Information Collaborative (RHIC). These include, but are not limited to, the following:

- Technology – Previous grant funds purchased RHIC's robust technology to bridge systems, networks, and people to create a comprehensible care model to keep patients in focus always. The technology required to achieve true interoperability between disparate systems requires additional significant financial investment.
- Complete information set - RHIC's information foundation is built on eligibility and claims data to provide immediate value to care providers. This allows the patient record to be filled with valuable information prior to integration with all care providers.
- Inclusion of non-traditional information - Social determinants of health impact (social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age) a wide range of health, functioning, and quality of life outcomes. These factors contribute up to 85% of a person's overall health. By developing an approach that integrates social determinants of health information with traditional health information, physical, behavioral, and oral health, RHIC can fill the gaps and provide a whole-person view. As well, additional social service agencies can be connected with the larger traditional healthcare providers.
- Focus on the most vulnerable population - RHIC includes priority Medicaid providers that serve the region's most vulnerable Medicaid population, including six Patient-Centered Primary Care Home (PCPCH) Federally Qualified Health Centers (FQHC) with two clinics located in rural East Linn County. RHIC HIE participant services include physical health, oral health, childhood and adult psychiatric and behavioral health, alcohol and drug, wrap-around services, developmental diversity, public health, social services, and child and youth school-based services.

Pursuing data rich connections on a local, state, and national level is key to supporting the overarching elements of TQS 6b (Health Information Technology: Analytics).

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

IHN-CCO's HIE, RHIC, is being further developed to pursue integrated connections. RHIC's infrastructure, HealthShare, supports regional and statewide HIE to facilitate the flow of critical information between physical, behavioral, oral, and other care providers.

The HealthShare platform meets federal interoperability requirements enabling reliable and secure connections for Health Information Exchange provider participants. Behavioral health organizations are provided training and technical assistance to work through technological and legal barriers in sharing behavioral health data. Multiple data integration methods are provided that include online entry and bulk data upload using standard formats, such as text files, to assist providers that are less technologically enabled.

Through work with Benton, Lincoln, and Linn counties' Behavioral Health Services, it was found that there is a range of Electronic Health Record (EHR) readiness to share information with RHIC. There are behavioral health providers able to

exchange information with RHIC and others that have technological barriers. An example of IHN-CCO working with behavioral health providers is the work done with Linn County. Linn County was faced with technology barriers that prohibited information sharing. IHN-CCO designed a shared-savings contract agreement to incentivize Linn County to find an information-sharing technology solution using a standards-based approach. IHN-CCO was able to provide financial support to assist Linn County's system upgrade; the shared savings is then spent on efforts to support the exchange of behavioral health information.

Effective care coordination begins by ensuring accurate clinical information is available. RHIC collects data across the continuum of care and across its communities and presents an aggregated view of the patient to the provider at the point of care. With a whole-person view of the patient, care providers are able to coordinate care in a more seamless manner. Transitions of care are included and viewable in RHIC's patient care plans.

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

Activity 1 description: The Collective Impact Model is utilized by RHIC to build information-sharing relationships. The long-term plans for information include both contracted providers and non-contracted providers.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: RHIC Core Team weekly meetings, project planning meetings with trackers built in to measure and monitor progress.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Data sharing partner roadmap is in process of being developed.	Full list of providers with Value Based Payment contracts will have onboarding plan.	12/2019	All Value Based Payment contracted providers onboarded.	12/2021

Activity 2 description: Develop social determinants of health service provider network as well as baseline data to provide better insight to the landscape and potential gaps.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: RHIC Core Team weekly meetings, project planning meetings with trackers built in to measure and monitor progress.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Roll out of SDoH closed-loop referral system.	Community partner network is using SDoH closed-loop referral system (Unite Us) and data being produced.	06/2019	Data from SDoH closed-loop referral system (Unite Us) is fed into HIE for advanced analytics.	12/2020

A. #10 Health Information Technology: Analytics: RHIC Data Analytics

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

B. **Primary component addressed:** Health information technology

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

C. **Primary subcomponent addressed:** HIT: Analytics

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

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

Currently our data reporting mechanisms are not providing the insight needed to positively impact the CCO metrics that IHN-CCO is not meeting. The data platform for robust data modeling to support IHN-CCO providers in meeting state and federal quality metrics to effect health outcomes will allow us to tie in future population health management tools and patient engagement tools.

