HEALTHINSIGHT ASSURE
Experts in Quality Review

External Quality Review Organization

Application for RFP 3491

Part I. Technical Proposal

Deliver To:

Ronda Miller
State of Nevada, Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Submitted by:
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TIN:
81-5464494

Section I – Title Page

Part IA – Technical Proposal	
RFP Title:	EQRO
RFP:	3491
Vendor Name:	HealthInsight Assure
Address:	6830 W Oquendo Rd #102 Las Vegas, NV 89118 Phone: (702) 385-9933
Opening Date:	2/22/18
Opening Time:	2:00 PM

HEALTHINSIGHT
ASSURE
Experts in Quality Review

February 20, 2018

Ronda Miller, Purchasing Officer II
State of Nevada, Purchasing Division
515 E. Musser Street, Suite 300
Carson City, Nevada 89701

RE: HealthInsight Assure Response to State of Nevada Purchasing Division Request for Proposal 3491 External Quality Review Organization

Dear Ms. Miller:

HealthInsight Assure, LLC (Assure) a division of HealthInsight Management Corporation (HealthInsight), is pleased to offer the enclosed response to the Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP) Request for Proposal (RFP) number 3491 to provide external quality review services for the State of Nevada.

You may be familiar with HealthInsight's Nevada affiliate, HealthInsight Nevada, as they have provided services to DHCFP and other state divisions since 1988, beginning with 15 years of service as a Medicaid Utilization Review contractor. Since then, HealthInsight has had a long and rich history working in and with the State of Nevada as the CMS Quality Innovation Network-Quality Improvement Organization (QIO).

A significant portion of the work will be done by staff who live and work in Nevada and staff from our other nearby offices will often travel to Nevada to execute the onsite portions of their work. Accordingly, we have attached a separate letter requesting the 5% preference referenced in the RFP.

Assure was recently created to combine our External Quality Review Organization (EQRO) work in separate states into an organization that is independent from HealthInsight's other affiliates and boards. Assure provides expert guidance to help health care programs ensure their customers can access timely, high-quality care. Our primary objective is to make a positive difference in health outcomes and the experience of health care for vulnerable citizens in our communities.

With 20 years of external quality review experience, Assure and its predecessor organizations have performed the full range of mandatory and optional EQR activities and have conducted many statewide initiatives and provider education activities to improve quality of care, patient safety and access to timely care for Medicaid service recipients.

Our deep Nevada roots and understanding of the local environment as well as our team's high-level strengths, passion and expertise distinguish us from other organizations in this line of business, and we are excited about the opportunity to work collaboratively with the State of Nevada to assess and make recommendations for improving the quality of health

care services furnished by each MCO, PAHP, and CMO including proactively helping the State to target goals and quality improvement objectives.

Enclosed please find our technical and business proposals. We have included both a CD and flash drive just in case there is a glitch with technology. Each contains one pdf of the technical and the business proposal. We have not designated any information as confidential, so have not included separate confidential files. HealthInsight Assure's offer is firm for a period of 180 days after the proposal due date.

We thank you for this opportunity and look forward to collaborating with DHCFP on this important work. Please feel free to contact me if you have any questions. I am available at your convenience by email at SDonnelly@healthinsight.org or by phone at (801) 892-6668.

Sincerely,

Sharon Donnelly, MS
Senior Vice President, Development
HealthInsight Assure Board Chair

HealthInsight Assure • 6830 W. Oquendo Road, Suite 102 • Las Vegas, NV 89118
Phone: 702-385-9933 • Fax: 702-385-4586 • **www.healthinsight.org**

HEALTHINSIGHT
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Experts in Quality Review

February 20, 2018

Ronda Miller, Purchasing Officer II
State of Nevada, Purchasing Division
515 E. Musser Street, Suite 300
Carson City, Nevada 89701

RE: HealthInsight Assure Request for 5% Preference
Request for Proposal 3491 External Quality Review Organization

Dear Ms. Miller:

HealthInsight Assure, LLC (Assure) a division of HealthInsight Management Corporation (HealthInsight), has submitted a response to the Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP) Request for Proposal (RFP) number 3491 to provide external quality review services for the State of Nevada.

HealthInsight's Nevada affiliate, HealthInsight Nevada, has provided services to DHCFP and other state divisions since 1988, beginning with 15 years of service as a Medicaid Utilization Review contractor. HealthInsight has had a very long and rich history working in and with the State of Nevada as the CMS Quality Innovation Network-Quality Improvement Organization (QIO).

Since we conduct EQRO work in multiple states, HealthInsight Assure was incorporated in Utah and registered with the State of Nevada as a foreign corporation. As a significant portion of the work for Nevada will be produced by staff living and working in Nevada and staff from our other nearby offices will often travel to Nevada to execute the onsite portions of their work, we are requesting the 5% preference referenced in the RFP in Section 9.2 on page 28, as follows:

> *Effective July 1, 2017, a five percent (5%) preference will be awarded to businesses based in Nevada. A Nevada business is defined as a business which certifies either that its 'principal place of business' is in Nevada, as identified in Section 3.1, Vendor Information or that a 'majority of goods provided for the contract are produced in Nevada.' The preference will be applied to the total score.*
>
> *9.2.1 Financial stability shall be scored on a pass/fail basis.*

Five individuals will be working out of HealthInsight Nevada's existing Las Vegas office or telecommuting from their homes in northern Nevada. We have listed those employees and their roles below. We estimate that their efforts, and the local support provided by our Nevada facilities (information technology, office space and supplies, etc.) and EQRO work performed in Nevada by other staff will encompass more than 50% of the work required for this contract.

- **Project Manager**- a Key Personnel who will be responsible for managing the timeline, tasks and deliverables for the contract
- **Nurse Reviewer**- a Key Personnel who will work on compliance review activities as well as other areas where an RN is preferred
- **Medical Director**- available when needed for consultation
- **Project Coordinator**- providing coordination and assistance to the team
- **Project Assistant**- providing support to the team

I, Sharon Donnelly, HealthInsight Assure Board Chair, certify that the DHCFP RFP 3491 for External Quality Review, if awarded to HealthInsight Assure, will result in a contract where the majority of goods for the contract are produced in Nevada.

We thank you for this opportunity and look forward to providing DHCFP with Nevada External Quality Review services. Please feel free to contact me if you have any questions. I am available at your convenience by email at SDonnelly@healthinsight.org or by phone at (801) 892-6668.

Sincerely,

Sharon Donnelly, MS
Senior Vice President, Development
HealthInsight Assure Board Chair

HealthInsight Assure • 6830 W. Oquendo Road, Suite 102 • Las Vegas, NV 89118
Phone: 702-385-9933 • Fax: 702-385-4586 • **www.healthinsight.org**

Section II – Table of Contents

Section Page

Section I – Title Page 1
Cover Letter 2
Request for Consideration of 5% Preference 4
Section II – Table of Contents 1
Index of Tables and Figures 3
List of Acronyms 7
Section III – Vendor Information Sheet 1
Section IV – State Documents 1
Section V – Scope of Work 1
Executive Summary 1
Assure and HealthInsight Management Corporation 2
Assure Strengths 2
External Quality Review Services 4
Customer comments 5
2.1 Scope of Work 6
2.1.1 Mandatory Activities 6
2.1.2 Optional Activities 21
2.1.3 Validation of MCO, DBA/PAHP and
2.1.4 Compliance Review 54
2.1.5 Technical Assistance and Optional Activities 56
2.2 Qualifications of External Quality Review Organizations 69
2.2.1 Vendor and Subcontractor Contract Requirements 69
2.2.2 Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities 78
2.2.3 Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors 81

2.2.4 Independence 82
2.2.5 Contract Restrictions 83
2.2.6 Vendor Contract Manager 84
2.2.7 Subcontract with an NCQA Certified CAHPS Vendor 84
2.2.8 Subcontract with an NCQA-Certified HEDIS Compliance Auditor 84
2.3 Vendor Operating Structure and Staffing 85
2.3.1 Adequate Staffing 85
2.4 Implementation 96
2.4.1 Detailed Work Plan and Timeline 96
2.4.2 Updates to Work Plan and Timeline 96
2.4.3 Deliverables and Modifications 97
2.5 Presentation of Findings 97
2.6 HIPAA Compliance Requirements 98
2.6.1 Vendor Representations 98
Section VI– Company Background and References 1
3. Company Background and References 1
3.1 Vendor Information 1
3.1.9 Company background/history 10
3.1.10 Length of time vendor has been providing services 15
3.1.11 Financial information 16
3.2 Subcontractor Information 17
3.3 Business References 24
3.4 Vendor Staff Resumes 26
Section VII – Attachment F – Proposed Staff Resumes 1
Section VIII – Other Informational Material 1

Index of Tables and Figures

Table 1. Assure Team Experience with PIP Validation
Table 2. Assure Team Experience with Performance Measure Validation
Table 3. Assure Team Experience with Compliance Review
Table 4. Assure Team Experience with Encounter Data Validation
Table 5. Assure Team Experience with Quality of Care Surveys
Table 6. Assure Team Experience with Performance Measure Calculation
Table 7. Assure Team Experience with Conducting Statewide PIPs
Table 8. Assure Team Experience with Quality Studies
Table 9. Assure Team Experience with Validating Performance Measures
Table 10. Example PIP Scoring Calculation
Table 11. PIP Scoring Ranges
Table 12. Confidence Levels for PIP Study Results
Table 13. Assure Team Experience with Performance Measure Validation
Table 14. Assure Team Staff Experience and Knowledge Domains
Table 14A. Experience with Medicaid Managed Care and FFS Programs
Table 15. EQR Staff Credentials and Certifications
Table 16. Assure Team Members for Nevada External Quality Review Services
Table 17. Contracts with State Agencies
Table 18. HealthInsight Corporate History and Milestones
Table 19. HealthInsight Assure EQR Contract History
Table 20. Business References

Figure 1. PIP Validation Framework
Figure 2. Steps in Performance Measure Validation
Figure 3. Steps in Compliance Review
Figure 4. Assure's Approach to Encounter Data Validation
Figure 5. Assure's Approach to Quality of Care Surveys
Figure 6. Steps in Oregon Medicaid Satisfaction Survey Process
Figure 7. Assure's Approach to Performance Measure Calculation
Figure 8. Steps in Conducting Oregon Statewide PIP
Figure 9. Activities in Assure's Quality Studies
Figure 10. Steps in Validating Network Adequacy
Figure 11. HealthInsight Assure Management Structure
Figure 12. HealthInsight Management Corp. Organizational Chart

Section II – List of Acronyms

Term	Definition
ADA	American Disabilities Act
AHRQ	Agency for Healthcare Research and Quality
BH	Behavioral Health
BJA	Bureau of Justice Assistance
BHSD	Behavioral Health Services Division
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CAS	Cost and Accounting Standards
CCO	Coordinated Care Organizations
CCP	Comprehensive Care Plans
CDPHP	Chronic Disease Prevention and Health Promotion
CFCW	Bureau of Child, Family and Community Wellness
CFR	Code of Federal Regulations
CHAP	Community Health Accreditation Partner
CHIP	Children's Health Insurance Program
CLAS	Culturally and Linguistically Appropriate Services
CMO	Care Management Organization
CMS	Centers for Medicare & Medicaid Services
CoLTS	Coordination of Long Term Services
CY	Calendar Year
DBA	Doing Business As
DBHR	Division of Behavior Health and Recovery
DCAA	Defense Contract Audit Agency
DHCFP	Division of Health Care Financing and Policy
DHCS	Department of Health Care Services
DHHS	Nevada Department of Health and Human Services
DOH	Department of Health

Term	Definition
DSN	Delivery System Network
EAS	Emergency Alert System
EDV	Encounter Data Validation
EQR	External Quality Review
EQRO	External Quality Review Organization
FAR	Federal Acquisition Regulation
FFS	Fee-for-service
FH	Fair Hearing
FISMA	Federal Information Security Management Act
FY	Fiscal Year
FWA	Fraud, Waste and Abuse
G&A	General and Administrative Expense
GAAP	Generally Accepted Accounting Principles
GOBHI	Greater Oregon Behavioral Health, Inc.
HA	Health Authority
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health
HMC	HealthInsight Management Corp.
HSD	Human Services Department
IDS/IPS	Intrusion Detection System/Intrusion Protection System
IDSS	Interactive Data Submission System
IHCPs	Indian Health Care Providers
IRR	Inter-rater Reliability
ISCA	Information Systems Capabilities Assessment
IS	Information Systems
IT	Information Technology
LEP	Limited English Proficiency

Term	Definition
LDL-C	Low Density Lipoprotein Cholesterol
LTSS	Long-term Services and Supports
MCO	Managed Care Organizations
MCP	Managed Care Health Plan
MLTSS	Managed Long-Term Services and Supports
MME	Morphine Milligram Equivalent
MMIS	Medicaid Management Information System
MSSP	Managed Security Service Provider
NCQA	National Committee for Quality Assurance
NDPP	National Diabetes Prevention Program
NEMT	Non-Emergency Medical Transportation
NIH	National Institute of Health
NF LOC	Nursing Facility Level of Care
NMMRA	New Mexico Medical Review Association
NOD	Notice of Direction
OHA	Oregon Health Authority
OMB	Office of management and Budget
PAHP	Prepaid Ambulatory Health Plan
PCP	Primary Care Physician
PII	Personally Identifiable Information
PDF	Portable Document Format File
PDMP	Prescription Drug Monitoring Program
PDSA	Plan, Do, Study, Act
PH	Physical Health

Term	Definition
PHI	Personal Health Information
PII	Personal Identifiable Information
PAHP	Prepaid Ambulatory Health Plans
PIP	Performance Improvement Project
PIHP	Prepaid Impatient Health Plan
PM	Performance Measures
PMP	Performance Measurement Program
PMV	Performance Measurement Validation
PQA	Pharmacy Quality Alliance
PRO	Peer Review Organization
QAPI/QAPIS	Quality Assessment Performance Improvement/Quality Assessment Performance Improvement Strategy
QHOC	Quality Health Oversight Committee
QHP	Qualified Health Plans
QIN	Quality Innovation Network
QIO	Quality Improvement Organization
QIO/QIN	Quality Improvement Organization/Quality Innovation Network
QIO/PRO	Quality Improvement Organization/Peer Review Organization
QM/QI	Quality Management and Quality Improvement
QRS	Quality Rating System
REDCap	Research Electronic Data Capture
RESPOND	Resources Encouraging Safe Prescription Opioid Medication Dispensing
RFP	Request For Proposal
RHIT	Registered Health Information Technology

Term	Definition
RSN	Regional Service/Support Network
SBIRT	Screening, Brief Intervention and Referral to Treatment
SHP	Strategic Healthcare Program:
SOW	Scope of Work
SPMI	Serious and Persistent Mental Illness:
SWBH	Southwest Behavioral Health
TANF	Temporary Assistance for Needy Families
UM	Utilization Management
VBP4P	Value Based Pay for Performance

Section III – Vendor Information Sheet

Vendor Shall:

A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 shall be used for development of the contract;

B) Type or print responses; and

C) Include this Vendor Information Sheet in Section III of the Technical Proposal.

V1	Company Name	HealthInsight Assure, LLC

V2	Street Address	6830 W Oquendo Rd #102

V3	City, State, ZIP	Las Vegas, NV 89118

V4	Telephone Number		
	Area Code: 702	Number: 933-7333	Extension:

V5	Facsimile Number		
	Area Code: 702	Number: 385-4586	Extension:

V6	Toll Free Number		
	Area Code:	Number: 1-866-708-1944	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: Sharon Donnelly
	Title: SVP Strategy, HealthInsight Assure Board Chair
	Address: 756 E Winchester St Suite 200, Murray, UT 84107
	Email Address: SDonnelly@healthinsight.org

V8	Telephone Number for Contact Person		
	Area Code: 801	Number: 892-6668	Extension:

V9	Facsimile Number for Contact Person		
	Area Code: 801	Number: 892-0160	Extension:

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: Sharon Donnelly	Title: SVP Development, HealthInsight Assure Board Chair

V11	Signature ***(Individual shall be legally authorized to bind the vendor per NRS 333.337)***	
	Signature:	Date: 2-20-2018

Section IV – State Documents

Attachment	Document	Section Page
IV-A	Confidentiality and Certification of Indemnification	2
IV-B	Vendor Certifications	3
IV-H	Certification Regarding Lobbying	5
IV-1	State of Nevada – Amendment 1	6
IV-2	State of Nevada – Amendment 2	25
IV-3	Vendor Licensing Agreements (Not Applicable)	27
IV-4	HEDIS Auditor Certification	28
IV-5	DataStat HEDIS Certification	33
IV-6	QIO-Like Certification	34
IV-7	Nevada Business License	36

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **shall not** be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information. In accordance with the submittal instructions of this RFP, vendors are requested to submit confidential information in separate files marked "**Part IB Confidential Technical**" and "**Part III Confidential Financial**".

The State shall not be responsible for any information contained within the proposal. If vendors do not comply with the labeling and packing requirements, proposals shall be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that shall be in an open meeting format, the proposals shall remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act shall constitute a complete waiver and all submitted information shall become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information.

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part IB – Confidential Technical Information			
YES		**NO ✓**	
Justification for Confidential Status			
N/A			

Part III – Confidential Financial Information			
YES		**NO ✓**	
Justification for Confidential Status			
N/A			

Company Name
HealthInsight Assure, LLC

Signature

Print Name
Sharon Donnelly

Date
2-20-2018

This document shall be submitted in Section IV of vendor's technical proposal

ATTACHMENT B – VENDOR CERTIFICATIONS

Vendor agrees and shall comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and shall not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.

(2) All proposed capabilities can be demonstrated by the vendor.

(3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.

(4) All proposal terms, including prices, shall remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, shall remain in effect throughout the contract negotiation process.

(5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals shall be made in good faith and without collusion.

(6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion shall be in writing and included in the proposal at the time of submission.

(7) Each vendor shall disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict shall be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest shall automatically result in the disqualification of a vendor's proposal. An award shall not be made where a conflict of interest exists. The State shall determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

(8) All employees assigned to the project are authorized to work in this country.

(9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.

(10) The company has a written policy regarding compliance for maintaining a drug-free workplace.

(11) Vendor understands and acknowledges that the representations within their proposal are material and important, and shall be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.

(12) Vendor shall certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

(13) The proposal shall be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

Vendor Company Name
HealthInsight Assure, LLC

Vendor Signature

Print Name
Sharon Donnelly

Date 2-20-18

This document shall be submitted in Section IV of vendor's technical proposal

ATTACHMENT H – CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or shall be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or shall be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By:

Sharon Donnelly — 2-20-18

Signature of Official Authorized to Sign Application — Date

For: HealthInsight Assure, LLC

Vendor Name

External Quality Review

Project Title

This document shall be submitted in Section IV of vendor's technical proposal

State of Nevada
Department Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 1to Request for Proposal 3491
RFP TITLE:	External Quality Review Organization (EQRO)
DATE OF AMENDMENT:	February 2, 2018
DATE OF RFP RELEASE:	January 10, 2018
OPENING DATE:	February 22, 2018
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Purchasing Officer II

The following shall be a part of RFP ***3491.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

RFP CHANGES:

1. Old language:

2.2.5 As described in (described in §438.310(c)(2)) an EQRO may not:

New language:

2.2.5 As described in (described in §438.**354**(c)(2)) an EQRO may not:

2 Old language:

2.1.5 Technical Assistance and Optional Activities

The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.58(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of health care initiatives. Optional activities described in 42 CFR 438.358(c) may include:

New language:

2.1.5 Technical Assistance and Optional Activities

The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR **438.358**(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of health care initiatives. Optional activities described in 42 CFR 438.358(c) may include:

3. ***RFP section deletions:***

RFP Section 2.2.9 to be deleted in its entirety.

4. ***RFP ATTACHMENT G – COST PROPOSAL REVISED:***

Vendors to submit cost on the following revised cost proposal:

EQRO Cost Sheet
Revised 2.1.18.xlsx

QUESTIONS AND ANSWERS:

1. Vendor Duties and Responsibilities-1.5-7-The RFP requests that vendors be available for regular meetings, including teleconference and face-to-face meetings in Nevada; however, the Cost Schedule provided in Attachment G does not include a category for teleconference and face-to-face meetings to be priced by vendors. Will the DHCFP consider issuing a Cost Schedule that includes meetings, as it has in prior RFPs?

   Yes, the Cost Schedule will be amended to include web meetings, teleconferences, and face to face meetings.

2. 2.1 and Attachment G – Cost Schedule-2.1.5.4.A, B, C-12 and 41-There does not appear to be a designated column on the Optional Activities Cost Schedule for the new Nevada ABD managed care expansion program. Under which column(s) should the vendor price the optional activities for the ABD managed care expansion program?

   Refer to the beginning of this amendment. Attachment G has been revised.

3. Attachment G – Cost Schedule--41-The entries in the Cost Schedule column labeled "RFP Citation" do not align with the RFP citations for the activities listed in Section 2. Will the DHCFP consider issuing a revised Cost Schedule to help ensure vendors address the correct RFP requirements for each price proposed?

Refer to beginning of this amendment for RFP submittal change.

4. Attachment G – Cost Schedule--41-Please confirm that not all cells on the Cost Schedule require that a price be entered. For example, on the Optional Activities schedule, the row for Technical Assistance – Onsite contract compliance audit of the contracted CMO vendor will only have a price under the CMO-FFS column.

Refer to the beginning of this amendment. Attachment G has been revised.

5. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Are there current contract requirements or other guidance for the MCOs and PAHP for Network Adequacy?

There are current network adequacy standards outlined in the MCO RFP 3260 Section 3.7.5 Access and Availability, and DBA RFP 3425 Section 3.6.5 Access and Availability.

6. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-What are the current network adequacy standards for the MCOs and PAHP?

Refer to MCO RFP 3260 Section 3.7.5 Access and Availability, and DBA RFP 3425 Section 3.6.5 Access and Availability.

7. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Has the State of Nevada developed the new managed care requirements, related to time and distance standards, format for annually certifying adequacy of their networks?

Refer to MCO RFP 3260 Section 3.6.3.2. Twenty-Five Mile Rule.

8. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Does Nevada contract with MCOs or PAHPs for long term services and supports?

Refer to MCO RFP 3260 Section 3.4.4.2 Excluded Populations, Services and Coverage Limitations for Individuals Enrolled in Managed Care. The DHCFP does not contract with the DBA for adult dental services.

9. 2.1.2.4-Conduct of PIPs in addition to those conducted by health plan; page 8-Please clarify who would be conducting these PIPs?

The selected EQRO vendor may be asked to conduct PIP activities in addition to the validation of MCO PIP activities.

10. 2.1.2.4-Conduct of PIPs in addition to those conducted by health plan; page 8-What is the EQRO's role with PIPs in addition to those conducted by health plan?

The EQRO's role would be to validate additional PIPs conducted by the PCCM/CMO related to Pay for Performance Measures (P4P).

11. 7-2.1.3-Validation of MCO, DBA/PAHP and CMO Performance Indicators; page 8-Which measures are the HEDIS measures?

The State does not understand this question. Is the vendor looking for a list or an amount of the HEDIS and non-HEDIS measures?

12. 2.1.3-Validation of MCO, DBA/PAHP and CMO Performance Indicators; page 8-Which measures are not HEDIS and will be validated using the CMS protocol?

Refer to the response provided in question 11.

13. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-Does DHCFP have a preference for whether the PIP topics are selected by DHCFP, the MCO or the EQRO?

Historically, the DHCFP has collaborated with both MCO and EQRO vendors to determine PIP topics based from performance measure data for the MCO vendors.

14. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-Does DHCFP have a preference for the selection of a single PIP topic across all MCOs or for allowing MCOs to select distinct and separate PIP topics?

The DHCFP has had the same PIPs across plans as well as selected distinct and separate PIPs. PIP selection is determined by performance indicators, as well as determined with Nevada Department of Health and Human Services health goals and objectives in mind.

15. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-If the MCO is allowed to select the PIP topic, is the topic vetted and approved by DHCFP or the EQRO before implementation?

Yes.

16. 2.1.3.5-Validation of the Nevada DHCFP State QAPIS in SFY 2019 and each subsequent EQR contract renewal year; page 9-Can the state provide more detail about what data or documents the EQRO might review as part of the QAPI to measure objectively the progress and status of Value Based Purchasing?

Validating performance measure data related to pay for performance programs outlined within CMO, MCO, or DBA contracts.

17. 2.1.4-Compliance Review; page 10-How many sections are in the compliance review?

IQAP Compliance Review Calendar		
Standard Number	Compliance Review Standard	Review Year
I	Internal Quality Assurance Program	**FY 2020**
II	Credentialing and Recredentialing	**FY 2018**
III	Member Rights and Responsibilities	**FY 2019**
IV	Member Information	**FY 2019**

V	Availability and Accessibility of Services	**FY 2018**
VI	Continuity and Coordination of Care	**FY 2019**
VII	Grievance and Appeals	**FY 2019**
VIII	Subcontracts and Delegation	**FY 2018**
IX	Cultural Competency Program	**FY 2020**
X	Coverage and Authorization of Services	**FY 2019**
XI	Provider Dispute and Complaint Resolution	**FY 2018**
XII	Confidentiality and Recordkeeping	**FY 2020**
XIII	Provider Information	**FY 2018**
XIV	Enrollment and Disenrollment	**FY 2020**
XV	Program Integrity	**FY 2020**

18. 2.1.5-Technical Assistance and Optional Activities; pages 10-11-Can you clarify whether cost information for the Technical Assistance and Optional activities described in Section 2.1.5 is requested for the Cost Proposal at this time; or whether it should be provided after a specific request and scope of work is provided by DHCFP (as indicated at the end of 2.1.5)?

    After a specific scope of work and request for costs is provided by the DHCFP.

19. 2.2.9-ICD-9 and EDI compliance; page 14-Section 2.2.9 indicates the vendor must maintain ICD-9 and EDI compliance as defined by CMS. Could the state cite the CMS regulations to which this compliance refers?

    Refer to beginning of this amendment for RFP submittal change.

20. 2.4.1-Implementation; page 15-Is a preliminary work plan required as part of the proposal?

    A preliminary work plan is not required as part of the RFP.

21. 9.2-Proposal Evaluation and Award Process, page 28-Is there a state statute, regulation or written rule that describes in more detail the specifics for the 5% discount for Nevada-based businesses? If not, can DHCFP elaborate on the criteria used to determine the 5% discount?

    Refer to Assembly Bill 280 dated March 13, 2017.

22. 7.-RFP Timeline; page 21-Is there a meeting of interested bidders prior to the submission of the bid?

    No.

23. 8.2.2.5-Part IA-Technical Response, Section V-Scope of work; page 24-Are there instructions on preferred response content for the Scope of Work sections?

    The State has no additional instructions. The State will accept a clarifying question.

24. 8.2.2.5-Part IA-Technical Response, Section V-Scope of work; page 24-The instructions indicate that the vendor shall place their responses to the technical sections immediately following the applicable RFP question, statement, and/or section. Does this mean that the vendor must respond to every section/subsection individually or can sections/subsections be combined where it makes sense?

Vendors shall respond to the Scope in its entirety.

25. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -The cost spreadsheet has citations that are supposed to be directed back to the RFP, but they are missing digits. For example, on the first line of the spreadsheet for the Activity of Performance Improvement Project Validation, one of the citations is 2.3.3. We cannot find a 2.3.3 in the RFP.

    Refer to beginning of this amendment for RFP submittal change.

26. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -In the cost spreadsheet, under Optional Activities, there is an Activity for Consulting. The citation is 2.5.6, but there is no 2.5.6 in the RFP. We believe it references Section 2.1.5.6 regarding consulting, however there is no scope of work (SOW) for that. In fact, this page (12) implies that a SOW would be submitted in writing from the state after the contract is awarded to the EQRO so that the EQRO may submit a cost proposal at that time. Can the state provide details for the consulting work if it is intended to be part of the cost proposal for this RFP?

    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

27. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -In the cost spreadsheet, can you clarify which Optional Activities that you expect proposed cost for at this time?
    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

28. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -For Optional Activities that do not include a scope of work, are you requesting hourly rates?
    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

29. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -For Optional Activities that do not include a scope of work, are these sections to be completed once a final vendor is selected and scope of work is provided?

    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

30. Section 2.1.3, Scope of Work, page 8. Can the State clarify the total number of plans that would undergo a Performance Measure Validation audit?

    3 MCOs, 1 DBA, and 1 CMO.

31. Section 2.1.3, Scope of Work, page 8. Can the State clarify the total number of HEDIS and non-HEDIS measures that it will require each of the entities to report or a maximum number of performance measures to be validated?

    MCOs- 26 HEDIS measures (9 hybrid measures).
    DBA- 1 HEDIS measure, and 3 non-HEDIS measures.
    CMO-22 HEDIS like measures.

32. Section 2.1.3, Scope of Work, page 8. Can the State clarify the number of hybrid measures that is expects each entity to report on?

Refer to the response provided to question 31.

33. Section 2.1.3, Scope of Work, page 8. Can the State clarify its expectations for the timing of performing the performance measure validation audits?

The start of this activity usually begins in January and the final audit report is presented in July.

34. Section 2.1.4, Scope of Work, page 10. It states "Conduct a compliance review evaluating the effectiveness of the quality strategy within the previous 3 years. This review will be broken out in sections to be reviewed annually." Can the State clarify as to what is meant by "broken out into sections to be reviewed annually"? What sections must be reviewed in SFY19?

Refer to the response provided to question 17.

35. Section 2.2.8 Qualifications of External Quality Review Organizations, page 14. Can the State clarify why an NCQA-Certified Health Employer Data Set (HEDIS) Compliance Auditor is a required position if the validation of performance measure activity can be conducted using the Centers for Medicare & Medicaid Services (CMS) Validating Performance Measure Protocol, which does not require the use of an NCQA-Certified HEDIS Compliance Auditor?

State choice.

36. Section 9, Proposal Evaluation and Award Process, page 27. RFP indicates "Conformance with the terms of this RFP" carries a weight of 10%. Does the submission of modifications/exceptions to the contract terms and conditions have any impact on the scoring of the vendor's proposal?

The evaluation committee may take into consideration any modifications/exceptions when scoring.

37. Section 9.8, part of Proposal Award and Evaluation, page 28. This section indicates "A Letter of Intent (LOI) shall be issued in accordance with NAC 333.170 notifying vendors of the State's intent to award a contract to a vendor, pending successful negotiations." Is the LOI sent directly to all vendors or posted on the website or provided in a different way?

The LOI only goes to the proposing vendors.

38. Section 10, Terms and Conditions, page 29 and Attachment C, Contract Form, page 37. Is the State willing to negotiate the terms and conditions of the contract? If yes, where should vendors include contract modifications/exceptions, e.g., attachment to cover letter, appendix of RFP response, etc.?

No.

39. General Question. Please provide the names of vendors who submitted questions. If the State is unable to provide the names, please provide the number of vendors who submitted questions.

Health Insight Assure, LLC; HSAG.

40. General Question. Health Services Advisory Group (HSAG) is the incumbent. What is the annual contract value and hours in their current contract? Is the scope of work requested in this RFP substantially similar to the current work being provided by HSAG?

The scope of work outlined within the RFP is similar to the current HSAG contract with the exception of some of the optional activities listed, as the DHCFP has potential to include the activities, but forward movement related to expanding coverage of the managed care populations and service areas has not yet been solidified.

41. General Question. What is the maximum budget for this project?

The State chooses not to disclose this information.

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

More than one MCO is currently NCQA accredited. This is not a current State of Nevada requirement.

43. 2.1.3.2-8-Can the vendor subcontract with a Certified HEDIS Compliance Auditor to conduct the validation of performance indicators task or is a NCQA licensed organization required?

Refer to RFP 3491 Section 2.2.8.

44. 2.1.3.2.A-8-Does DHCFP currently require submission of HEDIS data using IDSS to NCQA? Will DHCFP require this in the future?

Yes, it is currently submitted via IDSS and we foresee no change in this process.

45. 2.1.3.2.A-8-Will DHCFP require or expect the MCOs and CMO to report their HEDIS performance measures to NCQA? If yes, are the MCOs and CMO required to publicly report their HEDIS results?

The current EQRO vendor reports the performance measures to NCQA. The DHCFP publicly reports the performance measures within our External Quality Review Annual Technical Report.

46. 2.1.3.2.A-8-Are all performance measures HEDIS or are other types of measures included as well?

MCO- Currently, all MCO performance measures are HEDIS, but the state has used non-HEDIS measures before, and may elect to use them in the future.
CMO- There are 22 performance measures that are validated by the EQRO vendor. They are non-HEDIS measures.
DBA- 1 HEDIS and 3 non-HEDIS measures are validated for this program.

47. 2.1.3.3-8-Confirm the CMO is not required to conduct PIPs (only the MCOs and PAHP will conduct PIPs). If the CMO is required to conduct PIPs, how many? And, clinical or non-clinical?

The CMO is not currently conducting PIPs.

48. 2.1.3.3-8-Can DHCP provide a list of PIP topics currently underway or expected to be implemented?

The SFY 2017 Technical Report can be located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

49. 2.1.3.6-9-Will the vendor develop the first annual technical report using the current EQRO's audit information/reports?

Yes. The information is owned by the DHCFP.

50. 2.1.3.6-9-What is the due date to submit the first annual technical report to DHCFP?

Technical Reports are due October 2018.

51. 2.1.3.6.H-10-Can you provide a copy of the latest QAPIS and Performance Tracking Tool?

Please refer to the DHCFP Managed Care Report link located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

52. 2.1.4-10-Confirm the Compliance Review standards are broken out and approximately 1/3 of the standards will be reviewed annually. So in a three year period, a comprehensive review is completed.

Refer to question 17 of this amendment.

53. 2.1.4-10-Are the Compliance Reviews to be conducted on-site or via desktop? 2.1.4-10-What programs are to be reviewed under the Compliance Reviews? MCO, DBA/PAHP, and CMO?

Compliance reviews are conducted for all MCOs and the DBA. MCO/DBA compliance reviews have both on-site and desktop components. The last CMO compliance review was conducted in FY 2015 and the report, which outlines the review standards can be located here: http://dhcfp.nv.gov/Pgms/BLU/HCGPOriginal/ Nevada DHCFP is proposing to phase out of the CMO program, and if phase out is completed, then the CMO contract will end June 30, 2018. Nevada may elect to implement a similar program in the future, which may require EQRO compliance efforts.

54. 2.1.5.1. C-11-Please define what DCHFP means by "omission studies"?

During an encounter data validation, an EQRO vendor will often speak to the encounter data completeness and accuracy. This would include information related to data omission rates for various services.

55. 2.1.5.2-11-Provide clarification regarding the differences between the CMO, the Care Coordination Vendor, and the CMO Vendor.

2.1.5.2A. and B. are both referencing the same vendor. Currently, DHCFP has a contract with our CMO vendor through June 2018. This contract may not be extended if the CMO program is phased out, however a similar vendor/service for care coordination may exist in the near future (2019).

56. 2.1.5.2-11-Are activities A and B mandatory activities for the Nevada Medicaid Care Coordination program?

Yes, they are part of the Special Terms and Conditions of the waiver.

57. 2.1.5.6-13-Should the vendor submit technical assistance costs as part of the cost proposal or will costs be submitted on a case-by-case basis when a request is received from DHCFP?

These can be submitted on a case-by-case basis with a SOW when request is received from the Division.

58. 2.2.9-14-"Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for contractor's compliance."

This is not a question.

59. How does this statement apply to tasks under the EQRO scope of work? Can you provide a reference to the specific regulation this requirement refers to?

Refer to the beginning of this amendment. Section 2.2.9 has been removed.

60. Section 4- page 20-Can DHCFP revise the cost proposal template and shade or block the cells that do not require a cost (as not all tasks are being completed for each entity)? This will eliminate additional costs that are not necessary.

The Division has provided an updated cost proposal template. Cells for costs that are not necessary or that cannot be determined without an additional SOW have been removed.

61. Section 4- page 20-Clarify which tasks require a separate Title XIX (Medicaid) and XXI (CHIP) cost. For example, one Annual Technical Report will address Medicaid and CHIP. Would DHCFP like for the costs of one Annual Technical Report be broken down to the Medicaid and CHIP level?

Yes.

62. Section 4- page 20-Confirm a total (all three MCOs) Medicaid and CHIP cost should be provided for each activity and not a per MCO cost.

Costs should be broken out as outlined within the cost proposal template. The template does not allow for costs to be broken out by each separate MCO.

63. Section 4- page20-Please revise the RFP citations on the cost proposal template. The citations are not consistently matching up with the RFP. For example, references in the cost proposal template are based on three numbers X.X.X and references in the RFP are based on four numbers X.X.X.X.

Refer to beginning of this amendment for RFP submittal change.

64. Section 4- page 20-For Attachment G, detail is requested for the cost. Please give examples of what is expected.

Refer to the answer provided for question 60. Additional detail will not be provided at this time.

65. 1. PROJECT OVERVIEW-1.5-7-The RFP requests that vendors be available for regular meetings, including teleconference and face-to-face meetings in Nevada; however, the Cost Schedule provided in Attachment G does not include a category for teleconference and face-to-face meetings for pricing by vendors. Will the DHCFP consider issuing a Cost Schedule that includes meetings, as it has in previous RFPs?

See revised cost schedule at the beginning of this amendment.

67. 2. SCOPE OF WORK-2.1.2.1-7-Does the DHCFP anticipate conducting the encounter data validation study for the DBA in FY 2019 or FY 2020?

FY 2019

68. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Please confirm the anticipated number of entities to be considered in the studies (i.e., MCOs, FFS, PAHP).

Possibly 3 MCOs, 1 DBA, 1 CMO, and FFS.

69. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Will the data necessary to complete focused study analyses be obtained from the managed care entities (i.e., MCOs, PAHP, etc.), from the DHCFP, or through a direct connection to the DHCFP's data systems?

Depending on the study the data may come directly from managed care organizations, the DBA, or from the Division.

70. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Has the DHCFP identified clinical or non-clinical focused study topics for the first contract year? Are there clinical or non-clinical areas of interest to the DHCFP for purposes of studies on quality?

Topics have not yet been identified for the contract period.

71. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Please clarify the DHCFP's expectations regarding the frequency and timing of the focused studies (i.e., one study per year to be completed during the contract year).

The DHCFP has not determined the number of optional studies to be conducted during the contract period.

72. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

The study topic will likely determine the data sources. Previous studies have included administrative data, hybrid, and surveys.

a. If a hybrid methodology is requested, will the selected study sample be based on a statewide sample, or should the sample be stratified by FFS/MCOs such that inter-plan comparisons can be made?

It is likely that the sample would be stratified by FFS/MCO so that inter-plan comparisons can be made.

73. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.3-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, do the FFS/MCOs' provider contracts outline any requirements for the procurement and submission of medical records to the EQRO?

Reference RFP 3260 Section 3.10.18.1 Accessibility and Availability of Medical Records.

74. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11- As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, do the FFS/MCOs have a minimum required timeframe to procure and submit medical records for a focused study?

Timeframes for data submission specific to special projects are usually presented to the MCOs and adjusted if needed after discussion. A calendar of project deliverables and deadlines are provided to the plans for adherence.

75. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, will the FFS/MCOs be expected to procure and submit requested medical records to the EQRO for abstraction, or will the EQRO be required to abstract the medical records from either physician offices and/or the FFS/MCOs' offices?

The FFS/MCOs will be expected to procure and submit requested medical records to the EQRO.

76. 2. SCOPE OF WORK-2.1.3.4-9-Will the vendor be responsible for creating a crosswalk of MCO provider specialty types for all three MCOs and the FFS program to ensure consistency in categorizing providers?

Yes.

77. 2. SCOPE OF WORK-2.1.3.4-9-Will the vendor be responsible for working with the DHCFP to create network adequacy standards for specialty providers if such standards are not currently defined?

The DHCFP plans on adopting network adequacy standards as established by the Division of Insurance; however, for specialty providers that the DOI have not assigned network

adequacy standards for the DHCFP will require the EQRO to assist in identifying/establishing standards for the remaining provider specialties identified within 42 CFR 438.68(b).

78. 2. SCOPE OF WORK-2.1.3.4-9-Is the DHCFP interested in validation results reported for a specific list of provider specialties or provider groups? How many provider specialties does the DHCFP anticipate including in the analysis for each managed care entity (i.e., MCOs, and DBA/PAHP)?

Refer to the last DHCFP network adequacy report located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/
Future reporting requirements may not exactly mirror previous reports. The Division consults with the Department of Health and Human Services prior to proceeding with Network Adequacy studies to incorporate their recommendations.

79. 4. COST-4-20-The RFP states, "Vendors must provide detailed fixed prices for all costs associated with the responsibilities and related services. Clearly specify the nature of all expenses anticipated."

a. In addition to completing Attachment G, Cost Schedule, does the DHCFP require detail on all direct costs associated with the tasks, as well as a budget narrative?

The DHCFP does not require additional cost information outside of the documentation required within Attachment G.

80. 2. SCOPE OF WORK-2.1.5-10 - 11-The RFP states, “The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.58(c)....” Please confirm this citation should be 42 CFR 438.358(c), as stated later in the text.

The correct citation is 42 CFR 438.358 (C). Refer to the beginning of this document.

81. 2. SCOPE OF WORK-2.1.5-10, 11-The last sentence in the cited paragraph states, "Optional activities…may include." The list that follows, 2.1.5.2.a and b, includes compliance audit and performance measure validation for the CMO vendor, which are also listed in the requirement at 2.1.1 for the vendor to perform mandatory activities for the CMO, inclusive of a compliance review (2.1.1.3) and performance measure validation (2.1.1.2).

a. For purposes of completing the cost schedule, please clarify whether these are optional or mandatory activities the vendor must perform.

These are optional activities.

83. 2. SCOPE OF WORK-2.1.5.2 B-11-Will the vendor be required to provide a validation of source data (claims processing vendor) as part of the validation of performance measures for the DHCFP's CMO vendor?

Yes.

84. 2. SCOPE OF WORK-2.1.5.3-11-Does the DHCFP anticipate the vendor will be required to produce two Quality Rating Systems—one for Nevada Check Up and one for Medicaid?

Yes, one quality rating system inclusive of both Nevada Check Up and Medicaid beneficiaries.

85. 2. SCOPE OF WORK-2.1.5.4 C-12-Other than conducting performance measure calculation and/or validation, can the DHCFP clarify the activities associated with the evaluation of the implementation of performance measures for the ABD population?

The EQRO would calculate and validate the ABD performance measures.

86. 2. SCOPE OF WORK-2.1.5.4.B-12-The RFP references the need to conduct an information systems (IS) readiness review of a new ABD MCO vendor. Should this also include an operational readiness review that contains the elements described in 42 CFR 438.66(d)(4)?

Yes.

87. 2. SCOPE OF WORK-2.1.5.5.B-12-The RFP references the need to conduct an information systems (IS) readiness review of a new MCO vendor for rural county expansion. Should this also include an operational readiness review that contains the elements described in 42 CFR 438.66(d)(4)?

Yes.

88. 2. SCOPE OF WORK-2.1.5.4.A, B, C-12 & 41-There does not appear to be a designated column on the Optional Activities Cost Schedule for the new Nevada ABD managed care expansion program. Under which column(s) should the vendor price the optional activities for the ABD managed care expansion program?

Attachment G has been revised. Optional activities will be priced by project when a request and SOW is provided to the vendor. Refer to the beginning of this document.

89. 2. SCOPE OF WORK-2.2.5-13-The Code of Federal Regulations citation listed as the reference for the EQRO independence requirements (i.e., §438.310(c)(2) appears to be incorrect. Please confirm the DHCFP intended to refer instead to §438.354(c)(2).

§438.354(c)(2)is the correct citation. Refer to the beginning of this amendment.

90. 2. SCOPE OF WORK-2.2.9-14-Subsection 2.2.9 states, "Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance, as defined by CMS regulation and policy."

    a. Compliance with ICD and EDI are more applicable to the original data submitters, as opposed to secondary data users. Please clarify what constitutes compliance with ICD and EDI for secondary data users.

    Refer to the beginning of this amendment. Section 2.2.9 has been removed.

91. 2. SCOPE OF WORK-2.4.3 -15-The RFP states, "Unless otherwise agreed to by the DHCFP, submit to the DHCFP, within a minimum of ten (10) working days of the service state date, all deliverables to permit any DHCFP identified modifications." Will the DHCFP please specify the deliverables it expects to receive within 10 working days of the service start date? Are these

separate from the work plan, noted in Section 2.4.1 of the RFP, which is due no later than one month following notification that the vendor has been awarded the contract?

The work plan is to be delivered within one month from the notification of contract award. Within 10 days of the service start date the vendor will supply a list of all deliverables they are requesting modifications be made for. The DHCFP will have 20 working days from receipt to respond to the requested modifications/revisions. If the DHCFP does not respond by the 20th working day after receipt, then the DHCFP's approval of the submission will be assumed as granted.

92. 2. SCOPE OF WORK-2.1.1.2-7-Will the DBA performance measures be standardized measures or measures developed by the DHCFP?

DBA- 1 HEDIS and 3 non-HEDIS measures

93. 2. SCOPE OF WORK-2.1.1.2-7-If the DHCFP-developed performance measures are used, will the DHCFP update and maintain the methodologies, or will the vendor update and maintain the methodologies?

The vendor will update and maintain the methodologies.

94. 2. SCOPE OF WORK-2.1.1.2-7-Will the vendor be responsible for updating and maintaining the performance measure specifications for the CMO?

Yes.

95. 2. SCOPE OF WORK-2.1.1.2-7-Will the vendor provide technical assistance in determining or selecting performance measures for the CMO program?

The current vendor provided technical assistance with selecting performance measures for the CMO. CMO performance measures were identified at the beginning of the demonstration waiver. The demonstration waiver will expire 6/30/2018.

96. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will the vendor be required to administer a survey?

Yes.

97. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm only one (1) reporting unit (i.e., the entire Nevada Medicaid FFS population) will be sampled.

This is true of the current project. Future projects may differ in scope. The DHCFP would provide a request outlining the SOW of future projects and request a cost proposal at that time.

98. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will both adult and children be surveyed?

The population and type of CAHPS survey(s) would be determined prior to implementing the optional activity. The vendor would be provided a SOW and a cost proposal would be requested by DHCFP prior to initiating the project.

99. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. If children are surveyed, which version of the CAHPS survey instrument will be required for administration:

    (1) the Child Medicaid CAHPS Survey without the Children with Chronic Condition measurement set or;

    (2) the Child Medicaid CAHPS Survey with the Children with Chronic Conditions measurement set?

    See question 98 of this amendment.

100. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. How many supplemental items will be added to the standard CAHPS surveys?

    The DHCFP would determine project details once it is decided to move forward with the optional activity.

101. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm whether the DHCFP requires oversampling.

    In the event DHCFP selects this optional activity the Division would require oversampling.

102. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. In which languages will the surveys be administered?

    In the event DHCFP selects this optional activity the surveys would likely be administered in English and Spanish.

103. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm a standard mixed-mode methodology will be employed for all survey administration activities (i.e., two mailings, two reminder postcards, and telephone follow-up).

    The DHCFP would determine project details once it is decided to move forward with the optional activity.

104. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will survey results be submitted to the NCQA and/or AHRQ's CAHPS Health Plan Survey database?

    Yes.

105. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. What deliverables will be required for this activity?

The DHCFP would determine project details once it is decided to move forward with the optional activity.

106. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will the vendor be required to validate?

In the event DHCFP selects this optional activity the vendor would be required to validate.

107. 2. SCOPE OF WORK-2.1.2.3-8-Regarding the calculation performance measures, in addition to those reported by health plans, does the DHCFP anticipate having the vendor calculate hybrid measures?

Measures for this optional activity have not yet been selected. It is possible that hybrid measures may be selected.

108. 2. SCOPE OF WORK-2.1.2.3-8-Please confirm the vendor will validate both clinical and non-clinical PIPs, for a total of five (5) PIPs per MCO to be validated.

RFP 3491 Section 2.1.3.3 states that mandatory activities would include the validation of 2 clinical PIPs and 3 non-clinical PIPs (5 PIPs) per MCO; and one clinical PIP and one non-clinical PIP for the DBA.

109. 2. SCOPE OF WORK-2.1.2.3-8-Please provide the approximate number of measures the vendor will be required to calculate for the FFS population.

Currently, there are 9 administrative measures that are calculated for the FFS population.

110. 2. SCOPE OF WORK-2.1.2.3-8-Please provide the number of sub-populations within the FFS population the vendor will be required to calculate measures.

The FFS performance measures are: Follow up after hospitalization after hospitalization for Mental Illness (FUH), Mental Health Utilization (MPT), Follow up after ED visit foe Mental Illness, Follow up after ED visit for ETOH and other Drugs, Use of opioids at high dosage (UOD), Use of opioids from multiple providers (UOP), Children and Adolescents access to primary care (CAP), Annual Dental Visit (ADV), and Adult Access to primary care (AAP).