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

Using our vendor's, InterSystems, powerful data platform, this project is implementing an Analytics and Reporting layer over the Regional Health Information Collaborative (RHIC), leveraged from comprehensive patient-centric Clinical Data. This is crucial to assist providers in determining where they are with quality metrics, health outcomes, and patient care management. Patient data will be aggregated from all sources and providers, creating a Community Health Record (CHR) (longitudinal health record) to create the analytics models, packages and reports. The Clinical Data model is extendable to capture non-traditional information, such as social determinants of health and assist in supporting value-based payment models that align payment with health outcomes, as well as care coordination and case management. RHIC's single-source repository provides the ability to aggregate data from multiple providers, health care, and social service systems to support the overall goals of transformation.

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

Activity 1 description: Assessment of provider, case management, care coordination, value-based payment data needs. Work to identify and prioritize the 5 CCO Measures were identified for data modeling attributes. Data Quality Assurance was determined ahead of schedule with barriers that will be addressed in a later section.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: HIE Program, CCO Metrics and tracking system have been put in place and are reviewed on a weekly basis

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
The first 5 CCO metrics have been evaluated for data modeling needs the remaining CCO metric data needs will now be evaluated.	Stratified data to understand where gaps are in provider performance, care coordination and value-based payment models.	6/2019	Data will be used to determine regional data providers will be targeted for HIE onboarding to RHIC to expand data sets.	12/2019

Activity 2 description: Qualify appropriate IHN-CCO measures and data needs. Long range target goal activity will begin in accordance with target due dates.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: HIE Program Metrics and tracking system have been put in place and are reviewed on a weekly basis

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Assessment of provider data reporting needs. No assessments have been done.	Draft assessment developed.	9/2019	Assessments completed.	12/2019
Design a solution based on provider data reporting assessment needs. No design exists.	Solution designed, tested.	12/2019	Solution implemented.	1/2020
Assessment of case management data reporting needs. No assessments have been done.	Draft assessment developed.	9/2019	Assessments completed.	12/2019
Design a solution based on care coordination data reporting assessment needs. No design exists.	Solution designed, tested.	12/2019	Solution implemented.	6/2020
Assessment of value-based payment model data needs. No assessments have been done.	Draft assessment developed.	9/2019	Assessments completed.	12/2020
Design a solution based on value-based payment model data assessment needs. No design exists.	Solution designed, tested.	12/2019	Solution implemented.	12/2020

A. #11 Health Information Technology: Patient engagement: RHIC Member/Patient Engagement

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

B. **Primary component addressed:** Health information technology

i. Secondary component addressed: Patient-centered primary care home
ii. Additional component(s) addressed: Add text here
iii. If *Integration of Care* component chosen, check all that apply:
☒ Behavioral health integration ☒ Oral health integration

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

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

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

There have been many efforts to focus on bringing information together that will improve the quality and efficiency for care coordination. An opportunity exists to align these disparate, but complimentary efforts to achieve the optimal health information technology state. (All efforts will be made to incorporate patient engagement and provider engagement where applicable using data developed from TQS Component 5).

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

Using elements of Transformation and Quality Strategy components, not limited to 5a, 5b and others, engage providers via our Alternative Payment Methodology team, Provider Network/Contracting teams and others as necessary to provide CCO metric data to impact population health, and outcome-based services and eventually looking at providing a patient portal access strategy will be the Regional Health Information Collaborative's (RHIC) long-term focus.

RHIC is a centralized information infrastructure in a Collective Impact Model sharing the following common agenda:

- Improve quality and efficiency of healthcare coordination and delivery for IHN-CCO members by accelerating the adoption and use of Health Information Technology (HIT) and Health Information Exchange (HIE);
- Encourage patient-centered care with connection of care providers to ensure continuity of care for every patient;
- Increase patient understanding and involvement of their care;
- Enhance communication between patients, healthcare organizations, and care providers;
- Promote national standards to guide the sharing of information and electronic data interoperability; and
- Leverage existing health information systems.