111. 2. SCOPE OF WORK-2.1.2.6-8-Please clarify the type of assistance that will be required for the Quality Rating System for the FFS population. Will this assistance be limited to technical assistance or development and production of a Quality Rating System?

Development and production of the QRS.

112. 2. SCOPE OF WORK-2.1.3.2 C & D-8-Please confirm if the DHCFP anticipates including both Medicaid and CHIP HEDIS rates in the comparative analysis? If yes, does the DHCFP anticipate receiving separate reports for each population or a single report only?

The expectation is the Medicaid and CHIP rates will be included in a comparative analysis within in a single report. Please refer to our previous Technical Reports for more information.
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

113. 2. SCOPE OF WORK-2.1.3.2 A-8-The RFP states that validation will be required for HEDIS and other performance measures. Will the DHCFP provide a list of the non-HEDIS measures that are required for reporting by the MCO, DBA/PAHP, and CMO? Are any of the non-HEDIS measures required to use hybrid methodology?

Currently there are 26 HEDIS measures for the MCOs, 1 HEDIS and 3 non-HEDIS measures for the DBA, and 22 HEDIS like measures for the CMO. The non-HEDIS measures for the DBA have not yet been determined, and it is uncertain the number that may use a hybrid methodology at this time.

114. 3. COMPANY BACKGROUND AND REFERENCES-3.4-20 & 40-Section 3.4 states that a resume is required "for each key personnel…;" however, Attachment F indicates a resume is to be completed "for all proposed prime contractor staff and proposed subcontractor staff." Due to a significant difference in the number of resumes potentially required, please confirm whether the DHCFP requires submission of all proposed vendor and subcontractor staff resumes or only resumes for those designated as key vendor and contractor personnel.

Submit forms for all proposed contractor and subcontractor staff.

115. 9. PROPOSAL EVALUATION AND AWARD PROCESS-9.1-27-The scoring for cost indicates that the total cost for the proposal will be included in the cost formula to determine the cost criteria score. There are several tasks listed in Section 2.1.5 Technical Assistance and Optional Activities, that may or may not be requested by the DHCFP, which are included in the cost schedule in Attachment G. Further, Section 2.1.5.6 does not specify the tasks related to technical assistance or consulting, but the activity seems to be referenced in the cost schedule in Attachment G. Would the DHCFP consider removing costs associated with undefined technical assistance and consulting from the cost formula to determine the cost criteria score?

No, cost must be evaluated per NRS 333. However, the cost has been revised. Refer to beginning of this amendment.

116. 9. PROPOSAL EVALUATION AND AWARD PROCESS-9.6-28-This requirements states, "Each vendor shall include in its proposal a complete disclosure of any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation or investigations pending which involves the vendor or in which the vendor has been judged guilty or liable." Please provide the proposal part and section in which the State would like the response, even if there is nothing to report.

Refer to Section 3.1.7 of RFP 3491.

117. ATTACHMENT E – REFERENCE QUESTIONNAIRE-Attachment E-39-There is an inconsistency between the Instructions to Proposing Vendor and the Reference Questionnaire regarding where the Reference should be returned. The Instructions to Proposing Vendor states it should be returned to: rlmiller@admin.nv.gov. However, the Reference Questionnaire states:

Business reference is requested to submit the completed Reference Questionnaire via email or facsimile to:

State of Nevada, Purchasing Division
Subject: RFP 3491

Attention: Purchasing Division
Email: rfpdocs@admin.nv.gov
Fax: 775-684-0188

Please confirm the correct e-mail address for the return of the Reference Questionnaire.

The correct e-mail is rlmiller@admin.nv.gov

118. ATTACHMENT F– PROPOSED STAFF RESUME-Attachment F-40-Please clarify what is expected in the field entitled, "# of Years in Classification". Is this the number of years the staff member has been in their current position?

This is the number of years doing this type of service.

119. ATTACHMENT G – COST SCHEDULE-Attachment G-41-The entries in the Cost Schedule column labeled "RFP Citation" do not align with the RFP citations for the activities listed in Section 2. Will the DHCFP consider issuing a revised Cost Schedule to help ensure vendors address the correct RFP requirements for each price proposed?

Refer to beginning of this amendment for RFP submittal change.

120. ATTACHMENT G – COST SCHEDULE-Attachment G-41-Please confirm that not all cells on the Cost Schedule require that a price be entered. For example, on the Optional Activities schedule, the row for Technical Assistance – Onsite contract compliance audit of the contracted CMO vendor will only have a price under the CMO-FFS column.

The Cost Schedule has been revised. Please review revised Attachment G at the beginning of this amendment.

ALL ELSE REMAINS THE SAME FOR RFP 3491

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: HealthInsight Assure, LLC

Authorized Signature:

Sharon Donnelly, MS
SVP, Development
Title: Assure Board Chair Date: 2-20-18

This document must be submitted in the "State Documents" section of vendors' technical proposal.

State of Nevada
Department Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 2 to Request for Proposal 3491
RFP TITLE:	External Quality Review Organization (EQRO)
DATE OF AMENDMENT:	February 8, 2018
DATE OF RFP RELEASE:	January 10, 2018
OPENING DATE:	February 22, 2018
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Purchasing Officer II

The following shall be a part of RFP ***3491.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

Clarification from Amendment 1:

Old Response:

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

    More than one MCO is currently NCQA accredited. This is not a current State of Nevada requirement.

New Response:

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

    The MCO's are required to be accredited by a nationally recognized organization that provides an independent assessment of the quality of care provided by the vendor.

QUESTIONS & ANSWERS:

1. Since the State re-issued a new version of Attachment G Cost Proposal form, will the State please answer the following clarification questions:

    a. New Attachment G - Cost Proposal Form: Is the State expecting a price for each cell in this new Attachment (whether or not the Activity may be applicable to the listed column/program/entity)?

No. Cells that are not applicable shall be marked N/A.

b. New Attachment G - Cost Proposal Form: If PIPs are not currently conducted by the CMO-FFS entity, is the Vendor allowed to list a $0 price in the validation of performance improvement project cost cells? If not allowed, in what year does the State expect this Activity to be applicable to the CMO-FFS entity/program?

The state has no expectation of PIP activities for the current CMO-FFS vendor, and the state does not have a projected date of activity for future CMO-FFS vendors/projects. Please indicate N/A in cells that a cost is not applicable.

c. New Attachment G - Cost Proposal Form: If an Activity can be conducted under one entity/program, but cover multiple entities/programs, does the State want one price in the appropriate column (e.g., MCO Title XIX) and other columns/entities/programs listed with $0 (e.g., MCO Title XXI) or does the State want costs to be allocated across all columns/entities/programs?

The state expects a cost per activity by population (MCO Title XIX, MCO Title XXI, CMO FFS, etc). If the population is not applicable to the activity, then N/A can be indicated within the cell. The state would interpret $0 as an indication the activity would be completed for no charge.

2. Can the State please reconcile responses to Questions 36 and 38 regarding whether suggested modifications/exceptions to the contract are permitted or not?

No.

ALL ELSE REMAINS THE SAME FOR RFP 3491

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: HealthInsight Assure, LLC

Authorized Signature:

Sharon Donnelly, MS
SVP, Development

Title: Assure Board Chair Date: 2-20-18

This document must be submitted in the "State Documents" section of vendors' technical proposal.

Section IV-3 VENDOR LICENSING AGRREEMENTS

Not Applicable

Vendor Company Name
HealthInsight Assure

Vendor Signature

Print Name	Date
Sharon Donnelly	2-20-2018

NCQA HEDIS® COMPLIANCE AUDIT™

CERTIFICATION AGREEMENT

This NCQA Certification Agreement (the "Agreement"), is effective the 31st day of October, 2017 (the "Effective Date"), by and between the National Committee for Quality Assurance, a District of Columbia corporation having a place of business at 1100 13th Street, NW, Washington, DC 20005 ("NCQA") and GALINA PRILOUTSKAYA ("Auditor") (individually a "Party," and collectively, the "Parties").

WHEREAS, NCQA is an independent non-profit organization widely recognized as the authority on quality for health care organizations, including health plans and provider organizations ("Healthcare Organizations"), and NCQA has established the Healthcare Effectiveness Data and Information Set ("HEDIS®") to measure performance of Healthcare Organizations;

WHEREAS, NCQA has established a standardized methodology to audit HEDIS or performance measure data collected by Healthcare Organizations and has licensed certain organizations (individually a "Licensed Organization" and collectively, the "Licensed Organizations") to perform NCQA HEDIS Compliance Audits ("HEDIS Audits"); and

WHEREAS, Auditor has successfully completed NCQA's training session and examination for HEDIS auditors, and NCQA desires to certify the Auditor to perform HEDIS Audits pursuant to this Agreement, and Auditor desires to become Certified Auditor;

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledges, the Parties agree as follows:

1. **Grant of Rights.** NCQA hereby grants to Auditor a non-exclusive right to perform HEDIS Audits in accordance with *Volume 5, HEDIS® Compliance Audit Standards Policies and Procedures* (the "Audit Standards"), using only the most recent editions of those documents in effect as of the date each HEDIS audit is performed. Auditor shall perform HEDIS Audits only as an employee of or under contract with a Licensed Organization. Auditor's certification status is personal and non-transferable.

2. **Term.** Unless earlier terminated by the Parties in accordance with the provisions of this Agreement, the term of this Agreement shall commence on the Effective Date and shall expire at midnight two (2) years later. This Agreement shall be renewed automatically for additional two year periods unless either Party gives written notice to the other Party of its intent not to renew the Agreement at least eighty (80) days prior to expiration of the then current term.

3. **Certification Fees.** Auditor paid NCQA a non-refundable certification fee, as described in the Certification Handbook, at the time Auditor was accepted into the HEDIS auditor training program. Fees for renewal of certification after the initial 2-year term are as described in the Certification Handbook (the "Renewal Fee"). Renewal Fee must be paid by Auditor fourteen (14) days prior to the expiration of the current Agreement term; provided, that NCQA shall have the right to change such annual certification fee so long as NCQA notifies Auditor of any increase in the certification fee at least ninety (90) days prior to expiration of the then current term of this Agreement. Payments received by NCQA more than thirty (30) days after the due date will be assessed a service charge of $200. In addition, Auditor's certification shall be revoked until all late payments are received.

4. **Audit Standards.** HEDIS Audits performed by Auditor must be done in compliance with the Audit Standards. NCQA may amend or generate a new edition of the Audit Standards at any time but will give Auditor at least thirty (30) days notice prior to the effective date of any such amendment or new edition. Auditor shall not, use, copy or distribute the Audit Standards in any way that violates NCQA's copyright. Auditor's failure to comply with the procedures and standards set forth in the Audit Standards may result in termination of this Agreement.

5. **Minimum Number of Audits, Employment and Continuing Education.** Auditor must participate in a minimum of two (2) unique audits (i.e., audits of different health plans or clients) per license year for Auditor to retain certified status. Auditor must notify NCQA within seven (7) days if Auditor's employment or contract with a Licensed Organization is terminated. Auditor must also notify NCQA in writing within seven (7) days of Auditor's employment by or entrance into a contract with a Licensed Organization. Auditor must comply with the continuing education requirements as described by NCQA in the Certified Auditor's Handbook.

6. **Certification Handbook and Code of Professional Conduct.** Auditor acknowledges having reviewed the *NCQA HEDIS Compliance Audit Certification Handbook* (the "Handbook") which includes the Code of Professional Conduct for HEDIS Compliance Auditors and agrees to comply with all procedures and requirements contained therein. Auditor's failure to comply with the Handbook may result in immediate termination of this Agreement and Auditor's certified status. NCQA retains the right to amend the Handbook and any other HEDIS audit program policies at its sole discretion and with thirty (30) days' notice to Auditor.

7. **Performance and Monitoring.** NCQA may periodically monitor Auditor's performance under this Agreement, retroactively and contemporaneously, and accompany Auditors on HEDIS Audits performed annually by such organizations and Certified Auditors. Auditor agrees to cooperate with NCQA's audits and performance assessments. Auditor shall perform HEDIS Audits in a professional and workmanlike manner consistent with industry standards reasonably applicable to the performance of data audits and in accordance with the procedures and standards set forth in the Audit Standards.

8. **Complaints and Grievances.** Notwithstanding the responsibility of Licensed Organizations to investigate complaints against Certified Auditors, NCQA shall have the right to independently investigate any complaint or grievance filed by a Healthcare Organization against a Certified Auditor. Auditor agrees to cooperate fully in any such investigation by NCQA and to institute corrective actions deemed necessary by NCQA as a result of any such investigation. A valid and substantiated complaint may result in NCQA's termination of this Agreement and Auditor's certified status.

9. **Advertising Guidelines.** Auditor agrees to advertise or market his or her certification only if it is current and valid. Auditor further agrees that failure by Auditor to comply with such advertising guidelines, as revised by NCQA from time to time, may result in termination of this Agreement and Auditor certified status. All marketing materials must follow NCQA's Advertising Guidelines as described on the NCQA Web page: (www.ncqa.org/marketing.aspx).

10. **Confidentiality.** Except as otherwise provided in this Agreement, Auditor agrees to keep confidential and not disclose to any third party (including other clients), except the Licensed Organization for which Auditor is performing a HEDIS Audit, any information obtained by Auditor from a Healthcare Organization during a HEDIS Audit. Auditor further agrees to protect the privacy of any medical records or other patient identifiable information that Licensee may have access to during a HEDIS Audit in accordance with state and federal laws, rules and regulations, including the privacy and security requirements of the Administrative Simplification subtitle of the Health Insurance Portability

and Accountability Act of 1996 (HIPAA). Auditor shall not release such confidential information, except (i) on prior written authorization from the Healthcare Organization; (ii) as otherwise required by law or regulation; or (iii) in the event of fraud, falsification or manipulation of HEDIS data by a Healthcare Organization, which fraud, falsification or manipulation shall be reported to NCQA by the Licensed Organization or Auditor. Auditor further agrees to keep confidential any information about the business of NCQA obtained as a result of this Agreement.

11. **Termination of Agreement.** NCQA shall have the right to terminate this Agreement effective immediately in the event of a material breach of the terms of this Agreement by Auditor, provided NCQA has given Auditor written notice of the alleged breach and Auditor has failed to cure such breach within fourteen (14) days after receipt of notice of breach. This includes failure to take corrective actions prescribed by NCQA as a result of monitoring activities. Auditor acknowledges that NCQA has relied, in entering into this Agreement, upon representations made by Auditor in the application materials submitted to NCQA and the auditor's compliance with the Code of Conduct. In the event such materials contain false or misleading information, or the Code of Conduct is violated, NCQA shall have the right to immediately terminate this Agreement. Upon termination of this Agreement, Auditor shall no longer be able to represent that he or she has certified status and shall return immediately to NCQA any materials issued to Auditor by NCQA.

12. **Warranties**. Auditor warrants that he or she will perform HEDIS Audits in a professional and workmanlike manner consistent with industry standards reasonably applicable to the performance of data audits and in accordance with the procedures and standards set forth in the Audit Standards. NCQA warrants that Auditor's use of the procedures and standards set forth in the Audit Standards will not infringe any copyright or other proprietary right of a third party.

13. **Miscellaneous.**

A. Entirety of Agreement. This Agreement contains a complete statement of all the arrangements between the Parties with respect to its subject matter and supersedes all prior agreements. This Agreement may not be amended, altered, modified or otherwise changed in any respect except in writing signed by both of the Parties.

B. Governing Law and Jurisdiction. This Agreement will be governed by and construed in accordance with the laws of the District of Columbia, without reference to conflicts of law provisions, and disputes related to this Agreement shall be resolved in a court of competent jurisdiction within the District of Columbia.

C. Severability. If any term of this Agreement is held to be inconsistent with any present or future law, ruling, or regulation of any court or authority having jurisdiction over the subject matter of this Agreement, such term shall be deemed to be rescinded or modified to the minimum extent necessary to comply with such law, ruling or regulation, and the remainder of this Agreement shall not be affected thereby.

D. No Waiver. The failure of a party to insist upon strict adherence to any term of this Agreement on any occasion will not be considered a waiver or deprive or limit that party of the right thereafter to insist upon strict adherence to that term in the particular instance or that term or any other term of this Agreement in any instance. Any waiver must be in writing.

E. Relationship of the Parties. The parties have entered into this Agreement as independent contractors only, and nothing contained in this Agreement place or shall be construed to place the

parties in the relationship of legal representation, employer-employee, partners, joint ventures, or agency, and neither party will have the power or authority to obligate or bind the other party in any manner.

F. Notices. Any notice or other communication under this Agreement must be in writing and will be considered given when delivered personally or by certified mail, return receipt requested, or by reputable courier, to the Parties at the following addresses (or such other address as a party may specify by notice to the other):

NCQA: 1100 13th Street, NW
Washington, DC 20005
Attention: Director of Measure Validation
Copy: Office of General Counsel
Auditor: GALINA PRILOUTSKAYA
Address: 10904 Glendale Av NE Albuquerque NM 87122

G. HIPAA. To the extent that federal regulations that implement the privacy and security requirements of HIPAA require amendments to this Agreement, NCQA and Licensee will enter into an appropriate amendment to this Agreement.

H. Authorization to Execute. The undersigned represent that they are authorized to sign this Agreement on behalf of the Parties hereto.

I. Counterparts. This Agreement may be executed in two counterparts, and each counterpart shall constitute an original instrument, but both of which shall constitute one agreement.

IN WITNESS WHEREOF, the parties have signed duplicate originals of this Agreement effective on the date first set forth above.

National Committee for Quality Assurance (NCQA)
By: _____
Title: General Counsel & CPO
Date: 09/08/2017

Auditor Signature: _____ Date: 9/7/17

November 3, 2017

Galina Priloutskaya, CHCA
Independent Consultant
10904 Glendale Ave, NE
Albuquerque, NM 87122

Dear Galina:

Thank you for your continued participation in NCQA's HEDIS® Compliance Audit™ program.

Attached to this e-mail is your NCQA Certified HEDIS Compliance Auditor seal and executed Certification Agreement from NCQA's general counsel. The seal confirms that you met NCQA's requirements to maintain your status as a Certified HEDIS Compliance Auditor. Certification is valid for two years (expires October 31, 2019), contingent upon your compliance with the terms of the Certification Agreement.

Again, thank you for your continued support of the Audit program. If you have questions or comments, contact Ashley at 202-955-5159 or Buchanan@ncqa.org.

Sincerely,

Wendy Talbot
Director, Measure Validation
National Committee for Quality Assurance
1100 13 Street, NW, Third Floor
Washington, DC 20005
Telephone: 202.955.1708

National Committee for Quality Assurance

recognizes

DataStat

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2017
DATE GRANTED

October 31, 2018
EXPIRATION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-02-01
Baltimore, Maryland 21244-1850

Sharon Donnelly
Senior Vice President
HealthInsight Assure
756 East Winchester Street
Suite 200
Salt Lake City, Utah 84107

AUG 1 - 2017

Dear Ms. Donnelly:

We have reviewed your application of May 24, 2017 requesting that the Centers for Medicare & Medicaid Services certify HealthInsight Assure as a Quality Improvement Organization (QIO)-like entity for the State of Utah. As a result of this review, we have determined that HealthInsight Assure meets the requirements to be a QIO-like entity, namely:

- It is able to perform limited medical and quality review functions required under Section 1154 of the Act;
- It has one individual who is representative of health care providers and consumers on its governing body under section 1152 of the Act; and
- It is not a health care facility, health care facility affiliate, or payor organization as defined in 42 CFR 475.105.

This certification designates HealthInsight Assure as a QIO-like entity eligible to fully operate in Utah. HealthInsight Assure may also operate in other states with the exception of performing Medicare medical reviews. For the conduct of Medicare medical review work, a QIO-like entity must meet the requirement that the QIO-like entity have access to or agreements with peer reviewers in the state in question.

If the QIO-like entity determines to conduct Medicare medical review work in a state other than the state for which it has submitted a list of medical reviewers, this criterion must be met and submitted for approval by CMS before such work can be undertaken.

Your certification is granted for a period of 5 years and will expire on May30, 2022.

This certification of eligibility permits your organization to seek a contract with the states for review activities within the requirements. In addition, states have specific qualifications and performance requirements depending upon the scope of work they desire to procure. This certification does not reflect a determination as to whether your organization has the ability to meet those requirements. The state is responsible for making that determination.

We have certified your organization to review cases and analyze patterns of care related to medical necessity and quality review. We have not certified the organization as meeting the State Medicaid Agency's requirements for external quality review or related functions such as utilization review specified in 1903(a)(3)(c) and 1932(c)(2) of the Act. In addition, we have not evaluated the organization to perform the same functions as a QIO under contract with CMS.

You must provide an annual assurance statement of your continued adherence to certification requirements within 30 days of the last month of the first certification year and within 30 days of the last month of the second certification year. In addition, if there are any changes in the name, address, or pool of physician reviewers you must notify this office for a reevaluation of your certification. Recertification requires submission of the complete package a minimum of 60 days prior to the expiration of the current certification.

At any time during the certification period if HealthInsight Assure no longer meets the above criteria, you must notify the agency and it will no longer be considered a QIO-like entity. The certification will be terminated. You may reapply at any time if this occurs.

If you have questions, please contact Malinda Greene of my staff on (410) 786-7829 or Email, malinda.greene@cms.hhs.gov.

Sincerely,

Alfreda Staton, Director
Division of Program Management,
Communications and Evaluation

SECRETARY OF STATE

STATE OF NEVADA

NEVADA STATE BUSINESS LICENSE

HEALTHINSIGHT ASSURE, LLC

Nevada Business Identification # NV20171682698

Expiration Date: October 31, 2018

In accordance with Title 7 of Nevada Revised Statutes, pursuant to proper application duly filed and payment of appropriate prescribed fees, the above named is hereby granted a Nevada State Business License for business activities conducted within the State of Nevada.

Valid until the expiration date listed unless suspended, revoked or cancelled in accordance with the provisions in Nevada Revised Statutes. License is not transferable and is not in lieu of any local business license, permit or registration.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on October 23, 2017

Barbara K. Cegavske

Barbara K. Cegavske
Secretary of State

You may verify this license at www.nvsos.gov under the Nevada Business Search.

License must be cancelled on or before its expiration date if business activity ceases. Failure to do so will result in late fees or penalties which by law cannot be waived.

Section V – Scope of Work

Executive Summary

HealthInsight Assure (Assure) is pleased to offer this proposal to perform External Quality Review (EQR) services for the Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP) to:

- ***provide an external, independent assessment and evaluation of quality, timeliness, and access to the health care services provided by a managed care organization (MCO), prepaid ambulatory health plan (PAHP), and care management organization (CMO) or any of their contractors to Medicaid recipients;***
- ***make recommendations for improving the quality of health care services furnished by each MCO, PAHP, and CMO, including how the State of Nevada can target goals and objectives in the State's quality strategy; and***
- ***work collaboratively with the DHCFP and the contracted vendors throughout the contract period***

By performing these activities with distinction, Assure can help DHCFP achieve its quality goals and its mission to provide quality health care services, promote equal and affordable access to health care, restrain the growth of health care costs, and maximize potential federal revenue.

The team of qualified and highly experienced professionals at Assure can help your Medicaid program rise to meet the challenges facing both Medicaid members and state government administrators. Our team has helped other western states, including New Mexico and Oregon, strengthen their Medicaid programs and we are ideally poised to help you strengthen yours.

Assure offers:

- **Local Nevada presence**
- **30 years' experience as a QIO/PRO**
- **30-year relationship with DHCFP and other Nevada agencies**
- **20 years' experience providing EQR services**

Assure and HealthInsight Management Corporation

Assure is an independent QIO-like entity and a division of HealthInsight Management Corp. (HealthInsight), the Medicare Quality Innovation Network-Quality Improvement Organization (QIO/QIN) for Nevada, New Mexico, Oregon, and Utah. HealthInsight brings over 40 years of quality assurance and improvement experience as a QIO and peer review organization (PRO), and a rich history of working with state Medicaid agencies on various quality activities, beginning with Nevada in 1988, followed by Utah, Washington, Oregon and New Mexico in the 1990s. Today HealthInsight provides services to Medicaid agencies in five western states and operates as an EQRO in New Mexico and Oregon.

As a division of HealthInsight, Assure benefits from access to expertise available from its HealthInsight affiliates in Nevada, New Mexico, Oregon, and Utah.