RHIC's single-source repository provides the ability to aggregate data from multiple providers, health care, and social service systems to support the overall goals of transformation. Reliable and timely data are foundational elements of transformation and support a continuum of care that integrates behavioral health, oral health, physical health, public health, aging and disability services, transportation, the regional Early Learning Hub, and social services, by providing the technological foundation to support the triple aim.

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

Activity 1 description: Evaluate and understand patient centered and community centered Health Information Technology (or lack thereof) efforts that can align and complement each other using Health Information Exchange.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: CO 2.0 RFA preparation will reveal what systems/gaps are in place today

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Assess member engagement landscape. Define what is in place today and where improvements can be made.	Current provider engagement activities; including CHIP efforts will be identified and documented.	07/2019	Define target for where we want to be on provider engagement near term and future.	12/2019
Further analysis needed for planning.	Gap analysis to determine current provider engagement activities for patient engagement.	07/2019	Prioritize the gap findings to create action plans to address the gaps for patient engagement.	12/2019

A. #12 Integration of care: Children's SDoH and ACEs Screening

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

B. **Primary component addressed:** Integration of care (physical, behavioral and oral health)

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

C. **Primary subcomponent addressed:** Choose an item.

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

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

Research has shown that early childhood adversity poses a threat to health and well-being throughout a lifetime. Identifying early childhood adversity through the ACEs screening, can help stress the importance of prevention of this exposure and identify the need for treatment for those who have been exposed. SDoH, the circumstances in which a person lives, also greatly affects a person's health. Children are especially vulnerable to the negative impacts of living in poverty. Early detection of trauma and SDoH issues can lead to improved health, improved health care utilization, improved patient satisfaction, and improved clinical decision making, all which can potentially reduce health care costs. The patient will be screened for SDOH issues at the first appointment (new patient visit), the 9-month and 24-month wellchild checks, and yearly for ages 3-12. It is expected that the connection with social services (SDoH needs) will result in improved health and wellbeing. It is expected that this pilot will improve health equity by connecting those with needs with the local resources, particularly in the Spanish-speaking population. The ACEs screening tool will be used to screen patients at all behavioral health visits. It is expected that the screenings will identify children who have had trauma in their lives and connect them with mental health services. It is hoped that the connection with mental health will reduce the impact of trauma on their long term mental and physical health.

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

IHN-CCO is implementing Social Determinants of Health (SDoH) and Adverse Childhood Experiences (ACEs) screening tools at selected well child checks in a pediatric Patient-Centered Primary Care Home with a panel of over 50% IHN-CCO members. Positive screens will be referred to the Community Health Worker (CHW) or social worker embedded in the clinic based on the results of the screening; for behavioral health, mental health, or SDoH services. The primary pilot goal is to improve the health and wellbeing of families who are experiencing, or who have experienced, violence and trauma, and who have a need for connection with social resources. The provider administering the tool is bilingual (Spanish and English) and sees a larger portion of the Spanish-only speaking families than most other providers.

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

Activity 1 description (continue repeating until all activities included): Develop a screening tool for pediatric SDoH and have it integrated into Epic, the clinic's Electronic Health Record (EHR).

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Screening tool is developed. Integrate the screening tool into Epic.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Screening tool is developed	N/A	Completed	N/A	Completed

Integrated the screening tool into Epic	N/A	Completed	N/A	Completed

Activity 2 description: Develop and implement a clinic workflow integrating the screening tool. Workflow: Screening tool is used at well child checks. Positive screens are referred to the CHW or social worker based on the results of the screening. Follow up the patients/families who had positive screens at various intervals to determine if the issues identified were addressed and if they believe that there has been an impact on the health and wellbeing of the child/children/family.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Workflow is developed and integrated.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Workflow is developed	N/A	Completed	N/A	Completed
Workflow is integrated	N/A	Completed	N/A	Completed

Activity 3 description: Screen a pediatricians' selected well child checks using the screening tool. Create and use tracking system to track the ACEs and SDoH scores.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Create tracking system, implement tracking system, eligible well child checks are screened.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Create tracking system	N/A	Completed	N/A	Completed
Implement tracking system	N/A	Completed	N/A	Completed
80% of eligible well child checks are screened	100% of eligible well child checks are screened	12/2019	100% of eligible well child checks are screened	12/2019

Activity 4 description: Identify families in need and provide connection to resources.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Track the ACE scores of children screened. Track the families in need of the various services after the SDoH screening. Provide connection to resources for children with an ACEs score greater than 1 and children with a positive SDoH screen.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)

100% of ACEs scores screened are tracked	N/A	Completed	N/A	Completed
100% of families in need of the various services after the SDoH screening are tracked.	N/A	Completed	N/A	Completed
Providers are consistently referring to CHW for SDoH needs. Referrals for symptoms related to trauma are being referred to social workers in clinic or outside mental health professionals. Families are also offered parenting assistance for behaviors related to trauma.	N/A	Completed	N/A	Completed

A. #13 Severe and persistent mental illness: Decreasing Readmission to Psychiatric Inpatient

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

B. **Primary component addressed:** Severe and persistent mental illness

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

C. **Primary subcomponent addressed:** Choose an item.

i. Additional subcomponent(s) addressed: Availability of Services

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

SPMI Registry has been completed and findings reviewed at Behavioral Health Quality Committee (BHQC). The majority of individuals discharged received follow-up services in a timely manner. There were no specific concerns raised for services provided. Because of this, IHN-CCO Behavioral Health Quality Committee decided to modify the focus of response to individuals who have been readmitted to inpatient psychiatric within a six-month period. The goal is to conduct root cause analysis through interdisciplinary chart review of each individual readmitted to determine factors that influence readmits and identify appropriate pathways to improve care and prevent readmissions. We have expanded our review of members from Good Samaritan Regional Medical Center to include readmits to all psychiatric facilities.

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

Complete a chart review and root cause analysis on each individual readmitted to psychiatric inpatient within a six-month period to determine factors that influence readmits and recommend appropriate care pathways to resolve.

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

Activity 1 description: Report on mental health services provided to members within 30 days of inpatient psychiatric care.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Identify membership who have readmitted to Inpatient Psychiatric Facilities and analyze data.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Report request submitted for specified data.	Report will be completed.	02/2019	Analyze data. Begin chart reviews.	02/2019
Not developed.	Communicate readmissions monthly to county mental health programs.	02/2019	County mental health programs to conduct their own analysis.	03/2019

Activity 2 description: Identify services, set performance targets and monitoring system.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Develop the response team to conduct chain analysis and communication strategies.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not developed.	Identify response team to review readmission data.	04/2019	Response team reviews monthly.	06/2019
Not developed.	Create a format for discussion, developing categories for review to identify trends leading to readmissions.	04/2019	Readmission trends monitored, causal factors identified, response plans developed.	06/2019
Not developed.	Develop a report with recommendations to address causal factors of readmission with appropriate care pathways.	06/2019	Report presented to BHQC. Targets set to reduce readmission rate.	07/2019

A. #14 Social Determinants of Health: ICTs

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

B. **Primary component addressed:** Social determinants of health

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

C. **Primary subcomponent addressed:** Choose an item.

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

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

Social and health disparities are often associated with poor health outcomes. Further, members with special needs require intensive care coordination to ensure they have the access to care and services.

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

IHN-CCO convenes community Interdisciplinary Care Team (ICT) meetings for members with special needs or who are experiencing a gap in care. Special needs may include lack of stable housing, access to food or lack of natural or financial supports. IHN-CCO Medical Management care coordination team works with community partners and providers to determine if an ICT would benefit the member and schedule ICTs accordingly. ICT members may consist of Medical Management staff (clinical and non-clinical), Long Term Services and Supports case managers, providers from the medical, dental and/or behavioral health discipline and other community partners supporting the member. The ICT members work together to develop a person-centered plan of support to assist a member in addressing gaps the member is experiencing.

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

Activity 1 description: ICT meetings will be convened regularly to address member needs. Meetings will be documented through minutes and each member will have a person-centered plan of support completed. IHN-CCO will be responsible for sharing documentation with members of the ICT. Tracking will occur through IHN-CCO's system of record.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Members who have been identified for an Individual Care Team (ICT) meeting receive a documented meeting. This is for members with medical, behavioral, social, and oral health needs.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
IHN-CCO refined and strengthened the ICT infrastructure and system for identifying members, convening meetings, tracking plans and monitoring outcomes.	Responsive care team, timely ICTs and tracking outcomes.	03/2019	Effective tracking of ICT performance to ensure members are receiving effective care coordination.	03/2020.