HealthInsight provides technical assistance related to a variety of health reform efforts. For the past five years, under a subcontract with the Lewin Group, HealthInsight has supported the CMS Innovation Center and its Health Care Innovation Awardees program. This work involves helping awardees with:

- ***developing funding sustainability models***
- ***creating Medicare, Medicaid, managed care, bundled payments, shared savings, and other value-based payment strategies***
- ***reviewing existing and proposed payment policies for alignment with delivery system reform***
- ***understanding payment policy principles***
- ***supporting development of new value-based payment models***
- ***analyzing emerging trends in payment policy***

This national expertise, local knowledge, and experience in payment redesign from both HealthInsight and Assure can be brought to bear to assist Nevada Medicaid in:

- ***understanding and aligning with local initiatives***
- ***using the latest models to improve care and control costs***
- ***acting as a national leader in the Medicaid program, which will be increasingly important in the current political environment***

Assure Strengths

This proposal discusses the collective experience, qualifications, and capabilities of the Assure team. We bring the following high-level strengths that distinguish us from other EQROs.

- ***Medicaid Expertise.*** ***Three decades of experience working with Medicaid programs of Nevada, New Mexico, Oregon, Utah, and Washington have given our staff wide-ranging expertise in understanding local Medicaid policy, managed care operations, and regulatory requirements. We understand the needs and constraints of programs serving diverse and vulnerable populations—including CHIP, children with special health care needs or in foster care, and Medicare/Medicaid dual-eligible enrollees—and we can offer specialized guidance to help Medicaid agencies maintain program effectiveness and consistency as care standards and regulations evolve. Our expertise extends beyond physical health services to encompass in-depth understanding of long-term services and supports, behavioral health and dental services and the managed care organizations that provide those services.***
- ***Flexibility and Adaptability.*** ***While our EQR approaches and tools are founded on industry-standard best practices, we tailor our services to meet each Medicaid program's specific goals, requirements, and budget constraints. We have immense experience in adapting our processes and tools to clients' changing needs, enabling us to negotiate customized approaches to deliver the best results cost-efficiently. Our current EQRO contracts have spanned periods of substantial change in the Medicaid programs we serve, and we have adapted as necessary to continue to provide high-value services.***
- ***Customer Focus.*** ***At the heart of EQRO work, the ultimate customer is the Medicaid enrollee. As a mission-driven organization committed to improving health care and health outcomes, we focus first on the needs of the individuals and populations served by each state's Medicaid program, and then on helping our agency clients address those specific needs. In particular, we have many years of experience conducting clinical and non-clinical special focus projects, consumer surveys, and mental health utilization reviews to help Medicaid programs improve health outcomes. (See a sample of customer comments in the box at the end of this section.) At the heart of our customer service vision is availability, dependability, and responsibility.***
- ***Quality Improvement (QI) Orientation.*** ***Our organization has devoted its efforts to quality improvement for more than 30 years. Not only have we helped clients improve the quality of health care they deliver, we have internalized QI and process improvement as key facets of our corporate culture—for example, by using methods such as Lean and Six Sigma to improve our operational and administrative efficiency. Our clients and the managed care organizations they oversee benefit from this orientation as we help them introduce process improvements and efficiencies into their own programs and initiatives.***
- ***Technical Assistance.*** ***Our organization goes beyond the "audit checklist" approach to EQR. We provide extensive hands-on technical assistance and training to state agency and health plan staff to enhance their internal QI capabilities and equip them to respond to the findings and recommendations of each annual EQR cycle. We offer detailed consultation to help our agency clients and their contracted health plans meet Medicaid program requirements related to ensuring access to timely, high-quality health care for enrollees.***

External Quality Review Services

As a Medicaid EQRO, Assure performs EQR and related QI and quality assurance work on behalf of state Medicaid agencies and Medicaid enrollees. Our services have included all federally mandated and optional EQR-related activities, as well as complementary services, including but not limited to:

- ***monitoring health plans' compliance with federal and state regulatory and contractual standards for managed care (CMS EQR Protocol 1)***
- ***validating and calculating performance measures (CMS EQR Protocols 2 and 6)***
- ***validating and implementing performance improvement projects (PIPs) (CMS EQR Protocols 3 and 7)***
- ***validating the accuracy and completeness of Medicaid encounter data (CMS EQR Protocol 4)***
- ***assessing information system capabilities for Medicaid agencies and health plans (CMS EQR Protocol Appendix V)***
- ***validating and implementing consumer and provider surveys (CMS EQR Protocol 5)***
- ***performing specific focused studies for Medicaid populations (CMS EQR Protocol 8)***

Our experience as an EQRO has given the Assure team robust expertise in:

- ***Medicaid populations, policies, data systems, and processes***
- ***managed care delivery systems, organization, and financing***
- ***quality assessment and performance improvement methods***
- ***research design and methodology, including statistical analysis***

Our EQR approaches are grounded in thorough understanding of the CMS EQR protocols and extensive review of state requirements, including managed care contracts and subsequent directions from the Medicaid agency, state laws, and federal regulatory requirements. We use that information to guide the development of our review tools and criteria, in consultation with the Medicaid agency and the health plans to be reviewed. Our review tools cite the regulations we use to determine health plans' compliance with each of the review elements.

Our proposal will demonstrate that the Assure team has the organizational knowledge, experience, and abilities to provide analysis and evaluation of aggregated information on quality, timeliness, and access to covered health care services obtained from annual reviews of the DHCFP's contracted MCOs, PAHP, and CMO. Our proposal will also show that we offer a highly skilled team of professionals who will evaluate Nevada's managed care organizations with consistency, reliability and complete accuracy.

Customer comments

"HealthInsight team was really collaborative and helpful; provided a lot of technical assistance. The process they used to collect and submit documents was very easy and very clear. The [online] tool was user friendly and our partners did not express any difficulty with access or use when answering specific questions. The reviewers were prompt in answering clarifying questions, and timelines to submit were clear and reasonable."
— Health Share of Oregon

"The review was well organized. We appreciated having the protocols ahead of time and being able to ask questions about the intent. HealthInsight is very responsive and willing to provide guidance and/or clarification during all phases of the audit."
— PacificSource Community Solutions

"I appreciated the fact that they very carefully followed the [state regulations]; having copies of those documents for everyone at the table really helped to keep people on track… Always helpful and available when we call with questions."
— Umpqua Health Alliance

"The review provided a lot of feedback and insight on the work we are doing…The reviewers really had a broad scope, seemed to be very knowledgeable on the subject matter."
— Greater Oregon Behavioral Health, Inc.

2.1 Scope of Work

The services to be provided under the resulting contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for MCOs, DBA/PAHP, and the CMO. The contract will allow the DHCFP to be compliant with federal EQR regulations and rules. The specifications for deliverables required under this RFP may evolve from year to year in response to program changes.

2.1.1 Mandatory Activities

The selected vendor will be required under the contract to perform tasks and functions identified in the contract and to perform them according to specified levels of quality and comprehensiveness as determined by DHCFP. These mandatory activities are as follows:

The Assure team brings over 20 years of EQR experience working with diverse Medicaid agencies and enrollee populations through hundreds of changes in many state programs and waivers for more than two dozen managed care organizations at one time. We estimate that our EQR activities have impacted at least 2.5 million Medicaid enrollees in Oregon, Washington, and New Mexico.

We have performed the full range of mandatory and optional EQR activities and have conducted many statewide initiatives and provider education activities to improve quality of care, patient safety, and access to timely care for Medicaid enrollees. For example, the Assure team has provided focused health plan education on initiating a compliance program, care coordination for members with special health care needs, and transitions of care for nursing home residents. Our team's high-level strengths distinguish us from other organizations in this line of business. We have certified QI staff, staff with managed care experience, professional presenters, and healthcare data analysts who are ready to collaborate with DHCFP on the next phase of the Nevada Medicaid waiver. Our local and national staff are excited about the opportunity to bring our expertise to bear for the benefit of the State of Nevada.

Our processes are designed to execute the required EQR protocols efficiently and effectively, resulting in reliable, accurate, and complete information for the Medicaid agency to use to make sound decisions. During the course of our work, we document what meets which CMS EQR protocol requirement so that you can seamlessly monitor that all protocol requirements are being met and report your compliance in this area to CMS.

2.1.1.1 Performance Improvement Project Validation

<u>The Assure Advantage – PIPs</u>

- ✓ ***We have been working with Medicaid agencies and health plans on PIPs for over 20 years.***
- ✓ ***We provide specialized training and assistance to managed care staff.***
- ✓ ***We have facilitated statewide collaborative PIPs for more than 30 MCOs.***
- ✓ ***We have extensive experience conducting, monitoring, and reporting on PIPs to state agencies.***

<u>The Assure Approach to PIP Validation</u>

The Assure team conducts PIP validation reviews for 16 coordinated care organizations (CCOs) and one managed mental health organization in Oregon and for four MCOs in New Mexico. We provide specialized training and assistance to help managed care plan staff ensure that their PIPs produce meaningful improvements in clinical outcomes and service.

Our training sessions address understanding the purpose of PIPs; defining study indicators and populations; creating data collection and analysis plans; documenting interventions; interpreting and discussing results; and developing or modifying interventions to sustain quality improvement. We will customize our reviews to help each Nevada MCO/DBA/PAHP fill gaps in its understanding of valid PIP design and implementation in order to improve each health plan's ongoing compliance with the PIP validation criteria.

Our assistance is collaborative, personal, and professional. As indicated by the feedback below, many MCOs have expressed great appreciation of our feedback and assistance, and have found it very useful.

See Section VIII, Attachment 1 (Extract from 2016 GOBHI Report) as an example of our PIP validation work.

Health plan feedback on Assure's PIP support

"The [quarterly technical assistance] meetings were helpful both in terms of getting help with our own PIP and hearing what others were doing. [HealthInsight Assure staff] was great in walking through our report intervention by intervention and letting us know which ones needed more information."
— Health Share of Oregon

"The quarterly technical assistance meetings for the statewide PIP were very helpful. They gave us suggestions that applied specifically to our plan."
— Intercommunity Health Network

"Discussion of best practices at other plans was very helpful. Feedback on the PIP report was supportive and expectations were clear."
— FamilyCare, Inc.

The Assure team strives to provide a comprehensive and specialized approach to our PIP work. Figure 1 below lays out the framework by which we structure our PIP activities and the key steps that we take to ensure the success of our work.

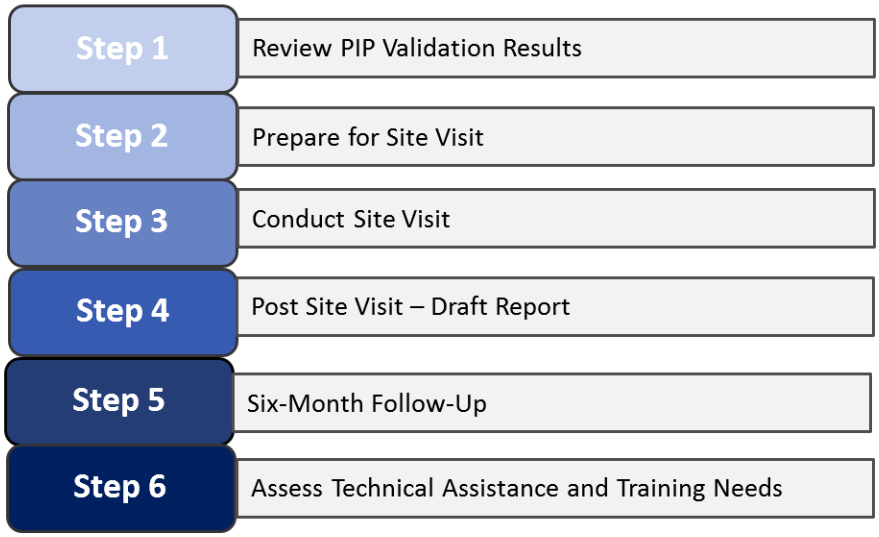

Figure 1. PIP Validation Framework.

Additional detail on our PIP framework:

1. ***Review PIP Validation Results:*** ***After receiving permission from DHCFP to commence the review, a dedicated project manager initiates the review by assessing the PIP validation results from the previous EQR. The project manager then develops a follow-up project work plan to address any deficiencies identified and shares this with DHCFP for review and approval. The Assure team values the historical perspective such a review provides as we help you guide the Nevada Medicaid program into the future.***
2. ***Prepare for Site Visit:*** ***Support staff experienced in managed care operations and QI initiatives obtain each MCO/DBA/PAHP's PIP documentation in advance of the site visit. This documentation is rigorously reviewed by qualified professionals to identify areas of concern and formulate questions designed to clarify the MCO/DBA/PAHP's compliance with the standards outlined by the CMS EQR Protocol 3. These questions are shared with the MCO prior to the site visit to prepare the MCO to provide documentation and to have knowledgeable staff on hand to answer the questions. We will also collaborate with DHCFP to resolve any areas of concern that warrant further consideration beyond the requirements of the protocol, to help DHCFP decide whether or not the Medicaid agency or MCO/DBA/PAHP needs to take action.***
3. ***Conduct Site Visit:*** ***During each site review, our project manager and QI reviewers meet with the MCO/DBA/PAHP's QI staff providing step-by-step evaluation of the PIPs and offering technical assistance to address standards that are not being met. For example, if the PIP has a well-developed study question but an incomplete plan for data analysis, we will advise the MCO/DBA/PAHP on how to craft an effective analytical plan. In this example, local analytic support staff provide input into the suggested best practice.***
4. ***Post Site Visit – Draft Report:*** ***After the site review, our review team, led by the project manager, creates a draft report summarizing the review findings and shares it with DHCFP and the MCO/DBA/PAHP for review and comment. With that input, our local communications specialists finalize the report and deliver it to DHCFP, making electronic copies available in PDF format. We will produce a clear, concise, professional report for each MCO/DBA/PAHP for full validation for each year, the results of which will be rolled up into the annual EQR Technical Report for DHCFP to present to CMS.***
5. ***Six-Month Follow-Up:*** ***Approximately six months after each MCO/DBA/PAHP's onsite PIP review, the project manager will arrange a videoconference call to check with the MCO/DBA/PAHP on the status of its progress on the PIPs and to***

offer technical assistance to address any barriers encountered. Our QI professionals and healthcare data analysts assist in the call to provide tailored assistance. This mid-year discussion of PIPs allows our review team to prevent any significant missteps in study design and to monitor the progress of the PIP implementation. This assistance will allow the MCOs to proactively address gaps in a timely manner and comply more fully with DHCFP's expectations.

6. ***Assess Technical Assistance and Training Needs:*** ***Assure's QI experts incorporate the information from all PIP reviews into an assessment of ongoing needs for technical assistance and training. Our staff, experienced in large group presentations, designs targeted trainings to address the identified needs and priorities of MCOs. Assure's past trainings on PIP methodology for Medicaid managed care staff across three states have resulted in improved compliance with PIP standards.***

Using our approach above, the Assure team has facilitated statewide collaborative PIPs for more than 30 MCOs each year that achieved and maintained statistically significant improvement in the target areas. These focused on areas such as diabetes monitoring in people with schizophrenia or bipolar disorder and on opioid safety. Our experience demonstrates that accelerated learning and superior outcomes are achieved when the MCOs work on a shared, collaborative project.

We strongly feel that this is a proven approach that delivers positive outcomes. When requested by the state Medicaid agency, we have been available to also work individually with each MCO in target areas. This personalized approach has resulted in iterative improvements over time. We provide technical assistance to MCOs in both creating and sustaining PIPs. At the direction of the state, we provide technical assistance to MCOs whose PIP performance does not meet standards.

Relevant Experience

The Assure team currently conducts PIP validation reviews for 16 CCOs and one managed mental health organization in Oregon and for four MCOs in New Mexico. These organizations provide physical health, behavioral health, dental and long-term services and supports to Medicaid members in their respective states. Highlights of our relevant experience are outlined in Table 1.

Table 1. Assure Team Experience with PIP Validation.

Customer	PIP Topics
Oregon Health Authority; conducted PIP validation for 16 CCOs	• ***2013–2015: Diabetes monitoring in people with schizophrenia or bipolar disorder*** • ***2016–2018: Opioid safety***
New Mexico Human Services Department; conducted PIP validation for 4 MCOs	• ***2005–present: Diabetes care; children's care (dental, pre-diabetes, asthma prescription fills)*** • ***2014–present: LTSS – fall-risks; care coordination staff training for members with special health care needs; prevent of readmissions for diabetes*** • ***2014–present: Behavioral health – 7- and 30-day follow up after hospitalization; monitoring of anti-depressant prescription fills***

2.1.1.2 Performance Measurement Validation

<u>The Assure Advantage – Performance Measure Validation (PMV)</u>

- ✓ ***Our QI professionals, information systems specialists, and healthcare data analysts have over 12 years of experience in conducting PMV.***
- ✓ ***We are adept at displaying performance results in comparative and trending formats and/or reports that clearly identify improvement needs for the client.***
- ✓ ***We have more than a dozen years of experience working with state Medicaid programs to conduct Information Systems Capabilities Assessments (ISCA).***
- ✓ ***We conduct PMV according to statistically sound methods, generating actionable QI recommendations for state Medicaid programs.***
- ✓ ***Our ISCA team includes experienced compliance, revenue cycle, and coding professionals who are skilled at examining organizations' information and data processing systems and reporting procedures.***
- ✓ ***Our reports are clear and concise, and include comparative and trending information to identify areas of strengths and improvement needs for the client.***

See Section VIII, Attachments 2, 3, and 4 (2014 Performance Measure Comparative Analysis Report; Appendix B; Appendix C) as examples of our PMV work.

<u>The Assure Approach to Performance Measure Validation</u>

The Assure team's approach to PMV is rooted in CMS EQR Protocol 2. Through more than a dozen years of PMV and ISCA experience, the Assure team has worked closely with state clients and MCOs to coordinate onsite, telephonic, or virtual meetings; lead

informative discussions on new tools; and provide well-designed reports ensuring that organizations have knowledge of strengths and areas for improvement.

After receiving permission to initiate the review, the dedicated project manager, with oversight by the HEDIS-certified auditor, initiates the review by completing a HEDIS Road Map for any HEDIS measures, following National Committee for Quality Assurance (NCQA) standards and guidance. This ensures that the performance measures validated in this review follow national guidelines.

Next, our compliance professional uses Appendix V of the CMS EQR Protocols (ISCA assessments) to determine the MCO's ability to comply with 42 CFR §438.242. The ISCA also assesses the completeness, accuracy, and timeliness of data received from providers, and the ability of an organization to make data available to the state.

Assure uses an ISCA protocol tool to assess MCOs' and third parties' IT data processing, including 11 comprehensive and distinct sections, from staffing to member enrollment and vendor management. Each section has clear scoring criteria and lists of required supporting documentation, ensuring that organizations are aware of expectations. The tool also includes a guidance section to educate users on industry norms such as password standards and links to the state's Administrative Rules.

As part of the PMV and ISCA assessment, the Assure team, led by the dedicated local project manager, works with each MCO and the state to gain an understanding of any new internal organizational leadership or staffing structure changes, planned or completed mergers, acquisitions or business service offering changes and any IT changes that may impact the ability to deliver accurate, complete, and timely data used to calculate performance measures.

Each MCO and the state receive a report identifying strengths and weaknesses or areas for improvement and are provided a two-week period to submit new documentation or information to address any weaknesses.

Next, using a similar ISCA tool, the compliance professional, healthcare data analyst and staff reviewers assess the state's production of performance measures. We follow CMS EQR Protocol Appendix V, ensuring that we meet state-specific IT and data configuration and needs.

Figure 2 outlines the process steps, following the CMS EQR Protocol 2, that take place before, during and after each audit.

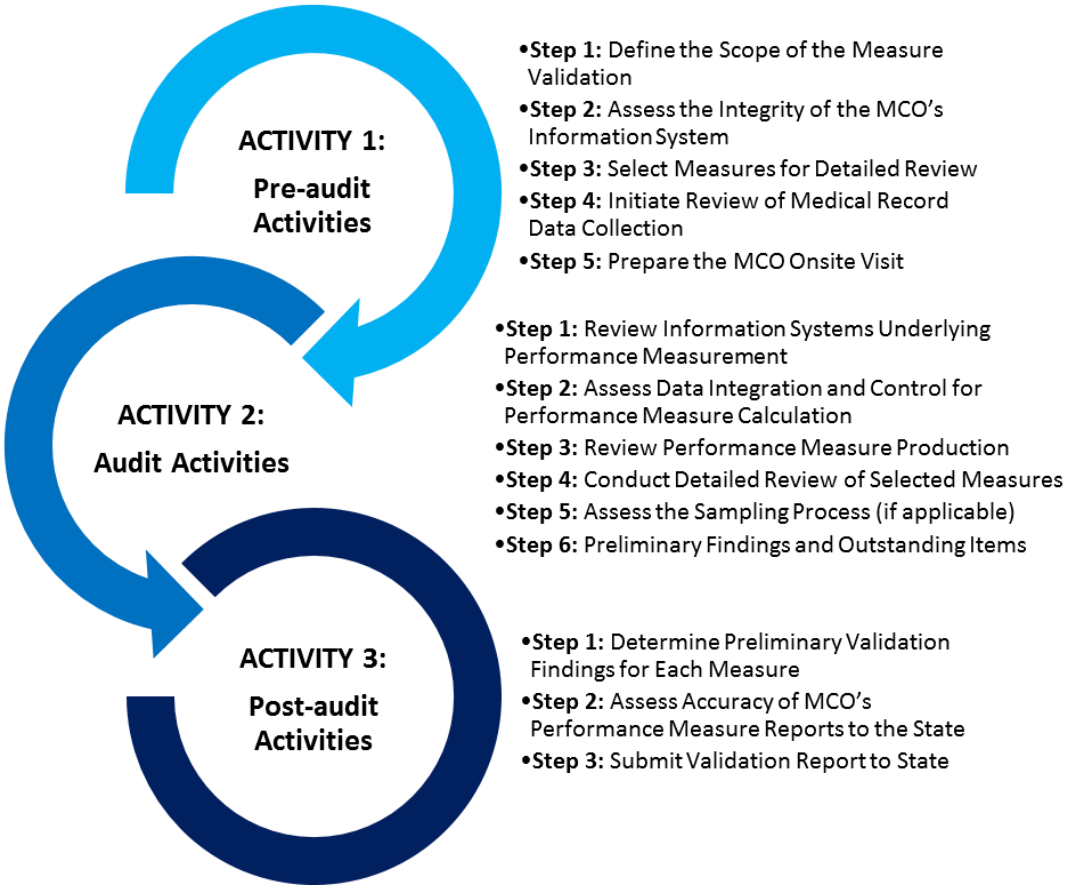

Figure 2. Steps in Performance Measure Validation.

<u>Relevant Experience</u>

The Assure team currently conducts PMV on seven of the State of Oregon's incentive performance measures, including measures related to child health, dental health, and behavioral health, in addition to a PMV on inpatient, outpatient, pharmacy, dental, and transportation services in New Mexico. Highlights of our relevant experience are outlined in Table 2.

Table 2. Assure Team Experience with Performance Measure Validation.

Customer	Project Details
Oregon Health Authority, 2005–present	***The Oregon Health Authority has developed incentive measures to evaluate the Oregon CCOs' performance on health care quality and access, and to hold CCOs accountable for improved outcomes. Assure conducted an ISCA on all CCOs, managed dental organizations, behavioral health organizations, third-party data managers, and the state, and subsequently validated the following incentive measures:*** • ***Adolescent Well Care Visits (age 12–21)*** • ***Alcohol or Other Substance Misuse (SBIRT) (age 12+)*** • ***Ambulatory Care: Emergency Department Utilization (all ages)*** • ***Dental Sealants (age 6–9, 10–14)*** • ***Developmental Screening in the First 36 Months of Life (age 0–3)*** • ***Effective Contraceptive Use (age 15–50)*** • ***Follow-up after Hospitalization for Mental Illness (age 6+)***
Washington, 2012–2014	***Assure performed a HEDIS audit for MCOs (physical health) and PMV and ISCA audits for Regional Service Networks (behavioral health). Year over year, the Assure team worked with local plans and the state to monitor progress on previous years' recommendations, ultimately improving the quality of the performance measure calculations.***
New Mexico Human Services Department, 2015	***The Assure team has performed a performance measure validation every year since 2005 on state-specified performance measures for both integrated and non-integrated MCOs. The PMV reviewed physical and behavioral health populations plus long-term services and supports over several waivers in the last 13 years. The Assure team has worked with the state Medicaid agency to identify recommendations for each MCO's PM process including follow up each year on previous EQR recommendations.***

As demonstrated above, the Assure team has significant experience conducting PMV for a variety of agencies. In our years of doing so, we have seen firsthand the impact of our work on the communities we serve. One such example is noted below.