A. #15 Special health care needs: Special Health Care Needs

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

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

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

C. **Primary subcomponent addressed:** Choose an item.

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

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

In order to collectively address system gaps and barriers across multiple child-serving systems such as; child welfare, developmental disabilities, juvenile justice, education, primary care, mental health, alcohol and drug treatment, and public health, communities will be identifying and communicating these gaps and barriers through the system of care governance structure. The Regional System of Care Executive Council will use this and other information sources to strategically develop and implement strategies to improve the system in our region.

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

Children and adolescents who need services from multiple systems and their families often experience a lack of coordination of services and resources, multiple sometimes conflicting expectations and inefficient use of resources. The establishment of a system of care governance structure from the child and family team level through a regional executive council will increase the efficiency in the system and improved outcomes for children and their families.

This strategy from 2018 is being modified. A Regional System of Care Executive Council has been established and meeting on a regular basis. The Council focuses on all children, youth and their families in the region and not just those involved in IHN-CCO or the Wraparound process. It particularly focuses on system issues and gaps found in at least 2 of the 3 counties and involve multiple systems. The agenda is built through issues identified through the local System of Care structures and recommended by the Regional SOC Advisory Committee. The Regional Executive Council works to resolve system gaps and barriers that require leadership solutions and investments

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

Activity 1 description: Develop a Regional System of Care Project Coordinator Position

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: System of Care Executive Council has drafted a shared funding model, Memorandum of Understanding, position duties, and the Early Learning Hub has agreed to house the position. This position will provide the necessary support to implement actions identified by the Executive Council and work collaboratively with each of the three counties SOC Governance structure. See Attachment 11: SOC Project Coordinator Position.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Finalize the MOU	Signature ready MOU sent to funding entities	02/2019	Signed by all parties investing in the position	07/2019

Draft position duties and position description	Linn Benton Lincoln Early Learning Hub completes position description and posts position	05/2019	Regional Coordinator begins employment	09/2019

Activity 2 description: SOC communication flow and barrier submission process

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: A key aspect of system of care work is to identify and problem solve issues and gaps as close as possible to the children, youth, and families. The process needs to be fully informed by children, youth, and families, then vetted and solved as soon as possible. The Executive Council has developed a communication process so that each county can develop their own barrier submission process and problem solve what they can within their own SOC governance structure. The communication plan includes the submission of a quarterly report that summarizes county level strengths, problems solved, and issues that remain unsolved that need to be escalated to the regional level. Those reports will go to the Regional Advisory Committee for analysis and prioritization for the Executive Council. The Council will then act and report back to the Advisory Committee and local systems of care. The Executive Council can escalate barriers and gaps to the state level. See Attachments 12: SOC Executive Council Charter, 13: SOC Communication Flow and Barrier Submission Forms, and 14: SOC Governance Structure.

Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Communication process established, and each county trained	Quarterly reports sent from each county	04/2019	Quarterly reports used to improve the system of services and support	12/2019

A. #16 Severe and persistent mental illness: Appropriate Services for Members Diagnosed with Major Depressive Disorder and Substance Use Disorder

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

B. **Primary component addressed:** Severe and persistent mental illness

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

C. **Primary subcomponent addressed:** Choose an item.

i. Additional subcomponent(s) addressed: Availability of services

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

Original registry had 8013 members identified with SPMI condition. Upon reviewing the data, Behavioral Health Quality Committee (BHQC) decided to narrow the focus to members with Major Depressive Disorder, which is the most prevalent condition. At the same time, the query was broadened to focus on Mental Health Diagnosis with Co-Occurring Substance Use Disorders, (SUD) and other Co-Occurring Mental Health diagnosis.

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

Identify current utilization patterns, appropriate responses and whether current network is adequate to provide services meeting best practice standards of care for members with Major Depressive Disorder. Develop appropriate and standardized care pathways for these members. Identify those individuals who have Co-Occurring Substance Use Disorders and implement best practice standard of care for these members.

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

Activity 1 description: Identify utilization patterns and best practice for care for members with MDD and MDD co-occurring with SUD

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Identify number of members with Major Depressive Disorder and their utilization patterns. Include a flagging for those with a Substance Use Disorder diagnosis.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Report request submitted	Report developed	04/2019	Utilization patterns identified	04/2019
Not developed	Present data on utilization patterns to BHQC and initial findings on best practice for MDD and MDD co-occurring with SUD.	05/2019	Best practices for standard of care are agreed upon and consensus to move forward.	05/2019

Activity 2 description: Determine best practices and network adequacy.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Apply analytic tools to identify member needs and evaluate whether provider network is adequate to address member needs.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Not developed	Determine whether current network is adequate to provide services.	09/2019	Discuss network at BHQC to identify gaps and establish appropriate pathways.	09/2019
Not developed	Develop system for appropriate response.	12/2019	Implement system.	01/2020

A. #17 Value-based payment models: VBP-PCPCH

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

B. **Primary component addressed:** Value-based payment models

i. Secondary component addressed: Patient-centered primary care home
ii. Additional component(s) addressed: Add text here
iii. If *Integration of Care* component chosen, check all that apply:
☒ Behavioral health integration ☒ Oral health integration

C. **Primary subcomponent addressed:** HIT: Health information exchange

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

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

IHN-CCO is spending 32% of its total medical costs on VBP agreements where quality is tied to payment. IHN-CCO has been successful in implementing VBP's with 94.5% of its contracted PCPCH's throughout the service area. The breakdown of the HCP Lan categories of the value-based payment models include:

Category 4B capitation Per Member Per Month (PMPM) + Pay for Performance (P4P): 75%

Category 2C Fee-for-service (FFS) + Case Management Fees (CMF) + P4P: 14%

Category 2B Pay for reporting on any claims data that helps IHN-CCO to achieve the State's performance metrics: 5.5%

The capitation PMPM payments are risk adjusted payments per member attributed to a PCPCH, and paid monthly. The PCPCH is evaluated on a quarterly basis to determine appropriate use of the capitation, including PCPCH infrastructure growth based on the Oregon Health Authority (OHA) PCPCH criteria, which includes CEHRT 2015 or higher, over and under-utilization of services (including non-clinical services such as care coordination), integration of services, and target areas for potential cost control.

Pay for Performance (P4P) agreements are risk-based payment arrangements either funded by additional incentives or based on a withhold agreements whereby the PCPCH must meet at least 50% of the agreed upon quality metrics to gain any of the incentive pool or withhold back, if applicable. IHN-CCO shares risk by reimbursing the subcontractor the total amount available if 80% of the agreed upon quality metrics are achieved. PCPCHs also agree to showing proof of their progress made in becoming at least a 4 or 5 tier PCPCH as designated by the OHA.

Case Management Fee (CMF) payments are risk adjusted PMPM additional payments made to PCPCH's, if applicable, to be used to incorporate non-traditional services for their members, such as care coordination, traditional health workers, behaviorists, and home visits.

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

To further support PCPCH infrastructure to be high functioning 5 tier PCPCH's with integrated whole-person care through a health equity lens, IHN-CCO is launching a project to pursue implementing a robust risk stratification methodology that includes social determinants of health in addition to predictive analytics based on conditions.

IHN-CCO will begin researching the best solution in Summer 2019 with the goal to have implemented by end of Winter 2019.

Upon implementation of the product or solution, IHN-CCO will use the risk stratification methodology to determine PMPM CMF payments to be reimbursed to PCPCH's. Payments will be reimbursed either in a monthly payment specified as PCPCH payments or as a PMPM enhancement to HCP LAN category 4B PMPM payments in place with PCPCH's where applicable

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

Activity 1 description: Risk Stratification Product or Solution Selection

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitor the selection of the risk stratification solution or product implementation.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Current risk stratification model used is manual and substandard.	Implementation of a risk stratification product or solution that is predictive and includes the ability to use SDOH information to calculate risk.	12/2019	Risk stratified payments include SDOH in the calculation to predict outcomes.	12/2021

Activity 2 description: Implementation of PCPCH CMF risk stratified payments

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor PCPCH CMF payments to ensure that they are risk stratified.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
14% of provider CMF payments are risk stratified, and are risk stratified using a substandard methodology.	100% of any PCPCH receiving CMF payments is receiving a fool-proof risk stratified CMF payment.	1/1/2020	100% of any PCPCH receiving CMF payments is receiving a full-proof risk stratification CMF payment that includes SDOH information.	01/2022