Targeting disparities in child immunization

Assure's analysis of HEDIS® performance measures for Washington MCOs revealed that children of Russian-speaking families were receiving most recommended vaccines at significantly lower rates compared with other Medicaid children. Also, children in rural areas were vaccinated at significantly lower rates compared with urban children. We recommended that the state design unique interventions to improve vaccination rates for underserved populations.

Result: The state Medicaid agency and health department pooled resources to develop an intervention aimed at improving service rates for children of Russian-speaking families. A series of focus groups with Russian speakers and their providers identified barriers to immunization that included misperceptions about vaccine safety, mistrust of medical professionals, and language barriers. Community input stressed the importance of sharing detailed information in Russian, through churches, social networks, and Russian-language media about vaccine benefits and risks.

2.1.1.3 Compliance Review

A review, conducted within the previous 3-year period, to determine plans' compliance with the standards set forth in subpart D of 42 CFR 438 relating to access; care coordination; amount, duration, and scope of covered services and other plan standards

<u>The Assure Advantage – Compliance Review</u>

- ✓ ***We work collaboratively with state Medicaid agencies and MCO staff as they create, implement and monitor their QI programs.***
- ✓ ***We have established and fine-tuned processes that are consistent with the CMS EQR protocols and we ensure that the state Medicaid agency has reliable information on each MCO's compliance with its contractual and regulatory obligations.***
- ✓ ***We provide efficient and effective reviews of MCOs, including keeping an eye on limiting administrative burden and duplicative review.***
- ✓ ***We respond timely to requests for clarification from MCOs and states throughout the process.***
- ✓ ***We outline compliance trends and needs to assist states in focusing their quality processes.***

<u>The Assure Approach to Compliance Review</u>

The Assure team conducts audits of each MCO's internal and delegated QI functions, and provides feedback and guidance to help the managed care plans provide better, safer care for enrollees and comply with regulatory or accreditation criteria. We collect, review, assess, and analyze information on the plans' compliance with managed care regulatory and contractual standards related to:

- ***enrollee rights and protections***
- ***grievances and appeals***
- ***certification and program integrity, including fraud, waste, and abuse***
- ***quality assessment and performance improvement***

Our reviews are designed to answer the following questions for each MCO, as appropriate. Our experienced auditors, healthcare data analysts and communication specialists work together to collect specific, actionable data on the results of the assessment of the compliance questions.

1. ***Does the MCO meet CMS regulatory requirements?***
2. ***Does the MCO meet the requirements of its contract with the state Medicaid agency?***
3. ***Does the MCO monitor and oversee contracted providers' performance of delegated activities to ensure regulatory and contractual compliance?***
4. ***Does the MCO have policies and procedures in place to discover and take action to address fraud, waste, and abuse when they occur in the Medicaid program?***
5. ***Is the MCO maintaining ultimate responsibility and oversight for adhering to and otherwise fully complying with all terms and conditions of its contract with the State despite having delegated those responsibilities to a subcontractor?***
6. ***Does the MCO have processes in place to monitor the effectiveness of its care coordination processes?***
7. ***Does the MCO have policies and procedures in place to facilitate smooth transitions for its members transferring to and from different health care settings?***

Our compliance review processes are similar from state to state, but can be adapted to meet specific Nevada needs. Our reviews are based on CMS EQR Protocol 1, with state-specific modifications developed in consultation with the Medicaid agency.

Figure 3 outlines the steps in the Assure approach to compliance reviews.

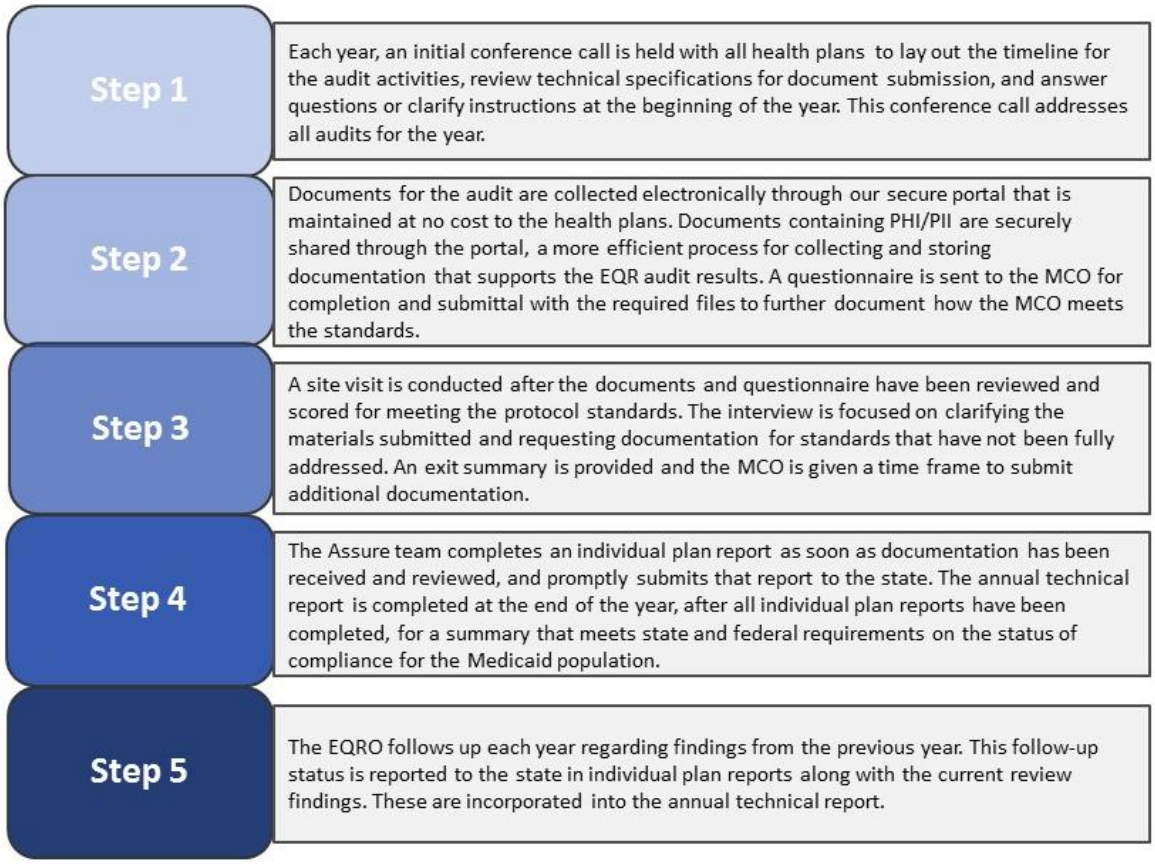

Figure 3. Steps in Compliance Review.

<u>Relevant Experience</u>

The Assure team currently conducts compliance reviews for 16 CCOs in Oregon and for four MCOs in New Mexico. Oregon CCOs provide integrated physical health, behavioral health, dental and non-emergent medical transportation to members in all 36 counties. New Mexico's MCOs provide physical and behavioral health and long-term support and services, and they oversee the dental, pharmacy, and transportation vendors for Medicaid managed care enrollees statewide.

In addition to current compliance reviews, Assure has performed compliance review of managed behavioral health and physical health plans in the state of Washington. Highlights of our relevant experience are outlined in Table 3.

Table 3. Assure Team Experience with Compliance Review.

Customer	Project Details
Oregon Health Authority, 2005–present	***The Oregon Health Authority has directed the EQRO to assess each of the 16 Oregon CCOs' adherence to contractual requirements, governmental regulations, and the performance of the health plans on providing timely access to quality healthcare services. Assure completed the assessment of all CCOs, managed dental organizations and behavioral health organizations in the following areas:*** • ***Enrollee rights and protections*** • ***Grievance and Appeal Systems*** • ***Certification and program integrity, including fraud, waste and abuse in the Medicaid program*** • ***Quality assessment and performance improvement***
New Mexico Human Services Department, 2005–present	***The Assure team carried out the direction from the Human Services Department (HSD) in New Mexico to assess each of the four MCOs' adherence to contractual requirements, governmental regulations, and the performance of the health plans on providing timely access to quality healthcare services. Assure completed the assessment on physical and behavioral health and long-term support and services provided by the MCOs in the following areas:*** • ***Care Coordination, including Health Risk Assessments and Comprehensive Needs*** • ***Assessments*** • ***Self-Directed Community Benefit*** • ***Provider Network*** • ***Provider Services*** • ***Medical Records Process Validation*** • ***Nursing Facility to Community Transitions of Care*** • ***Adverse Benefit Determinations*** • ***Member Materials, which included member communications letters, Member Handbook, Member Rights and Responsibilities, Material Distribution, Provider Directory, and Member Health Education Plan*** • ***Member Services, including call center performance standards, interpreter/translator services, and access to electronic versions of the member's personal health record***

- *Grievance and Appeal System*
- *Program Integrity, including fraud, waste and abuse*
- *MCO Reporting Requirements to the State*
- *Primary Care Provider and Pharmacy Lock-ins*

2.1.1.4 Network Adequacy Validation

The Assure Advantage – Network Adequacy Validation

- ✓ ***The Assure team is highly skilled at network adequacy assessment and validation, and can customize the related processes to meet state-specific needs.***
- ✓ ***We have experience with supporting states and MCOs in meeting network adequacy requirements through collaborative training and reporting.***
- ✓ ***We understand the unique environments of both urban and rural/frontier MCOs, and statewide and regional MCO's and are able to assess and validate their network adequacy.***

The Assure Approach to Network Adequacy Validation

In 2016, the Medicaid Managed Care and CHIP Managed Care Final Rule established network adequacy standards for Medicaid and CHIP managed care providers, allowing flexibility for states to set specific standards unique to each state. These network adequacy standards are specific to time and distance and timely access.

The Assure team understands state Medicaid contractual requirements and is skilled at working with states to assess network adequacy as outlined by federal and state regulation. Assure has experience in assessing and validating MCO network adequacy using the following process:

1. ***Develop Network Adequacy Report requirements in coordination with state Medicaid authority.***
2. ***Review network adequacy documentation submitted by the MCOs to meet federal and state requirements, including:***
   - ***Assurance that all services covered under the State plan and contract are available and accessible to managed care enrollees***
   - ***Demonstration that the managed care program and its networked providers meet State standards for timely access to care and services, taking into account the urgency of the need for services***
   - ***Mechanisms to ensure compliance with timely access and monitoring of network providers to determine compliance and demonstration of corrective action plans, if non-compliant***

- ***Demonstration of an appropriate range of preventive, primary care, and specialty services***
- ***A network of providers sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area***
- ***Provider-specific information, including state-specified time and distance standards throughout all geographic areas covered by each managed care program***
- ***Description of characteristics and health care needs of the populations covered in the contract***
- ***Demonstration of how the managed care program provides for access and cultural considerations and accessibility considerations for enrollees***
- ***Status of agreements with Indian health care providers to ensure timely access to services for enrollees***

3. ***Score each MCO to compare, contrast, and highlight strengths and areas for improvement.***
4. ***Report to the State confirming the managed care program's network adequacy compliance with federal and state requirements.***

<u>Relevant Experience</u>

For the past two years (2016 and 2017), the Oregon Health Authority (OHA) has asked the Assure team to review the CCOs' Delivery System Network (DSN) reports and provide feedback and recommendations using an integrated care lens. Assure looked at responses that covered all services delivered by the CCOs (both urban and rural), including but not limited to physical and mental health, substance use disorder services, dental care, non-emergency medical transportation, acute care, and specialty care. These reports have included possible network validation adequacy requirements, such as reviewing CCO plans for meeting state-specific time and distance access standards for various provider types and assessing compliance with standards such as wait times for appointments. Assure's reports to OHA summarized and validated the results of the reviews, including recommendations related to the need for technical assistance or clarification regarding OHA expectations.

The Assure team has experience with validating network adequacy through techniques such as member surveys, encounter data validation, and secret shopper calls. We will partner with DHCFP to develop further validation methods in compliance with the network adequacy validation protocol as it is being developed and issued.

In April 2017, OHA collaborated with the Assure team to provide technical assistance training for all 16 CCOs in Oregon regarding the expectations for DSN reporting.

2.1.2 Optional Activities

During the length of the contract, work requests may be made of the Vendor at the sole discretion of the DHCFP for optional activities described in 42 CFR 438.358(c) or comparable activities that assess the quality of care or provide for the control of utilization of the DHCFP fee-for-service program. Optional activities may include:

As demonstrated throughout this proposal, the Assure team has all of the expertise and qualifications to meet DHCFP's EQR needs, including performing the optional activities listed in this section. We have performed EQR and related QI and quality assurance work on behalf of multiple state Medicaid agencies and for Medicaid enrollees as detailed below. In addition to using the mandatory CMS EQR protocols, Assure has designed and implemented all optional EQR-related activities for multiple MCOs over many years, including:

- ***designing and conducting focused studies of care***
- ***conducting individual medical and mental health case review***
- ***validating nursing facility level-of-care decisions***
- ***assessment of treatment costs within the emergency room***

In addition, Assure has collected, assessed, and reported quality ratings of physicians, similar to the quality rating activities expected to be part of the optional EQR activities found in the Code of Federal Regulations.

2.1.2.1 Validation of encounter data

<u>The Assure Advantage – Validation of Encounter Data (EDV)</u>

- ✓ ***The Assure team includes experienced clinical reviewers and QI, revenue cycle, coding, and data analytics staff both locally and regionally with extensive experience in validation of encounter data.***
- ✓ ***Our team has made relevant, timely, and actionable recommendations to state Medicaid agencies, their information systems staff, and key stakeholders for improving encounter data.***

<u>The Assure Approach to EDV</u>

Encounter data must be reliable, complete, and accurate to be useful in assessing and improving health care quality, monitoring program integrity, and determining capitation payment rates. Regularly scheduled EDV is aimed at improving the completeness and accuracy of encounter data through continuous monitoring of data

integrity. The Assure team has conducted EDV in New Mexico and Washington to validate managed care plans' encounter data. The team has made relevant, timely, and actionable recommendations for improving the reliability, accuracy, and completeness of encounter data to state Medicaid agencies, their information systems staff and key stakeholders who rely on encounter data for decision making.

Our EDV processes are standardized for maximum efficiency, and our reviews are based on CMS EQR Protocol 4 (see Figure 4 below). This approach enables ongoing quality improvement. For example, in one state, our data analytics and clinical review staff identified problems with regard to data structure, data dictionary definitions, physical record structure, and the content of clinical notes. In response to our reports and recommendations, our reviewers observed statewide progress and improvement in these areas in the years that followed. We worked closely with the state to prioritize the issues identified in each year's EDV study for follow-up study in subsequent years.

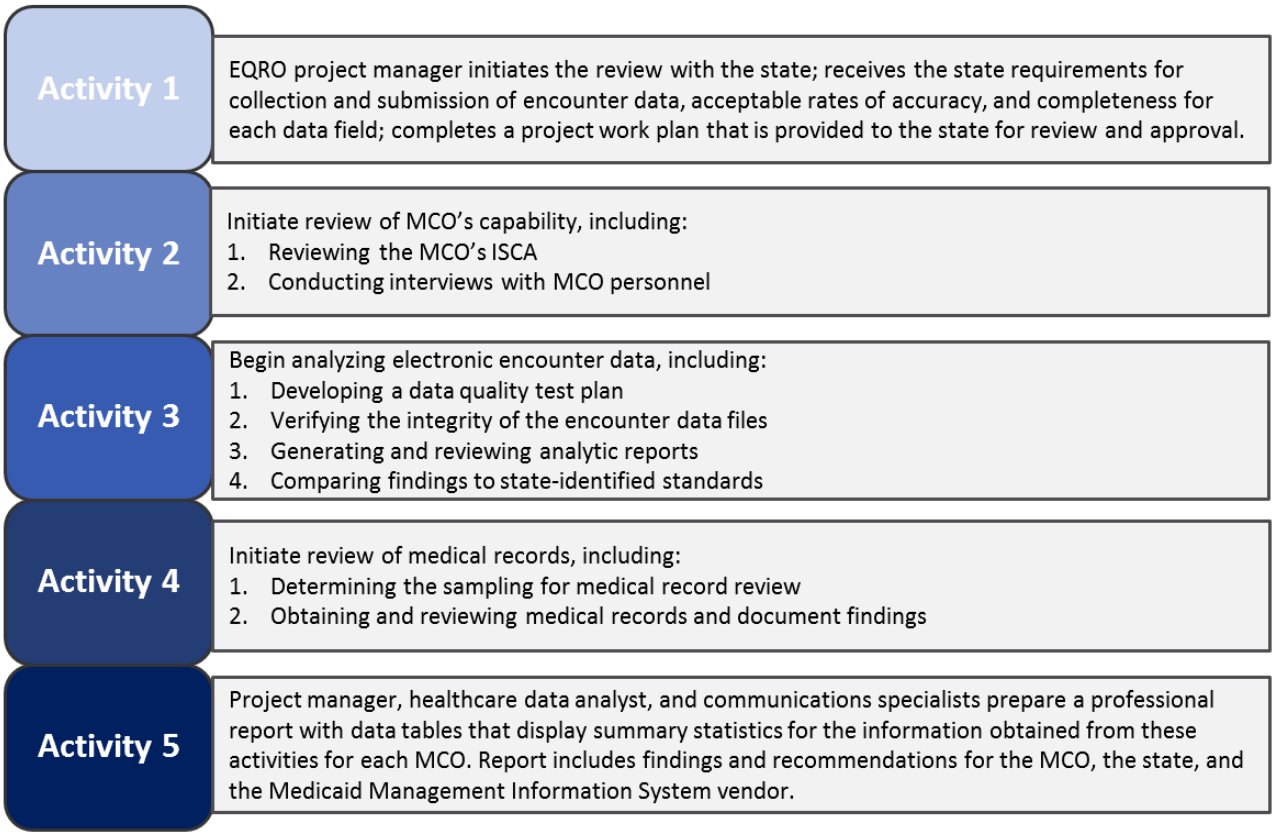

Figure 4. Assure's Approach to Encounter Data Validation.

Relevant Experience or Examples

The Assure team currently conducts EDV for four MCOs and for the state Medicaid agency in New Mexico. Assure also conducted EDV for the Division of Behavioral Health and Recovery (DBHR) in Washington State for five years. Highlights of our relevant experience are outlined in Table 4.

Table 4. Assure Team Experience with Encounter Data Validation.

Customer	Project Details
New Mexico Health Services Division, 2007	***Assure followed the CMS EQR protocol (called "cross validation audits" at that time) to assess the MCOs' physical health encounter data. Assessment areas included primary care, dental services, and transportation services for physical health. Assure staff worked closely with the State Medicaid agency and their information systems vendor on implementing the recommendations provided in the comprehensive report.***
New Mexico Health Services Division, 2009	***Conducted another cross validation audit, in this instance to assess vision, dental, pharmacy, and physical health services.***
Washington Division of Behavioral Health and Recovery, 2009–2013	***Annual Regional Service Network (RSN) EDV to determine the accuracy and completeness of encounter data submitted by providers. As an independent check of the RSNs' EDV results, Assure staff audited and verified the EDV process used by each RSN.***
Southwest Behavioral Health (SWBH), Washington, 2015	***Assure staff performed a special-request EDV, comparing specific data fields in clinical records of the county's mental health service provider against SWBH's electronic data sets to determine whether data submitted by the provider were accurate and complete.***
New Mexico Health Services Division, 2016	***Assure team collaborated with Myers and Stauffer, LC to complete an EDV of the first year of the new Medicaid waiver, Centennial Care, for inpatient, outpatient, pharmacy, dental, and transportation services. Assure presented the results to Medicaid agency leadership and provided follow-up technical assistance to the MCOs and the state to answer specific questions about the EDV results.***

2.1.2.2 Quality of Care Surveys

Administration or validation of consumer or provider surveys of quality of care

<u>The Assure Advantage – Quality of Care Surveys</u>

- ✓ ***The Assure team has designed and conducted consumer surveys and focus groups to gather feedback on consumer satisfaction with health plans and providers, and on the health behaviors of specific populations.***
- ✓ ***We have expertise administering existing survey instruments, adapting existing instruments, and creating and validating new instruments.***
- ✓ ***We use effective strategies and best practices to maximize response rates.***
- ✓ ***Our analysts and communications staff expertly analyze and report results, providing high-quality and actionable information to our customers.***

<u>The Assure Approach to Quality of Care Surveys</u>

Assure has conducted Quality of Care surveys for multiple clients since 2005. Our survey approach, based on CMS EQR Protocol 5, is shown in Figure 5.

See Section VIII, Attachments 5, 6, 7, 8, 9, and 10 (HCBS Survey Report; HCBS Survey Report Appendices A, B, C; 2016 Adult Survey Report; 2016 Youth Survey Report) as examples of our Quality of Care survey work.

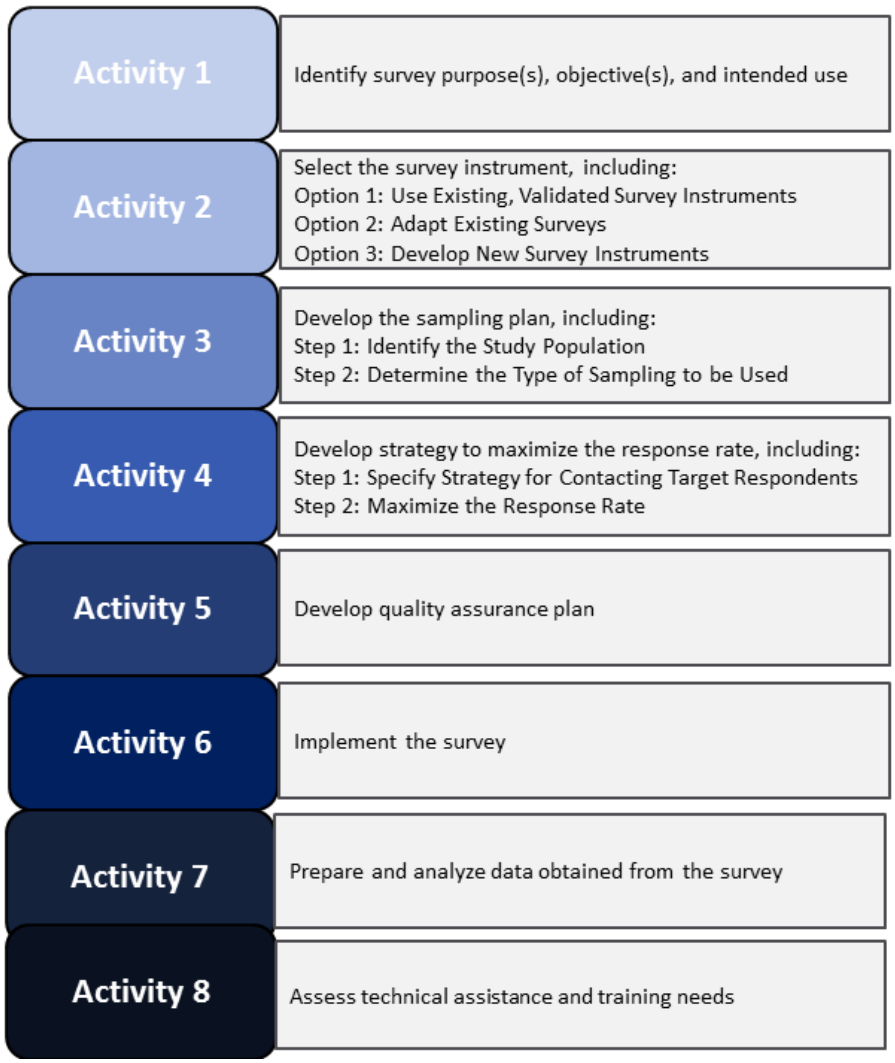

Figure 5. Assure's Approach to Quality of Care Surveys.

The actual deployment of this protocol varies based on state needs. In Oregon, we have administered an annual care satisfaction survey to over 40,000 Medicaid members receiving behavioral health services. This project includes advising the state on sampling methodology for four distinct surveys, multiple mailings through a mail house, online and paper survey collection, data management, gift card incentives, and careful attention to compliance with all Americans with Disabilities Act standards, including provision of survey materials in alternate formats and languages, as needed. This sample process is illustrated in Figure 6 below.

Figure 6. Steps in Oregon Medicaid Satisfaction Survey Process.

<u>Relevant Experience or Examples</u>

While the details vary by project, the Assure team has extensive experience working with state Medicaid agencies to understand the goals and objectives of state projects and deploying our survey processes accordingly. Table 5 highlights our experience conducting surveys for various clients.

Table 5. Assure Team Experience with Quality of Care Surveys.

Project name	Project Time Frame	Customer	Project Description
Mental Health Utilization	***2009–present***	***Oregon Health Authority, Health Systems Division***	***Following federal and state criteria, our staff perform special surveys that include site visits, chart reviews, and staff interviews, producing detailed reports regarding the perception by staff of the quality of care in residential facilities.***
Mental Health Services Consumer Survey	***2005–present***	***Oregon Health Authority, Health Systems Division***	***Each year, Assure surveys more than 40,000 Oregonians to gauge consumer satisfaction with Medicaid-funded mental health services for children and adults. We advise OHA on survey design and sampling methods, manage the survey timeline to ensure that the state meets reporting deadlines, and provide technical assistance and translation services as needed by consumers. We produce detailed reports including methodology, results, statistical tests, and interpretation. These reports provide key programmatic input on the***

Project name	Project Time Frame	Customer	Project Description
			state's efforts to improve mental health services and supports.
Home and Community-Based Services Survey	*2015*	*Oregon Health Authority, Department of Human Services, and agency partners*	*Assure surveyed more than 4,000 providers and 19,000 consumers of home and community-based services. We worked with multiple state agencies to create a single sample, and with more than 100 provider organizations to identify and survey individual providers; coordinated with multiple stakeholders to disseminate information regarding the survey; and provided assistance in completing the survey to both consumers and providers. We summarized methodology in a report and presented data in interactive Tableau workbooks at the request of the state.*
Prescription Drug Monitoring Program (PDMP) Research Study	*2012–2018*	*National Institutes of Health*	*HealthInsight partnered with Oregon Health & Science University and OHA's Public Health Division to conduct a provider survey and qualitative interviews to identify effective clinical practices and barriers to PDMP use; documented clinical decision-making processes to understand how PDMP data are integrated into clinical practice; and collected and analyzed quantitative data on patient outcomes. Results were published in several peer-reviewed journals.*
Resources Encouraging Safe Prescription Opioid Medication Dispensing (RESPOND) Toolkit Study	*2015–Present*	*Agency for Healthcare Research & Quality*	*HealthInsight partnered with Oregon State University School of Pharmacy to conduct focus groups, semi-structured interviews, and pre-post surveys with pharmacists, prescribers, and patients to understand quality issues related to opioid dispensing. We are analyzing these data in combination with dispensing data and PDMP query data to evaluate whether implementation of the toolkit results in safer opioid use.*
Behavioral Risk Factor Surveillance Survey and SF-12	*2004–2005*	*Oregon Department of Human Services*	*Assure staff adapted components of the Behavioral Risk Factor Surveillance Survey and SF-12, along with questions about Oregon Medicaid services, to conduct a statewide survey of Medicaid enrollees. Health care researchers and Oregon DHS have used the results to gain a better understanding of the effect of changes in state policies on enrollees.*

2.1.2.3 Performance measure calculation

Calculation of performance measures in addition to those reported by health plans

<u>The Assure Advantage – Performance Measure Calculation</u>

- ✓ ***The Assure team has been calculating performance measures, including medical record extraction, specification modification, calculation, benchmark and goal setting, and reporting for over 12 years.***
- ✓ ***We have seen measurable improvement in patient health and wellbeing as a result of targeted QI initiatives based on our performance measure calculation.***

<u>The Assure Approach to Performance Measure Calculation</u>

Figure 7 illustrates the Assure team's approach to performance measure calculation, based on CMS EQR Protocol 6.

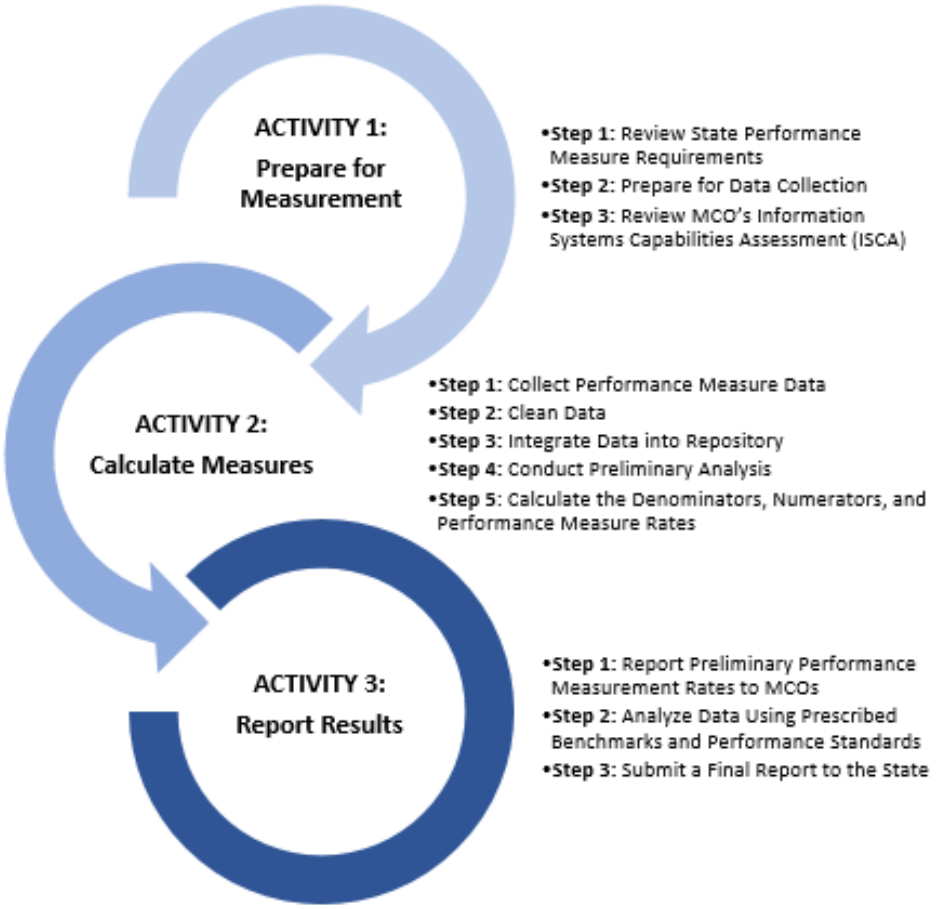

Figure 7. Assure's Approach to Performance Measure Calculation.

We propose to use the following mechanisms to implement the three activities shown in Figure 7.

Activity 1:

- ***Engage with DHCFP early and often throughout the life cycle of the project to understand what the DHCFP needs for the MCOs to measure and how that information should be reported to the State and to CMS.***
- ***For each required performance measure, the Assure team will:***
  - ***Construct the review tools necessary to appropriately gather, analyze, and report the information as specified by DHCFP.***
  - ***Develop analytical tools and resources to manage and interpret the data***
- ***Discuss with DHCFP what the Assure team is encountering in the field that might be informative to DHCFP.***

Activity 2:

- ***Communicate with the MCOs on what is required for the review, including:***
  - ***Data delivery schedule***
  - ***Site visit dates***
  - ***Technical specifications for each measure***
  - ***Any supplemental documentation that may be required***
- ***Complete the review of the submitted documentation, including:***
  - ***Conduct data cleanup and integration***
  - ***Conduct analysis***
  - ***Complete the interpretation required of the data for report preparation.***

Activity 3:

- ***Communicate with the MCOs regarding performance measures.***
- ***Write and submit a technical report to DHCFP outlining the process and providing detailed findings and recommendations for improvement.***

The deployment of this protocol varies according to the specific project. For example, in one performance measure calculation project, Assure performed a medical record review to collect the data elements required to calculate three statewide clinical performance measures, also collecting additional clinical information requested by the state. We hired 10 clinically certified temporary employees to review more than 1,300 medical records in 88 cities in Oregon over seven weeks. Assure advised the state on the sampling methodology; securely managed large, sensitive datasets with personal health information; created data entry tools; trained reviewers; and ensured high ongoing inter-rater reliability. A senior analyst used measure specifications from the

state to calculate the performance measures, and the communications team delivered a high-quality summary report to the state.

Relevant Experience

The Assure team has calculated HEDIS-like performance measures year-over-year for the Medicaid program in New Mexico, in addition to calculating three clinical performance measures to establish a baseline in Oregon. Table 6 presents highlights of our relevant experience.

Table 6. Assure Team Experience with Performance Measure Calculation.

Customer	Project Details
Oregon Health Authority, 2014	***OHA contracted with Assure to perform a medical record review across Oregon to collect the data elements required to calculate three statewide clinical performance measures:*** ***1. Diabetes Control: Hemoglobin A1c Poor Control*** ***2. Controlling High Blood Pressure*** ***3. Depression Screening and Follow-Up*** ***We used measure specifications from the state to calculate the performance measures.***
New Mexico Human Services Department, 2005–present	***Assure regularly works with HSD to calculate plan performance on identified measures using claims data submitted by each plan, performing data quality checks before measure calculation. Reports provide the state Medicaid agency with performance data more quickly than the annual HEDIS cycle calls for.*** ***In 2015, HSD expanded its contract with Assure to propose and adopt modified measure specifications that were rooted in HEDIS measures. The specifications had to be modified to account for a limited look-back period, the result of a new Medicaid waiver (Centennial Care).***

2.1.2.4 Conduct of PIPs in addition to those conducted by health plans

The Assure Advantage – Conducting PIPs

- ✓ ***We have worked with state Medicaid agencies and health plans on PIPs for over 20 years.***
- ✓ ***We provide specialized training and assistance to managed care staff.***
- ✓ ***We have facilitated statewide collaborative PIPs for more than 30 MCOs.***

<u>The Assure Approach to Conducting PIPs</u>

Our methodology for conducting PIPs (see Figure 8) is rooted in CMS EQR Protocol 7 and is similar to that used for validating PIPs (Protocol 3). The following 10-step process is based on detailed steps from the CMS protocol.

1. ***Review the study topic the MCO has selected to determine that it is relevant and prioritized.***
2. ***Assess the MCO's study question to determine if it is clearly defined and if it can be measured.***
3. ***Assess whether the MCO's study population is clearly defined and, if a sample is used, appropriate methodology is used.***
4. ***Assess whether the MCO's study indicator is objective and measurable.***
5. ***Review the MCO's data collection process to validate that valid and reliable data are being reported to the state.***
6. ***Determine whether the MCO's data and analysis results are presented for baseline and first remeasurement.***
7. ***Determine whether the MCO is interpreting its results in accordance with generally accepted analytical methods.***
8. ***Determine whether the MCO is developing and implementing improvement strategies that are accurately designed to change performance based on the quality indicator.***
9. ***Determine whether the MCO's data and analysis results are presented for all measurement periods.***
10. ***Validate that the PIP has demonstrated sustained improvement over time.***

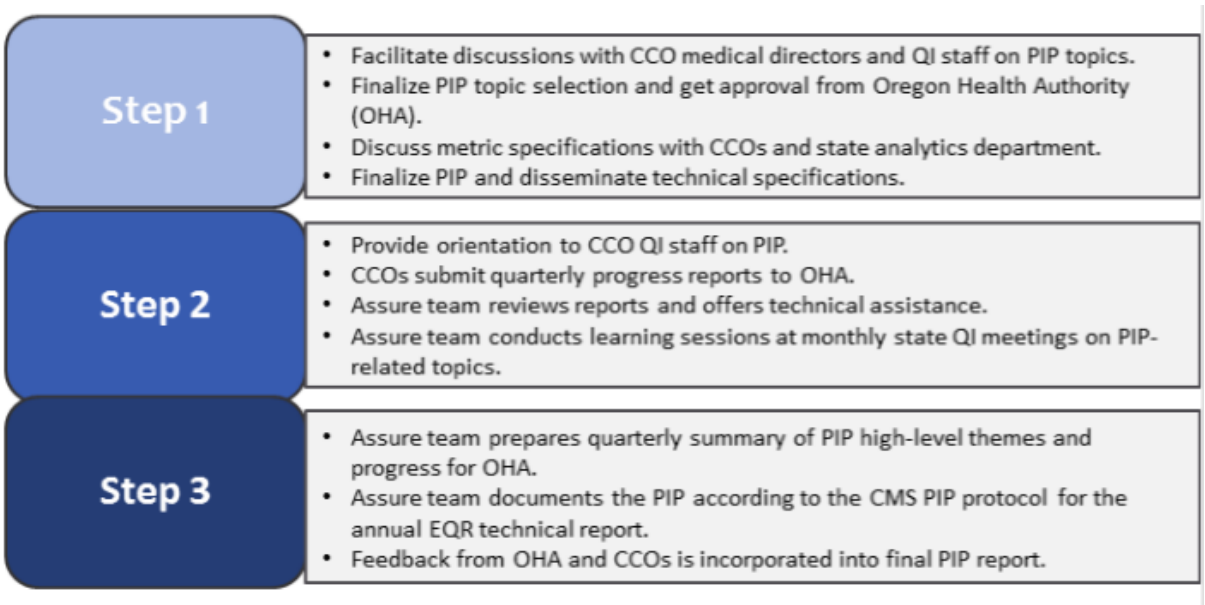

Figure 8. Steps in Conducting Oregon Statewide PIP.

See Section VIII, Attachment 11 (PIP presentation from April Quality Health Outcome Committee) as an example of our Performance Improvement Project work.

<u>Relevant Experience</u>

In Oregon, Assure has facilitated two statewide collaborative PIPs for the state Medicaid agency, as listed below.

Table 7. Assure Team Experience with Conducting Statewide PIPs.

PIP Title	Metric
2013–2015: ***Diabetes Monitoring in people with schizophrenia or bipolar disorder***	***The percentage of Medicaid enrollees aged 18 years or older with co-occurring diagnoses of diabetes and schizophrenia or bipolar disorder who received at least one or more HbA1c test and at least one or more LDL-C test during the measurement year***
2016–2018 ***Opioid safety: reducing prescribing of high morphine milligram equivalent (MME)/day doses***	***<u>#1</u>: The percentage of Medicaid enrollees age 12 years and older who filled prescriptions for opioid pain relievers totaling ≥120 MME on at least one day within the measurement year*** ***<u>#1a</u>: The percentage of Medicaid enrollees age 12 years and older who filled prescriptions for opioid pain relievers totaling ≥120 MME for thirty consecutive days or more within the measurement year*** ***<u>#2</u>: The percentage of Medicaid enrollees age 12 years and older who filled prescriptions for opioid pain relievers totaling ≥90 MME on at least one day within the measurement year*** ***<u>#2a</u>: The percentage of Medicaid enrollees age 12 years and older who filled prescriptions for opioid pain relievers totaling ≥90 MME for thirty consecutive days or more within the measurement year***

In addition to our work in Oregon, Assure has recommended that New Mexico conduct a statewide PIP on issues we have identified within the system. The state Medicaid agency is considering our idea but has not come to a final decision. Once that decision is made in the affirmative, Assure stands ready to help the Medicaid agency develop and implement the measure to improve the quality of health care delivered to Medicaid beneficiaries in the state.

2.1.2.5 Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time

The Assure Advantage – Quality Studies

- ✓ ***Our expert clinicians, researchers, and analysts can design studies to drill down for root causes behind performance and patient satisfaction scores, to help identify high-leverage opportunities for improvement.***
- ✓ ***We have studied topics such as perinatal care, childhood immunizations, behavioral health, asthma, nursing facility care, and well-child care, including Medicaid-mandated Early and Periodic Screening, Diagnosis and Treatment, and quality issues involved in the delivery of managed mental health care.***
- ✓ ***We have extensive experience with focused clinical studies, and our team includes clinical experts with the clinical and QI experience to efficiently and effectively design and perform clinical studies.***
- ✓ ***Members of our team have experience leading HEDIS review, from hiring and training staff to completing submission to NCQA.***
- ✓ ***Our agile and flexible approach provides near real-time information that states can use to make decisions on program management.***

The Assure Approach to Quality Studies

The Assure team has developed several reliable and streamlined approaches for conducting quality studies for both clinical and non-clinical topics. Our approaches are rooted in CMS EQR Protocol 8 and are tailored to the Medicaid agency's needs and the Medicaid population to be studied.

Clinical Approach: ***We used a clinical approach with the Nursing Facility levels of care review in New Mexico for nursing facility and community members who need assistance with their activities of daily living. In this approach, we used a team of nurses from a variety of specialties and certifications, led by a certified Registered Health Information Technology coder. The team reviews MCO documentation of decisions made to provide nursing facility level of care services to Medicaid members in nursing facilities and in the community. Monthly, quarterly and annual reports are provided to the State Medicaid agency to assist their Quality Bureau staff in monitoring the decisions made by the MCOs.***

Data Approach: ***We used a data approach for a project called the HEDIS-like Project. A certified professional project manager worked with a team of analysts to provide the state with rate calculations that were available earlier than those available through the standard NCQA HEDIS review process. During the first year of implementation of***

the New Mexico Centennial Care waiver, the state requested performance data early that did not allow for the continuous enrollment and time lags required by NCQA. Assure's flexible, well-informed professional staff enabled us to rise to the challenge and meet the needs of the state Medicaid program during a time upheaval in the Medicaid waivers program.

***Person-centric Approach:* In Washington, we conducted focus groups with consumers and advocates, Regional Support Network (RSN) and hospital staff, law enforcement, and mental health professionals to assess the degree to which the RSNs had implemented the state's priority standards for managed mental health services.**

In addition to the customized approaches outlined above, our team uses the following protocol activities to guide our quality studies.

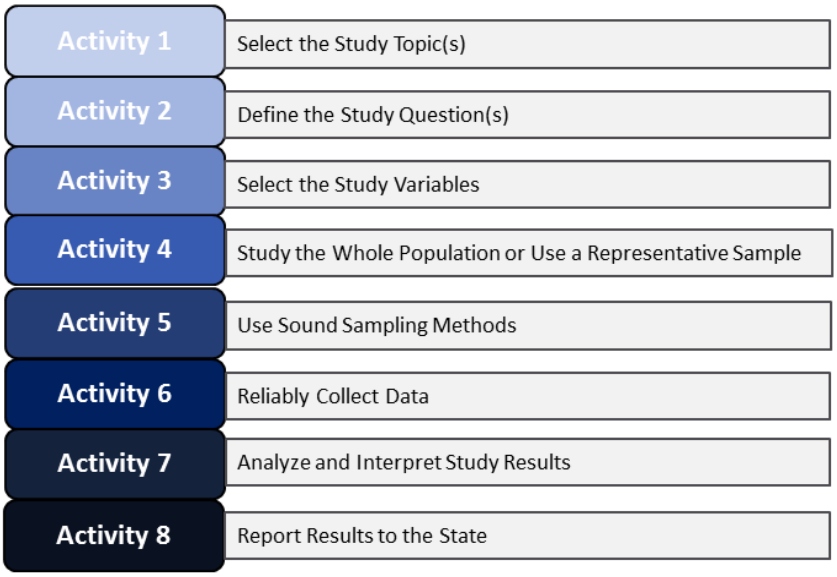

Figure 9. Activities in Assure's Quality Studies.

<u>Relevant Experience</u>

The Assure team has designed, conducted, and reported on many quality studies. Table 8 presents an overview of recent projects we have conducted.

Table 8. Assure Team Experience with Quality Studies.

Customer	Activity Details
Oregon Health Authority, 2017–present	***Assure is reviewing discharges of enrollees hospitalized for serious and persistent mental illness. This two-year study requires a review of ~600 records per quarter, assessing the level of discharge planning for the Oregon Performance Plan with the U.S. Department of Justice.***

Customer	Activity Details
Washington Health Care Authority, 2014	***Assure studied the progress made by mental health RSNs in implementing the state's guiding principles for serving children, adolescents, and young adults with behavioral health challenges. We interviewed RSN staff to probe barriers to implementation and RSNs' plans to address those barriers. We reviewed children's clinical records at 27 outpatient clinics to determine whether the records documented a cross-system care plan.***
Washington Health Care Authority, 2010	***Assure conducted a special study to assess the degree to which the RSNs had implemented the state's priority standards for the delivery of managed mental health services. We reviewed clinical records of mental health service providers for all RSNs; conducted focus groups with consumers and advocates, RSN and hospital staff, law enforcement, and mental health professionals; and reviewed 20 special-population clinical files for each RSN to determine whether care plans were developed with enrollee input and addressed the identified needs. We assessed the implementation of Culturally and Linguistically Appropriate Services (CLAS) standards and age-appropriate services, and identified system strengths, best practices, and service gaps.***
New Mexico Department of Health, 2014-Present	***Assure designed, conducted, and reported on reviews of MCO determinations for high and low levels of care for Medicaid members who receive care in nursing facilities or in the community. These Nursing Facility Level of Care (NF LOC) reviews present up-to-date information to state agency staff on the status of the NF LOC review process with the MCOs, providing an opportunity to communicate process improvements to MCO staff early in the new Centennial Care program. The Assure team worked with the state Medicaid agency to make sure not only that Medicaid beneficiaries were getting the care they need, but that the care was being provided in the proper setting.***

2.1.2.6 Assistance with the Quality Rating System.

<u>The Assure Advantage – Quality Rating System</u>

- ✓ ***The Assure team understands the requirements of the Quality Rating System for Medicaid managed care.***
- ✓ ***We are skilled at working with states to meet their requirements as outlined by federal and state regulation.***

<u>The Assure Approach to Assisting States with QI Activities</u>

In 2016, the Medicaid Managed Care and CHIP Managed Care Final Rule established requirements for adopting and implementing a Quality Rating System (QRS) for states contracting with Medicaid and CHIP MCOs and PAHPs. CMS expects to implement the QRS over the next four years after a public engagement process to develop a proposed framework and methodology, using similar process to that adopted by the (currently under development and implementation) Marketplace QRS for Qualified Heath Plans (QHP). States must implement a QRS within three years from the date of the final notice published in the Federal Register.

The current QRS for QHP issuers includes requirements to submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data to CMS. CMS will calculate the quality performance ratings for QHPs and apply the QRS rating methodology to the validated clinical measure data and a subset of the QHP Enrollee Survey response data to produce quality ratings on a 5-star rating scale. The QRS measure set includes the NCQA HEDIS® measures and a Pharmacy Quality Alliance measure. The measure set also includes survey measures based on questions from the QHP Enrollee Experience Survey.

Assure has assisted states in developing and implementing methods to improve the quality of managed care since we began working in this arena more than 20 years ago. We have assisted states with projects that include stakeholder input, development of performance measures, and meeting other state and federal requirements.

- ***<u>Quality Assessment and Performance Improvement (QAPI) reviews:</u> Assisted the Oregon Health Authority (OHA) in organizing subject matter experts to review the QAPI plans of CCOs, using a secure web application for data capture, and provided comprehensive data for state review.***
- ***<u>Network adequacy assessment and validation:</u> In partnership with OHA, we designed tools, reporting requirements, and training for CCOs on Network Adequacy reporting. We completed a Network Adequacy Assessment and Validation of data submitted by CCOs in 2016 and 2017.***

- ***Consumer satisfaction surveys:*** ***Each year, Assure administers the nationally normed Mental Health Statistical Improvement Project survey to more than 40,000 Oregonians to gauge consumer satisfaction with Medicaid-funded mental health services for children and adults.***
- ***Active participation in Oregon Quality Health Oversight Committee (QHOC) meetings:*** ***Oregon CCOs are required to participate in monthly QHOC meetings at which CCO clinical leaders coordinate QI efforts to support implementation of innovative health care practices. QHOC's primary goal is to coordinate clinical community efforts to promote care integration, efficient working relationships, and data-driven decision making. These meetings provide peer-to-peer learning experiences, subject matter expert education, and QI strategies. The Assure team leads learning collaborative sessions, seeks feedback on EQR processes, and builds working relationships with CCO and state leadership.***
- ***Active participation in Oregon Metrics and Scoring Committee meetings:*** ***This committee identifies outcome and quality measures, including measures for ambulatory care, chemical dependency and mental health treatment, oral health care, and all other health services provided by the CCOs.***
- ***Performance measure validation:*** ***As outlined previously, the Assure team has experience assessing the accuracy of performance measures reported by MCOs and determining the extent to which performance measures calculated by MCOs follow the state specifications and reporting requirements.***

2.1.3 Validation of MCO, DBA/PAHP and CMO Performance Indicators

The Assure team has many years of experience working with state Medicaid programs to evaluate the accuracy and the extent to which Medicaid-specific performance measures followed HEDIS® specifications for the calculation of performance measures. We have expertise applying HEDIS Compliance Audit™ Standards, Policies and Procedures and CMS EQR Protocol 2 for Validating Performance Measures. With an experienced team of auditors, analysts, and communications staff, we are experts at displaying results clearly and concisely, including comparative and trending data that clearly identify areas of strengths and improvement needs for the client.