A. #18 Integration of care: Integrated Foster Child Wellbeing

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

B. **Primary component addressed:** Integration of care (physical, behavioral and oral health)

i. Secondary component addressed: Special health care needs
ii. Additional component(s) addressed: Access, Health Equity, Social determinants of health
iii. If *Integration of Care* component chosen, check all that apply:
☒ Behavioral health integration ☒ Oral health integration

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

i. Additional subcomponent(s) addressed: Access: Timely access, Health Equity: Cultural Competency

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

One-third of children entering foster care have a chronic health condition and up to 80% have a significant mental health need. Adolescents in foster care are more likely to engage in risk taking behaviors than their non-foster peers and are 2.5 times more likely to experience pregnancy by age 19. Substance use is higher, and these youths tend to have a poorer social support system. They are more likely to have an ACE score of 4 or higher. They are more likely to have a diagnosis of ADD, PTSD, depression, use tobacco and have asthma. Even when the child is no longer in foster care, many of these health conditions remain at rates higher than non-foster children. The current American Academy of Pediatrics (AAP) recommendation is that all children entering foster care have a health screening within 72 hours of placement with medically complex children receiving care within 24 hours, and all children in care a comprehensive health assessment at or around 30 days after placement in care. The AAP classifies children in foster care as children with special health care needs (CYSHN), requiring more frequent medical visits and care-coordination.

Currently, foster families struggle to have the children seen in a timely manner, the care is often fragmented and mental health assessments challenging to complete. Pediatricians have 20 to 30 minutes to see children who often have complex needs and medical history that is often incomplete. Coordinating care for a child in foster care is often complex and challenging. Transitions back to the biological family, or when children age out of the foster system, are critical times for on-going case management.

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

The mission of the Integrated Foster Child Wellbeing Program (IFCW): To optimize the wellbeing of all children and youth involved with child welfare by facilitating and coordinating the care in the areas of medical, mental health, dental, and developmental/education from birth to transition to adulthood.

The goals of the Integrated Foster Child Wellbeing Program are: 1. Develop a steering committee that facilitates and coordinates among the three counties with the Patient-Centered Primary Care Home (PCPCH) as the center of the coordination model; 2. ensure assessments for foster children are not fragmented, redundant, or untimely; and 3. improve the CCO Incentive Metric Assessments for Children in DHS Custody.

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

Activity 1 description: Develop a steering committee that facilitates foster care coordination among the three counties and all partnering agencies.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Committee developed and engaged.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No steering committee	Committee members identified	06/2019	Committee members engaged	12/2019

Activity 2 description: Develop and implement a model of foster child care coordination with the PCPCH at the center.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Care coordination model identified and implemented.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No model.	Care coordination model identified and agreed upon.	06/2020	Care coordination model implemented.	12/2020

Activity 3 description Determine best methods to obtain medical records (Primary Care Physician [PCP] assignment and visits/oral health assignment and visits/mental health visits) in a timely manner.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Obtaining complete medical records in a timely manner.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No methods identified.	Methods identified.	10/2019	Methods identified.	10/2019

Activity 4 description Ensure assessments for foster children are not fragmented, redundant, or untimely.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Improve the CCO Incentive Metric Assessments for Children in DHS Custody.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2017 final result: 79.5%.	2019 final result: 82.5%.	06/2020	2020 final result: 90%.	06/2021

A. #19 Value-based payment methods: VBP-Maternity Case Management Plus Program

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

B. **Primary component addressed:** Value-based payment models

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

C. **Primary subcomponent addressed:** HIT: Health information exchange

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

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

The current VBP model in place for Maternal Case Management Plus is a PMPM VBP, category 4N model where the county public health partners are contracted to provide maternal case management services to the members that reside in each of the counties. IHN-CCO will be expanding this program to address the needs of the population with a higher category VBP model in place that supports providing access to more IHN-CCO pregnant women and families from the onset of pregnancy to postpartum, promoting the integration of care with the whole provider community, and the evaluation of quality outcomes and program effectiveness.