2.1.3.1 Calculation and Submission of Performance Measures

Performance measures are calculated and submitted annually to the DHCFP by the contracted MCOs; the DBA/PAHP; and the CMO. The Contractor will evaluate the accuracy and the extent to which Medicaid-specific performance measures followed Health Effectiveness Data and Information Set (HEDIS®) Specifications for the calculation of performance measures using one of two methods:

1) A HEDIS® Compliance Audit™ Standards, Policies and Procedures or
2) CMS Validating Performance Measures Protocol

The Assure team will perform these two activities if and when requested by DHCFP, drawing on our long-standing experience described below.

1) HEDIS®Compliance Audit

<u>The Assure Approach to HEDIS Compliance Audits</u>

Assure has 12 years of experience conducting HEDIS, pay-for-performance, and data validation audits with an NQCA HEDIS compliance auditor on staff. Assure staff have led more than a hundred audits for MCOs in California, Montana, Florida, Washington, and Oregon; 60 Value Based Pay for Performance (VBP4P) audits in California; and 30 CMS data validation audits in California and Arizona.

The Assure team works with each state agency to develop a model of auditing and reporting that addresses the state's specific needs. Assure appreciates that each state's Medicaid program, members, and administrators are unique and that a one-size-fits-all approach will not work in the context of a Medicaid program. We pride ourselves on our flexibility, programmatic knowledge, and analytical expertise to design solutions that meet the state's specific needs while still adhering to the CMS requirements.

An example of our customized model is that of our California (Medi-Cal) audits. The major steps in our audit of Medi-Cal managed care health plans (MCPs) include:

- ***annually report performance measurement results***
- ***produce Plan-Do-Study-Act (PDSA) cycle worksheets for poor performance***
- ***conduct ongoing PIPs***
- ***participate in the administration of consumer satisfaction surveys***

The state Department of Health Care Services (DHCS) selects a set of performance measures, called EAS measures, to evaluate the quality of care delivered by MCPs to their beneficiaries. DHCS selects most EAS measures from HEDIS, providing a standardized method to objectively evaluate MCPs' delivery of services. MCPs must annually collect and report rates for EAS measures. When applicable, MCPs are also

required to report rates for any statewide collaborative measure chosen by DHCS and the MCPs.

1. ***Annual Onsite EAS Compliance Audit consists of an assessment of an MCP's (or its vendor's) information system capabilities, followed by an evaluation of an MCP's ability to comply with specifications outlined by DHCS for HEDIS and non-HEDIS measures. This audit uses the NCQA HEDIS Compliance Audit methodology for HEDIS measures to assure standardized reporting of quality performance measures throughout the health care industry.***
2. ***Contracted EAS audits include performance measure validation.***
3. ***Managed Long-Term Services and Supports (MLTSS) Measures: To comply with federal reporting requirements, DHCS requires those MCPs that provide MLTSS to report on a small set of measures selected by DHCS. MCPs that provide MLTSS must provide the necessary data specific to these measures to DHCS. The measures are reported in the same time frame as the rest of the EAS.***
4. ***Consumer Satisfaction Surveys using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®3) surveys to assess member satisfaction with MCPs: We conduct the CAHPS® survey for the adult and child Medicaid population every three years, and for the Children's Health Insurance Program Medicaid population, including children with chronic conditions.***

2) CMS Protocol for Validating Performance Measures

<u>The Assure Approach to Validating Performance Measures</u>

The Assure team has many years of experience working with state Medicaid programs to conduct PMV and ISCA activities, working collaboratively to evaluate the accuracy and the extent to which Medicaid-specific performance measures follow HEDIS specifications. We hold our team to the highest standards, always conducting PMV according to statistically sound methods and generating actionable QI recommendations for state Medicaid programs. The ISCA team is skilled at examining organizations' information and data processing systems and reporting procedures to determine the extent to which they support the production of valid and reliable state performance measures and the capacity to manage the health care of the organization's enrollees. With an experienced team of auditors, analysts, and communications staff, we are experts at displaying results clearly and concisely, including comparative and trending data that clearly identify areas of strengths and improvement needs for the client.

The Assure team's approach to performance measure validation is rooted in the CMS EQR protocol and will include the following steps.

***Step 1:* We will complete a HEDIS Road Map for any HEDIS organization following NQCA standards and guidance. The Roadmap is an organizational assessment that describes the organization's services (e.g., medical, vision, behavioral, pharmacy), systems (e.g., claims and encounter processing, provider credentialing and enrollment), and data sources and infrastructure (e.g., data collection, management, storage, mapping to HEDIS reporting).**

***Step 2:* We will conduct an ISCA, assessing each organization's ability to comply with 42 CFR §438.242. The ISCA also assesses the completeness, accuracy, and timeliness of data received from providers, and the organization's ability to make data available to the state. Assure uses an ISCA protocol tool to assess MCOs' and third parties' IT data processing, including 11 comprehensive and distinct sections, from staffing to member enrollment and vendor management. Each section has clear scoring criteria and lists of required supporting documentation, ensuring that organizations are aware of expectations. The tool also includes guidance to educate users on industry norms such as password standards and links to the state's administrative rules. Each MCO and the state receive a report identifying strengths and weaknesses or areas for improvement and are provided a two-week period to submit new documentation or information to address any weaknesses.**

***Step 3:* Using a tool similar to the ISCA tool, the PMV will assess the state's production of performance measures. We follow the CMS EQR protocol, ensuring that we meet state-specific IT and data configuration needs.**

The Assure team performs all PMV and ISCA activities. We have worked closely with state clients and MCOs to coordinate onsite, telephonic, or virtual meetings; lead informative discussions on new tools; and provide well-designed reports ensuring that organizations understand their strengths and areas for improvement.

As part of the PMV and ISCA assessment, the Assure team works with each MCO and the state to gain an understanding of any new internal organizational leadership or staffing structure changes, planned or completed mergers, acquisitions or business service offering changes, and any IT changes that may impact the ability to deliver accurate, complete, and timely data used to calculate performance measures.

See Section VIII, Attachment 12 (Oregon Performance Measure Calculation – Summary Report of 2013 Measures) as an example of our Performance Measure Calculation work.

<u>Relevant Experience</u>

The Assure team has calculated HEDIS-like performance measures year-over-year for the Medicaid program in New Mexico, in addition to calculating three clinical

performance measures to establish a baseline in Oregon. Highlights of our relevant experience are outlined in Table 9.

Table 9. Assure Team Experience with Validating Performance Measures.

Customer	Project Details
Oregon Health Authority, 2005–present	***OHA has developed incentive measures to evaluate the Oregon CCOs' performance on health care quality and access, and to hold CCOs accountable for improved outcomes. Assure conducted an ISCA of all CCOs, dental organizations, behavioral health organizations, third-party data managers, and the state, and subsequently validated the following incentive measures:*** • ***Adolescent Well Care Visits (age 12–21)*** • ***Alcohol or Other Substance Misuse (SBIRT) (age 12+)*** • ***Ambulatory Care: Emergency Department Utilization (all ages)*** • ***Dental Sealants (age 6–9, 10–14)*** • ***Developmental Screening in the First 36 Months of Life (age 0–3)*** • ***Effective Contraceptive Use (age 15–50)*** • ***Follow-up after Hospitalization for Mental Illness (age 6+)***
Washington, 2012–2014	***Assure performed a HEDIS audit for MCOs (physical health) and performance measure validation and ISCA audits for Regional Service Networks (behavioral health). Year over year, Assure worked with local plans and the state to monitor progress on previous years' recommendations, ultimately improving the quality of the performance measure calculations.***
New Mexico Human Services Department, 2015	***The Assure team has been completing a full ISCA every two years since 2005, initially for 7 MCOs in a previous waiver (Salud and CoLTS), and then for 4 Centennial Care MCOs. The ISCA was for each MCO and their delegated vendors—pharmacy, dental, transplant and transportation.***

2.1.3.2 Verification of methods used to collect HEDIS performance measures. The validation process will be accomplished through methods described in the most recent version of the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ Specifications or the CMS Validating Performance Measures protocol. The audit will be conducted for SFY contract years 2019 and each subsequent EQRO contract renewal years.

If and when requested, Assure will initiate the validation process through methods described in the NCQA HEDIS Compliance Audit™ Specifications or CMS EQR Protocol 6 for Validating Performance Measures.

The Assure team has extensive experience verifying data collection methodology using both NCQA HEDIS Compliance Audit specifications and CMS EQR Protocol 6. With an experienced team of auditors, analysts, and communications staff, we are experts at displaying results clearly and concisely, including comparative and trending data that clearly identify areas of strengths and improvement needs for the client.

A. Validation of HEDIS and performance measures reported (as required by the State) during the preceding 12 months.

Assure will validate HEDIS™ and performance measures reported as required by DHCFP during the preceding 12 months.

As described in Table 9, Assure has been completing a full ISCA every two years since 2005, initially for 7 MCOs and then for 4 Centennial Care MCOs. The ISCA was for each MCO and their delegated vendors—pharmacy, dental, transplant and transportation.

The State of Oregon has modified several HEDIS measures, deviating from the original specifications to evaluate the Oregon CCO's performance on health care quality and access, and to hold CCOs accountable for improved outcomes. Assure conducted an ISCA on all CCOs, dental organizations, behavioral health organizations, third-party data managers, and the state, and subsequently validated the following incentive measures:

- ***Adolescent Well Care Visits (age 12–21)***
- ***Alcohol or Other Substance Misuse (SBIRT) (age 12+)***
- ***Ambulatory Care: Emergency Department Utilization (all ages)***
- ***Dental Sealants (age 6–9, 10–14)***
- ***Developmental Screening in the First 36 Months of Life (age 0–3)***
- ***Effective Contraceptive Use (age 15–50)***
- ***Follow-up after Hospitalization for Mental Illness (age 6+)***

In Washington, to ensure data integrity, Assure subcontracted with an NCQA-certified HEDIS auditor to evaluate each plan's data collection process. The NCQA HEDIS

Compliance Audit™ assured purchasers and health plans of fair and accurate comparisons of plan performance.

B. Audited HEDIS Data using Interactive Data Submission System (IDSS). Submit information to NCQA, if applicable.

If and when requested, Assure will audit HEDIS™ data using the Interactive Data Submission System (IDSS) and will submit information to NCQA, if applicable.

The Assure team has expertise using the IDSS to submit audited HEDIS™ data to NCQA. In our contract with Washington Health Care Authority, Assure compiled individual MCO data from the NCQA-audited IDSS results. We derived the state average for each measure by adding individual MCO numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and converting the ratio to the appropriate reporting unit.

In New Mexico, the Assure team uses the IDSS data to report, analyze, and provide trended results to the state Medicaid agency as part of the performance measure validation. Our analysis provides valuable insight to the state on how the Medicaid program is performing and on areas for concern that may require additional attention. The Assure team uses the IDSS data and its own analysis and interpretation of those data to provide recommendations to the state and the MCOs for process improvement and PIP focus areas.

C. HEDIS™ Comparative Analysis for SFY 2019 and each subsequent EQR contract renewal year.

If requested, Assure will conduct a HEDIS™ Comparative Analysis for SFY 2019 and each subsequent EQR contract renewal year.

Assure performed a HEDIS™ Comparative Analysis as part of our EQRO contract with the Washington Health Care Authority (HCA). All five contracted MCOs were required to hold NCQA accreditation by December 31, 2016, and Assure worked with the state and MCOs to meet this requirement.

HEDIS results for a measurement year were gathered, audited, and reported the following year. Results were based on a statistically valid random sample of health plan enrollees. Assure compiled individual MCO data from the NCQA-audited IDSS results. We derived the state average for each measure by adding individual MCO numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and converting the ratio to the appropriate reporting unit.

D. The awarded vendor is required to submit a comparative analysis and production of a HEDIS report using HEDIS performance measures data submitted by each MCO and DBA/PAHP

If requested, Assure will prepare and submit a comparative analysis report using HEDIS performance measure data submitted by each MCO and DBA/PAHP.

Assure produced a HEDIS™ performance measure comparative analysis report for the Washington Health Care Authority (HCA) each year from 2007 to 2014. These reports analyzed and reported on the difference between HEDIS™ rates calculated through the administrative vs. the hybrid method. The Washington MCOs reported five hybrid measures: childhood immunizations, adolescent immunizations, weight assessment and counseling, comprehensive diabetes care, and the well-child measure set.

Assure worked with MCOs to use supplemental data to calculate their HEDIS™ measures. Three distinct categories of supplemental data apply to HEDIS™ reporting: Standard, Nonstandard, and Member-reported. All Washington MCOs used auditor-approved supplemental data in calculating their HEDIS™ measures. We examined HCA's processes and source data as a component of the MCO audit. All MCOs reported that the state-supplied data had a positive impact on their well-child measures.

2.1.3.3 Validation of Performance Improvement Projects (PIPs).
The awarded vendor will be required to annually evaluate and validate two clinical PIPs and three non-clinical PIPs for the MCO; and one clinical PIP and one non-clinical PIP for the DBA/PAHP.

Assure will annually evaluate and validate two clinical PIPs and three non-clinical PIPs for the MCO, and one clinical PIP and one non-clinical PIP for the DBA/PAHP.

The Assure team conducts PIP validation according to the CMS protocol to ensure that each PIP is designed, conducted, and reported according to methods that align with CMS requirements, thereby establishing confidence in any reported improvements. Our 10-step process includes:

1. ***Review the study topic the MCO has selected to determine that it is relevant and prioritized.***
2. ***Assess the MCO's study question to determine if it is clearly defined and if it can be measured.***
3. ***Assess whether the MCO's study population is clearly defined and, if a sample is used, appropriate methodology is used.***
4. ***Assess whether the MCO's study indicator is objective and measurable.***

5. ***Review the MCO's data collection process to validate that valid and reliable data are being reported to the state.***
6. ***Determine whether the MCO's data and analysis results are presented for baseline and first remeasurement.***
7. ***Determine whether the MCO is interpreting its results in accordance with generally accepted analytical methods.***
8. ***Determine whether the MCO is developing and implementing improvement strategies that are accurately designed to change performance based on the quality indicator.***
9. ***Determine whether the MCO's data and analysis results are presented for all measurement periods.***
10. ***Validate that the PIP has demonstrated sustained improvement over time.***

To determine the level of compliance with the PIP validation standards, Assure scores each PIP following the guidance of the CMS protocol. Each standard has a potential score of 100 points for full compliance. The total points earned for each standard are weighted and combined to determine an overall PIP score. The overall score is weighted 85% for demonstrable improvement in Year 1 (Standards 1–8) and 15% for sustained improvement in later years, as demonstrated by remeasurement (Standards 9–10). Table 10 shows an example scoring calculation.

Table 10. Example PIP Scoring Calculation.

Standard	Compliance rating	Assigned points	Weight	Points score
Demonstrable Improvement				
1	Fully met	100	15%	15.00
2	Fully met	100	5%	5.00
3	Partially met	50	10%	5.00
4	Partially met	50	15%	7.50
5	Fully met	100	10%	10.00
6	Minimally met	25	10%	2.50
7	Partially met	50	10%	5.00
8	Partially met	50	10%	5.00
		Demonstrable improvement score		50.00
Sustained Improvement				
9	Substantially met	75	5%	3.75
10	Partially met	50	10%	5.00
		Sustained improvement score		8.75
		Overall PIP score		58.75

For a PIP that has completed no more than one remeasurement, the maximum overall score is 85 points. If the PIP has progressed to at least a second remeasurement, enabling reviewers to assess sustained improvement, the maximum overall score is 100. Table 11 shows the PIP scoring ranges used.

Table 11. PIP Scoring Ranges.

Compliance rating	*Description*	*100-point scale*	*85-point scale*
Fully met	***Meets or exceeds all requirements***	***80–100***	***68–85***
Substantially met	***Meets essential requirements, has minor deficiencies***	***60–79***	***51–67***
Partially met	***Meets essential requirements in most, but not all, areas***	***40–59***	***34–50***
Minimally met	***Marginally meets requirements***	***20–39***	***17–33***
Not met	***Does not meet essential requirements***	***0–19***	***0–16***

Validity and reliability of study results

Assure will assess the overall validity and reliability of the study results for each PIP. Confidence levels and their definitions are shown in Table 12.

Table 12. Confidence Levels for PIP Study Results.

Confidence Level	Definition
High confidence in reported results	***Standards for data collection and interpretation of results are substantially to fully met. Any identified gaps are minor and do not impact validity or reliability of results.***
Low confidence in reported results	***Standards for data collection and interpretation of results are partially met, indicating study weakness, such as unmitigated threats to validity or unexplained changes to the study design. Validity of reported results is questionable.***
No confidence in reported results or data analysis plan	***Standards for data collection and interpretation of results are not met. Study results are neither valid nor reliable. Data analysis plan is unlikely to produce valid results.***

The Assure team is highly experienced in helping MCO staff develop and implement meaningful, sustainable PIPs. Assure incorporates information from all PIP reviews and meetings with the state and MCOs to develop an assessment of technical assistance and training needs. After evaluating the current MCO staff's knowledge base and

report documentation skills, the Assure team develops trainings that address MCO staff knowledge gaps and build on strengths. PIP trainings have been well received by MCO staff and have led to improved compliance with PIP standards. Training topics have included selecting a PIP topic, conducting a root cause analysis, using tracking and monitoring tools, implementing PDSA cycles, interpreting results, potential threats to validity, and common PIP pitfalls.

For example, a training on PIP topic selection would include the needs of the contractor and the enrollees in the service areas, as well as the current status and prior work, so that the study topic meets the needs of Nevada's Medicaid population as well as the CMS criteria. Topics must be relevant and measureable with a need supported by data. MCOs must collaborate with their provider systems to ensure support for the topic and the ability to ensure improvement/outcomes.

Once a topic is selected, the Assure team performs root cause analyses to identify critical levers for change and then teaches the rapid cycle improvement method, which allows testing of ideas quickly with small populations before investing time and other resources in processes that are flawed in design. This methodology allows for constant evaluation of a process and nimble changes to achieve successful interventions on a small scale that can be spread to larger populations once fully developed. Additional training sessions on defining study indicators and populations, creating data collection and analysis plans, identifying appropriate interventions, and interpreting study results have helped MCO staff ensure that their PIPs produce meaningful improvements in clinical outcomes and service.

2.1.3.4 Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months.

Assure will conduct a validation of MCO and DBA/PAHP network adequacy during the preceding 12 months. Our team will provide guidance and support to DHCFP in meeting the state's requirements to ensure adequate access and availability for Medicaid members, following the steps illustrated below.

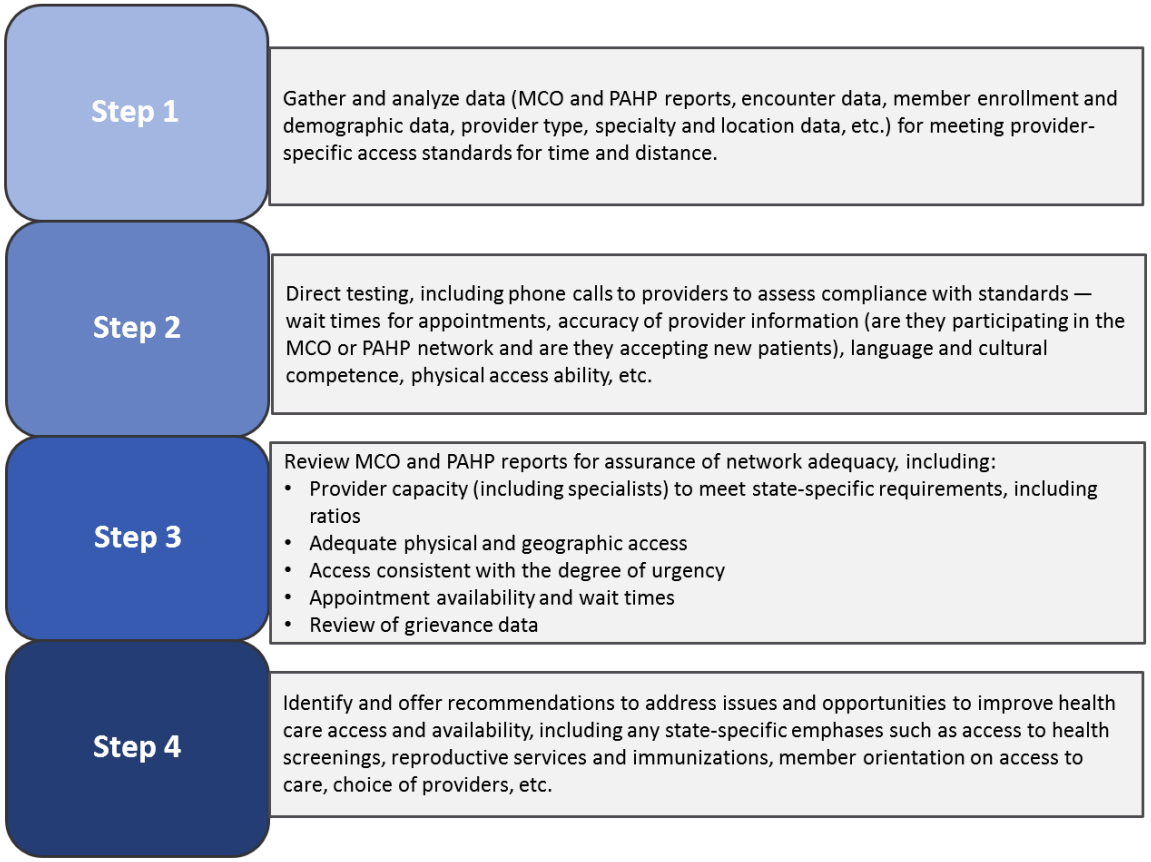

Figure 10. Steps in Validating Network Adequacy.

In addition to the steps outlined above, the Assure team will partner with DHCFP to modify validation methods in compliance with the network adequacy validation protocol as it is being developed and issued.

> ***2.1.3.5 Validation of the Nevada DHCFP State Quality Assessment and Performance Improvement Strategy (QAPIS) in SFY 2019*** and each subsequent EQR contract renewal year. The comprehensive quality assessment and performance improvement program must include PIPs; collection and submission of performance measurement data; mechanisms to detect both underutilization and overutilization of services; and mechanisms to assess the quality and appropriateness of care furnished to recipients with special health care needs as defined by the State in the quality strategy under 438.340.

Assure will validate DHCFP's State Quality Assessment and Performance Improvement Strategy (QAPIS) in SFY 2019 and each subsequent EQR contract renewal year.

The Assure team has reviewed and validated the state QAPIS in Oregon and Washington. Each of these reviews used a different approach based on the state Medicaid agency's requirements.

The initial QAPIS validation reviews were narrowly focused on determining whether the QAPIS addressed all relevant federal requirements. Examples of these reviews are attached in Section VIII, Attachments 13 and 14 (Extract from OMHAS Quality Strategy Review; Quality Strategy Review Report).

The Washington Medicaid agency required a more robust approach for the managed care program for mental health services. The review was focused on the Quality Strategy outcomes, including compliance with regulatory requirements, performance measurement, quality initiatives, and strategic planning. Assure interviewed Regional Support Network (RSN) staff and stakeholders and conducted clinical record reviews to determine whether the Quality Strategy initiatives were being implemented by the RSNs and the contracted providers. A sample report from this review is attached in Section VIII, Attachment 15 (Extract from 2013 WA EQR Annual Report).

For the past two years, Assure has reviewed the annual QAPI program documentation of each of the 16 CCOs in Oregon. The CCOs were required to address the federal requirements included in their contracts and outlined in the Medicaid waiver. Assure reviewed QAPI documentation of over- and underutilization and system activities for physical, dental, and behavioral health services for members with special health care needs, such as those with severe and persistent mental illness.

As part of this review, Assure reviewed CCO PIPs for evidence of an adequate quality management structure, a quality strategy work plan with goals and objectives, assessment of the effectiveness of the QAPI program, identification of gaps in improvement, and the method for monitoring and implementing PIPs.

A. The awarded vendor will evaluate the completeness of the state quality assessment and performance improvement strategy, examining strengths, limitations, and recommending improvements in the description or implementation of the strategy

Assure will evaluate the completeness of the state QAPIS, examining strengths and limitations and recommending improvements in the description or implementation of the strategy.

As part of this review, we will review MCO PIPs for evidence of an adequate quality management structure, a Quality Strategy work plan with goals and objectives, assessment of the effectiveness of the QAPI program, performance measurement,

identification of gaps, and the method for monitoring and implementing PIPs. These reviews will also include over- and underutilization, assessment of access to services (availability, timeliness), cultural considerations, care coordination (especially for those with special health care needs) and integration of services. As part of this review, Assure will coordinate and compile subject matter expert review of the MCOs' QAPI plans in meeting the state's quality strategy goals. We will provide recommendations for each element to the Medicaid agency.