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

The purpose of the Maternal Case Management Plus Program is to expand upon the current delivery system to achieve the mutual goal of IHN-CCO, the non-clinical providers, public health providers, and the clinical providers in the community to help IHN-CCO women have healthier pregnancies, healthier outcomes, and to raise healthy children.

County public health partners will work collaboratively and connect women and their families to Obstetricians, Behavioral Health providers, Traditional Health Workers, Dental providers, PCPCH's, and to other health and parenting resources in Public Health and in the community, such as prenatal care and parenting classes. All providers shall visit pregnant women and new mothers where convenient for the member.

Nurse Family Partnership (NFP) services will be delivered using evidence-based home-visiting services per the National Service Office of Nurse Family Partnerships. This model includes building community resources and community service partners to support social determinants of health and coordination with clinical providers, traditional health workers and other community-based organizations.

Partners included in coordinating Maternal Case Management Plus Program care will use HIT systems supported by IHN-CCO to collect data, including at a minimum social determinants of health information, ACE's scores, Health Risk Assessments to manage appropriate care plans and to ensure communication and information sharing with the appropriate non-clinical, public health and clinical providers included in the care plan.

IHN-CCO will implement an HCP LAN category 4B VBP with the County Public Health providers, and will collect data to monitor the performance outcomes of members included in the Maternity Case Management Program to determine quality payments in a P4P agreement.

The P4P agreement will be a risk-based payment arrangement funded by additional incentives whereby the county public health partner must meet at least 50% of the agreed upon quality metrics to gain any of the incentive pool. IHN-CCO will share risk by reimbursing the county public health partner the total amount available if 80% of the agreed upon quality metrics are achieved.

IHN-CCO will monitor the following performance metrics in year 1:

1. Completion of Health Risk Assessments (Family Connects)
2. Patient Satisfaction Survey Results
3. Services and outreach provided to other family members in the home
4. The percentage of pregnant women enrolled in the program
5. The number of case management services provided
6. Referrals for oral health
7. Referrals for behavioral health
8. Referrals to PCPCH
9. Alcohol and Drug Screenings performed
10. Completion of ACE's questionnaires

IHN-CCO will monitor the following performance metrics in PCPCH P4P contracts, dental care organization P4P contracts, and traditional health worker contracts:

PCPCH:
1. Timeliness to Prenatal Care and Postpartum Care
2. Childhood Immunizations
3. Developmental Screenings in the first 36 months of life

Dental Care Organizations:
1. Increase the percent of members who have a dental visit during pregnancy

Traditional Health Workers:
1. Childhood Immunizations
2. Developmental Screenings in the first 36 months of life
3. Referrals to Maternal Case Management Plus Program

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

Activity 1 description : Increase the number of members served in the community through the Maternity Case Management Plus Program

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Monitor members enrolled in program.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
5% of all pregnant women enrolled in MCM Plus Program – 73 members.	10% of all pregnant women enrolled in MCM Plus Program – an increase of 92 members.	12/2019	20% of all pregnant women enrolled in MCM Plus Program – an increase of 257 members.	12/2020

Activity 2 description: HIT adoption rates of all providers involved in care coordination for the purposes of tracking SDOH, referring for treatment to non-clinical and clinical service providers, and reviewing care plans fed by HRA's and ACE's Questionnaires.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor provider adoption of HIT solutions.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 providers are using Unite Us and Care Connect (previously known as PreManage)	All 3 county Public Health and Mental Health, 4 Traditional Health Worker agencies, and Samaritan Obstetrics department are using these tools.	12/2020	Primary Care and Dental Care providers are using the tools.	12/2021

Activity 3 description: Reduction in adverse delivery outcomes including premature births

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: As part of the long-term plan, IHN-CCO will see a reduction in adverse delivery outcomes through the MCM Plus Program

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
49% adverse delivery outcomes	42% adverse delivery outcomes.	12/2020	30% adverse delivery outcomes.	12/2022

Definition for adverse deliveries include:

An adverse delivery/outcome includes at least one or more of the following:

- An ICU/NICU rev code
- ICD-10 P00-P96 diagnosis code for the newborn
- A stay of more than 48 hrs if delivered vaginally
- A stay of more than 96 hrs if delivered by caesarian section
- A 3rd or 4th degree laceration
- A blood transfusion
- A Nursery Level 2 or higher rev code