B. The awarded vendor will provide technical assistance to the Division as needed to incorporate changes and recommendations for the development of the Quality Strategy and performance tracking tool for the MCOs, DBA/PAHP, and CMO.

Assure will provide technical assistance to DHCFP as needed to incorporate changes and recommendations for the development of the Quality Strategy and performance tracking tool for the MCOs, DBA/PAHP, and CMO.

The Assure team is ready to assist DHCFP in incorporating EQR recommendations into the Quality Strategy, and will work with DHCFP to develop a performance tracking tool for the health plans to use. We can provide technical assistance on the use of tools and can modify the tools as audit criteria change based on the prior-year experience and review. Assure has experience in Oregon facilitating collaborative workgroups in which MCOs share best practices and specific interventions for targeted populations to address needs identified in the QAPIS review.

C. The evaluation in each year should include information about the State's progress and status of goals; trends in clinical or service quality performance improvement programs; corrective actions and sanctions; progress and status of value based purchasing; and an assessment of the overall structure and process of the State Quality Assessment and Performance Improvement Strategy. Findings from this assessment will be incorporated as a chapter in the EQR Technical Report described below, entitled "External Quality Review Technical Report".

Assure will include a chapter in the EQR Technical Report with information about the state's progress and status of goals; trends in clinical or service quality performance improvement programs; corrective actions and sanctions; progress and status of value-based purchasing; and an assessment of the overall structure and process of the State QAPIS.

The Assure team has incorporated the QAPI review results into the annual EQR report for Oregon, including trends in service quality, performance measure trends, and PIP results. Summary data are included on findings and related corrective action with updates on the status of the corrective action. We have incorporated data trends as appropriate, and a summary of the overall State QAPIS, as evidenced by the review of the individual MCOs.

D. DHCFP requires an electronic copy of the final report in PDF and Word Format annually and three (3) hard copies of the final report for distribution.

Assure will provide an electronic copy of the final report in PDF and Word format annually and three hard copies of the final report for distribution.

2.1.3.6 Annual External Quality Review Technical Report –

The vendor will be required to produce a detailed technical report that must include:

A. Objectives; technical methods of data collection and analysis; description of data obtained, including validated performance measure data for each activity; and conclusions drawn from the data.

B. An assessment of each MCO's and DBA/PAHP's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

C. Recommendations for improving the quality of health care services furnished by each MCO and DBA/PAHP including how the State can target goals and objectives in the quality strategy, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid recipients.

D. Methodologically appropriate, comparative information about all MCOs and DBA/PAHP, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).

E. An assessment of the degree to which each MCO and PAHP, has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

F. Revision. States may not substantively revise the content of the final EQR technical report without evidence of error or omission.

G. Availability of information. (1) The State must contract with a qualified EQRO to produce and submit to the State an annual EQR technical report in accordance with paragraph (a) of this section. The State must finalize the annual technical report by April 30th of each year,

H. Each year the Vendor will include a Chapter in the EQR Technical Report summarizing the findings from the assessment of the DHCFP's implementation of the State Quality Assessment, Performance Improvement Strategy and Performance Tracking Tool. DHCFP requires an electronic copy of the final report in PDF and Word Format annually and three (3) hard copies of the final report for distribution.

The Assure team will produce an Annual EQR Technical Report that complies fully with 42 CFR §438.354(a) and that meets all requirements listed above. In our capacity as EQRO in other states, we have produced such reports each year since 2005. Assure strives to produce reports that are readable, comprehensible, and usable, and we have a track record of producing reports that reflect these considerations across multiple states for many years. Our reports identify strengths and weaknesses at the system level and for individual MCOs. We have the clinical and administrative expertise to identify efficiencies and best practices that MCOs and the state can implement to improve the health of Medicaid beneficiaries while controlling costs and administrative burden.

Our annual EQR technical reports provide specific, actionable recommendations to key stakeholders, including MCOs and, in some instances, the state Medicaid agency, as we identify best practices and other efficiencies. Our recommendations often result in contractual changes and are credited with directly improving the efficient delivery of appropriate care to Medicaid beneficiaries.

Assure's annual EQR technical reports focus on performance comparisons and best practices across the state's managed care plans. Our general process for creating these comparisons includes:

1. ***Complete all MCO-specific reports with strengths, weaknesses, and corrective action plans.***
2. ***Synthesize all MCO-specific results into the aggregate technical report.***
3. ***Draw out statewide recommendations based on results of the MCO-specific analyses.***

Our organizational approach is to incorporate the required federal regulatory criteria into the presentation of results for each review activity (e.g., compliance review, PIP validation, performance measure validation and assessment, network adequacy, and

EDV, as well as any additional optional activities), one review activity per chapter. Each chapter includes an introduction detailing:

- ***the objectives of the EQR activity and associated methodology***
- ***how we gathered, validated, and analyzed the data for the assessment (e.g., review of documentation, desktop audits, onsite interviews of health plan and provider staff, phone interviews)***
- ***the type of data and documentation we received (e.g., policies and procedures, program descriptions, survey results, monitoring tools, monitoring results, protocols, work flow documentation)***

In scoring and presenting the results of the EQR monitoring activities, Assure uses the categorical scoring of "Met" (pass), "Partially Met" (pass), or "Not Met" (fail) for each evaluation component. The categorical scores allow both the state and the managed care plans to understand clearly which assessment components passed the review and which components require a corrective action plan. For each section in the annual report, we note strengths and weaknesses, both system-wide and specific to individual health plans, as well as improvement opportunities and recommendations requiring a corrective action plan. In subsequent reports, we follow up on and address the corrective action plans that were issued during the previous-year's EQR.

Finally, we include an executive summary at the beginning of the Annual Technical Report to provide readers with ready access to strengths and recommendations, followed by a brief overview of the state's health care landscape.

To maximize reader comprehension, we present strengths and weaknesses in bulleted form, organized by timeliness, access, and quality; recommendations requiring corrective action plans in shaded call-out boxes; and comparative results of all MCOs in table format using visual displays for each score. We also include individual MCO profiles in a report appendix, summarizing the results of all monitoring activity in easily accessible form.

Each section of the annual report undergoes an intensive editing and review process to ensure that the writing is clear, concise, and straightforward. Once we produce a draft of the report, we submit it to the state Medicaid agency for feedback and comment, which our team incorporates into a final version. This process ensures that we produce easy-to-read, polished, and informative reports with actionable recommendations that managed care plans and the state will find valuable.

Examples of our reports are attached in Section VIII, Attachments 16 and 17 (2016 OHA Annual EQR Report; 2016 OHA Annual EQR Report, Appendix A).

2.1.4 Compliance Review

Conduct a compliance review evaluating the effectiveness of the quality strategy within the previous 3 years. This review will be broken out in sections to be reviewed annually.

Assure will conduct a compliance review evaluating the effectiveness of the quality strategy within the previous three years. This review will be broken out in sections to be reviewed annually.

The Assure team conducts audits of each MCOs' internal and delegated QI functions, and provides feedback and guidance to help the managed care plans provide better, safer care for enrollees and comply with regulatory or accreditation criteria. We collect, review, assess, and analyze information on the plans' compliance with managed care regulatory and contractual standards in the areas of:

- ***enrollee rights and protections***
- ***grievances and appeals***
- ***certification and program integrity, including fraud, waste, and abuse***
- ***quality assessment and performance improvement***
- ***care coordination and transitions of care***
- ***delegation to subcontractors***
- ***credentialing of contracted providers***
- ***adverse benefit determination***
- ***delivery system availability of services***
- ***coverage and authorization of services***
- ***provider selection and credentialing***
- ***practice guidelines***
- ***health information systems***

Our reviews are designed to answer the following questions.

1. ***Does the MCO meet CMS regulatory requirements?***
2. ***Does the MCO meet the requirements of its contract with the state Medicaid agency?***
3. ***Does the MCO monitor and oversee contracted providers' performance of delegated activities to ensure regulatory and contractual compliance?***
4. ***Does the MCO have policies and procedures in place to discover and take action to address fraud, waste, and abuse when they occur in the Medicaid program?***
5. ***Is the MCO maintaining ultimate responsibility and oversight for adhering to and otherwise fully complying with all terms and conditions of its contract with the State despite having delegated those responsibilities to a subcontractor?***
6. ***Does the MCO have processes in place to monitor the effectiveness of its care coordination processes?***

7. ***Does the MCO have policies and procedures in place to facilitate smooth transitions for its members transferring to and from different health care settings?***

While our compliance review processes are similar from state to state, each is tailored to meet the specific needs of each state. We will adapt them to meet the needs of Nevada's program. As stated throughout this proposal, our reviews are based on the CMS EQR protocol, with state-specific modifications developed in consultation with the Medicaid agency.

Our general process is as follows:

1. ***The Assure team works with the state Medicaid agency to determine areas of particular interest or concern to the state.***
2. ***At the beginning of each year, an initial meeting is held with all health plans to lay out the timeline for the audit activities, review technical specifications for document submission, and answer questions or clarify instructions. This meeting, which can be conducted either in person or via teleconference, addresses all audits for the year.***
3. ***Documents for the audit are collected electronically through our secure portal that is maintained at no cost to the health plans. Documents containing personal health information are quickly and securely shared through the portal, allowing for more efficiency in collecting and storing documentation that supports the results of the EQR audit.***
4. ***The Assure team completes the review, offers the health plans an opportunity to resubmit any documentation that will further support their compliance, and completes a report for each individual plan.***
5. ***Assure completes the report based on the requirements set forth by the state. The report includes a summary analysis of scores and findings along with accompanying recommendations for improvement.***
6. ***Assure follows up in subsequent years regarding findings, opportunities for improvement, and observations collected in the initial review. The follow-up status is reported to the state in individual plan reports and in the final annual technical report.***
7. ***Throughout the review, Assure uses current technology to communicate with MCOs and their staff by providing educational opportunities in person, remotely, and on demand. Reviews are completed in the Assure office so the time used at the annual site visit at each health plan focuses on staff interviews and opportunities to discuss best practices to improve enrollee care. MCOs have***

expressed positive feedback with the reduction in time their staff is required to travel or be onsite for EQR audits.

2.1.5 Technical Assistance and Optional Activities

The Assure team provides in-person and remote assistance to the Medicaid agency and managed care plan staff, individually or in groups. Technical assistance topics range from using secure electronic portals for sharing sensitive data, to how to create and monitor PIPs for Medicaid populations. We have also provided trainings on quality assurance and performance improvement, disaster recovery/business continuity planning, Medicaid EDV and care transitions.

The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.358(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of health care initiatives. Optional activities described in 42 CFR 438.358(c) may include:

2.1.5.1 Nevada Medicaid FFS population activities such as:

A. Clinical focused studies;
B. Healthcare Effectiveness Data and Information Set (HEDIS®) or HEDIS like calculations and audits;
C. Encounter data validation and omission studies; and
D. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.

As requested, Assure will provide technical assistance and/or optional activities described in 42 CFR §438.358(c), or comparable activities that assess the quality or utilization of services in the fee-for-service program, to DHCFP and the participating MCOs, PAHP, and CMO during the contract period.

Examples of our expertise and previous work related to 2.1.5.1 A through D are described below:

Subsection A: Clinical focused studies

Section 2.1.2.5 above provides detailed examples of Assure's expertise and experience designing, developing, implementing, and reporting upon clinical focused studies. Our expert clinicians, researchers, and analysts can design studies to drill down for root causes behind performance and patient satisfaction scores, to help identify high-leverage opportunities for improvement. Past topics have included perinatal care, childhood immunizations, behavioral health, asthma, nursing facility care, and well-child care, including Medicaid-mandated Early and Periodic Screening, Diagnosis and Treatment, and quality issues involved in the delivery of managed mental health care.

The Assure team has extensive experience with focused clinical studies. The clinical experts on our team have both the clinical and QI experience to efficiently and effectively design and perform clinical studies.

Subsection B: HEDIS or HEDIS-like calculations and audits

Members of the Assure team have experience leading HEDIS review, from hiring and training staff to completing submission to NCQA. We have also designed methods for calculating HEDIS-like rates. Following New Mexico's rollout of Centennial Care in 2014, the New Mexico Human Services Department contracted with Assure to produce HEDIS-like measure specifications to be used for oversight of managed care organizations in the state.

The purpose of the HEDIS-like project was to provide the state Medicaid agency with performance data more quickly than the annual HEDIS cycle allows. The Assure team collaborated closely with the state Medicaid agency to determine what areas were of greatest concern and developed methods to gather and analyze information quickly and accurately. The Medicaid agency used this rapid cycle information to make decisions on programmatic changes much faster than would otherwise have been possible. This ad hoc project is just one example of the Assure team's willingness to work closely with Medicaid agencies to provide useful, accurate, and timely data to help the entire Medicaid program succeed.

Our staff proposed measure specifications, then calculated plan performance on those measures using claims data submitted by each plan, performing data quality checks before measure calculation.

Subsection C: Encounter data validation and omission studies

The Assure team has direct expertise and experience designing methods for gathering, analyzing, and reporting on encounter data. In 2017, the Assure team developed and implemented an EDV project with the New Mexico Medicaid agency. Assure worked to reconcile the encounter data submitted to the EQRO by the MCO and the data accepted

in the state's Medical Management Information System (MMIS). The project was designed to satisfy part of the work requirements set forth in Activity 3 of the CMS EQR Protocol 4, which requires a determination of the completeness, accuracy, and quality of the encounter data submitted by each MCO. CMS EQR Protocol 4 is a way to assess whether the encounter data can be used to determine program effectiveness, accurately evaluate utilization, identify service gaps, and make management decisions. In addition, the protocol requires an evaluation of Medicaid agency policies and of the health plan policies, procedures, and systems to identify strengths and opportunities to enhance oversight.

The Assure team worked closely with the state Medicaid agency, the state's contracted MMIS vendor, and MCO technical staff to gather and analyze data, provide technical assistance, report findings, and provide recommendations for improvement.

Subsection D: CAHPS® surveys

If asked to provide services that require a certified CAHPS vendor, Assure will subcontract with DataStat. We have signed a teaming agreement with DataStat to enable expedient contracting once a scope of work is identified.

2.1.5.2 Nevada Medicaid Care Coordination program activities such as:

A. A comprehensive on-site contract compliance audit of DHCFP's Care Coordination Vendor.
B. Validation of up to 5 Performance Measures for DHCFP's CMO Vendor. The EQRO will conduct the Validation of Performance Measures review in compliance with the CMS Protocol, Validating Performance Measures.

A. A comprehensive on-site contract compliance audit of DHCFP's Care Coordination Vendor

Assure is skilled in onsite auditing for contract compliance and in providing technical assistance and education for contractors. As the State of Nevada implements new CMO programs, Assure will work in partnership with DHCFP to outline a comprehensive audit process to ensure compliance with applicable contractual and regulatory requirements. The current CMO contract (effective through June 30, 2018) is part of the Nevada Comprehensive Care Waiver and mandatory for specific recipients.

Approach

The Assure team will work with DHCFP to audit CMO(s) for contract compliance in the following manner:

- ***Outline all contract requirements, including applicable state and federal regulations.***
- ***Develop a focused audit to review and address the priorities of DHCFP.***
- ***Review the audit tool and required documentation with the CMO(s).***
- ***Schedule the onsite audit with DHCFP and CMO(s).***
- ***Develop the agenda for onsite audit.***
- ***Request and review submitted documentation ahead of the audit.***
- ***Conduct the onsite audit of CMO(s), including:***
  - ***technical assistance and education regarding areas of noncompliance***
  - ***exit interview to reflect initial status of contract compliance***
  - ***opportunity to provide additional documentation***
- ***Provide DHCFP with a report of the CMO(s) compliance with applicable contractual and regulatory requirements.***
- ***Conduct further technical assistance, education, or review for CMOs as directed by DHCFP.***

The contract compliance audit may include, but is not limited to:

- ***enrollment and disenrollment accuracy***
- ***review of populations to ensure that they meet criteria***
- ***member rights and member information***
- ***coordination and monitoring of primary health care services for the identified population***
- ***availability and accessibility of services***
- ***timeliness of services***
- ***documentation review of care planning and other required clinical documentation***
- ***member outreach and education activities***
- ***coordination with behavioral health systems and other providers***
- ***compliance with federal requirements regarding Indian health care providers***
- ***review of operations information data (including policies and procedures, customer service call center operations, medical records compliance, etc.)***
- ***program integrity***
- ***claims review, utilization and practice patterns***
- ***QI activities, including member satisfaction surveys and other data collection***

<u>Examples of Relevant Experience</u>

The Assure team has significant experience with auditing contract compliance. Our review of the MCOs throughout Oregon, Washington, and New Mexico has included review of compliance with the state's contract with MCOs and applicable state and federal requirements (see section 2.1.1.3). Assure has worked closely with states to outline the compliance requirements for review. A significant piece of development of the audit criteria has been reviewing the audit tools and required documentation with

the MCOs and receiving the MCOs' feedback. In addition, Assure works closely with the Oregon Health Authority to provide service authorization for the Medicaid and CHIP fee-for-service populations receiving services in psychiatric residential treatment facilities and state hospital levels of care. Authorization of these services involves review of coordination of services with the local communities (urban and rural) to ensure that treatment goals are achieved and maintained.

B. Validation of Performance Measures

Assure recognizes the importance of care coordination and understands the value of accurately calculated performance measures to improve care coordination. We have 12 years of experience working with state Medicaid programs to conduct performance measure validation (PMV), including Information Systems Capabilities Assessments (ISCA). We hold our team to the highest standards, always conducting PMV according to statistically sound methods and generating actionable QI recommendations for state Medicaid programs. With an experienced team of auditors, analysts, and communications staff, we are experts at displaying results clearly and concisely, including comparative and trending data that clearly identify areas of strengths and improvement needs for the client.

<u>The Assure Approach to Performance Measure Validation</u>

The Assure team's approach to PMV is rooted in the CMS protocol. First, we complete a HEDIS Road Map for any HEDIS measures following NQCA standards and guidance. Then, the ISCA assesses an organization's ability to comply with 42 CFR §438.242. Next, the PMV assesses the state's production of performance measures.

As part of the PMV, the Assure team works with each MCO and the state to gain an understanding of any new internal organizational leadership or staffing structure changes, planned or completed mergers, acquisitions, or business service offering changes, and any IT changes that may impact the ability to deliver accurate, complete, and timely data used to calculate performance measures.

<u>Relevant Experience</u>

Table 13. Assure Team Experience with Performance Measure Validation.

Customer	Project Details
Oregon Health Authority, 2005–present	***OHA has developed incentive measures to evaluate the Oregon CCOs' performance on health care quality and access and to hold CCOs accountable for improved outcomes. Assure conducted an ISCA on all CCOs, dental and behavioral health organizations, third-party data managers, and the state, and subsequently validated the following incentive measures:***

	• *Adolescent Well Care Visits (age 12–21)* • *Alcohol or Other Substance Misuse (SBIRT) (age 12+)* • *Ambulatory Care: Emergency Department Utilization (all ages)* • *Dental Sealants (age 6–9, 10–14)* • *Developmental Screening in the First 36 Months of Life (age 0–3)* • *Effective Contraceptive Use (age 15–50)* • *Follow-up after Hospitalization for Mental Illness (age 6+)*
Washington Health Care Authority, 2012–2014	***Assure performed a HEDIS audit for MCOs (physical health) and performance measure validation and ISCA audits for Regional Service Networks (behavioral health). Year over year, Assure worked with local plans and the state to monitor progress on previous years' recommendations, ultimately improving the quality of the performance measure calculations.***
New Mexico Human Services Department, 2015	***The Assure team has performed a performance measure validation every year since 2005 on state-specified performance measures for both integrated and non-integrated MCOs. The PMV reviewed physical and behavioral health populations plus long-term services and supports over several waivers in the last 13 years. The Assure team has worked with the state Medicaid agency to identify recommendations for each MCO's PM process including follow up each year on previous EQR recommendations.***

2.1.5.3 Development and/or implementation of the Medicaid managed care quality rating system

The awarded vendor may be asked to assist with the development and/or implementation of the Medicaid managed care quality rating system within 3 years of the date of the final notice in the FEDERAL REGISTER by:

A. Adopting the Quality Rating System developed by CMS, in consultation with States and other stakeholders and after providing public notice and opportunity to comment, will identify performance measures and a methodology for a Medicaid managed care quality rating system that aligns with the summary indicators of the qualified health plan quality rating system; or

B. Adopting an alternative Medicaid managed care rating system approved by CMS that utilizes different performance measures or applies a different methodology as long as the ratings generated by the alternative rating system yield information regarding the MCOs, and PAHP performance is substantially comparable to that yielded by the system developed by CMS.

The Assure team will work with DHCFP to development and implement the Medicaid managed care Quality Rating System by:

- ***leveraging our experience in assisting state Medicaid agencies with improving quality (see section 2.1.2.6)***
- ***partnering with DHCFP to gather stakeholder input (including public comment and input from the state's Medical Care Advisory Committee), identify performance measures, and develop and implement a methodology for the Medicaid managed care quality rating system***
- ***providing technical assistance to the MCOs and PAHP on implementation and ongoing compliance with the adopted quality rating system***
- ***annually assisting DHCFP in collecting the data from each MCO and PAHP and issuing an annual quality rating for each plan***

2.1.5.4 Quality activities for Aged Blind and Disabled program

The awarded vendor may be asked to perform the following quality activities for a new Nevada Medicaid Aged Blind and Disabled (ABD) managed care expansion program. Tasks may include:

A. Provide consulting to DHCFP for ABD performance measures. The EQRO will identify/recommend new or revised performance measures applicable to the ABD population;
B. Conduct an Information Systems (IS) Readiness Review on selected ABD MCO Vendors; and
C. Evaluate implementation of performance measures.

Assure staff is qualified and interested in taking on the specified activities to serve the ABD Medicaid population in Nevada. Similar experience is described below.

<u>Subsection A: ABD performance measures consulting</u>

Assure assisted the New Mexico Medicaid agency in review of two MCOs that were contracted to oversee the state's Coordination of Long Term Services (CoLTS) Medicaid waiver. The CoLTS program targeted low-income elderly people who might require nursing home care were it not for the services provided under this program. CoLTS

offers care services and non-care support to enable older adults and people with disabilities to remain living in their own homes and/or assisted living communities instead of being placed in a nursing home.

After the review, the Assure team completed all the EQR mandatory protocol activities for both MCOs contracted within the CoLTs program.

In addition, the Assure team performs mandatory and optional review protocols for MCOs in the current New Mexico Medicaid waiver, Centennial Care, where each MCO is responsible not only for physical and behavioral health services but also for long-term supports and services to Medicaid enrollees. The Assure team includes licensed nurses with direct patient care and auditing experience for the aged, blind, and disabled population, and we understand the barriers this population experiences to access to timely and quality care. Assure has provided focused technical assistance to the MCO care coordination staff and to Medicaid agency staff about this population and their specific needs.

<u>Subsection B: IS readiness review</u>

Assure completes regular ISCA projects adhering to the requirements set forth in CMS EQR Protocol Appendix V. We send an extensive questionnaire to the MCOs which then submit the completed questionnaire along with supporting documentation. Assure reviewers, analysts, and IT experts review the data to assess completeness and adequacy. Once that analysis is finished, we follow the reporting method specified by the state Medicaid agency. The ISCA report can either be a standalone report or it can be incorporated into one of the other standard EQR reports.

Assure performed an ISCA readiness review in 2013 for the newly contracted CCOs under Oregon's revised waiver. We worked with the state Medicaid agency to define what would be included in the readiness review for the newly formed organizations. The ISCA review focused on the how the CCOs adapted their information systems and infrastructure to the new model of care and on their readiness for the full ISCA in the following year. Assure reviewed the CCOs' documentation related to their information systems, interviewed relevant staff members and partners, and identified strengths and recommendations to improve in certain areas in preparation for the ISCA.

Each CCO received feedback in its EQR report on strengths and areas for improvement. The readiness review covered:

1. ***Information system used for producing reports and performance measures***
2. ***Hardware***
3. ***Security, including a data center walk-through***
4. ***Data processing***
5. ***Enrollment systems***

6. ***Provider compensation (structure and monitoring)***
7. ***Vendor data processing***
8. ***Electronic health records***

Assure summarized the results of this review in the annual EQR technical report.

Subsection C: Evaluation of Performance Measures

Starting in 2005, the EQRO validated PMs for the two, statewide long-term care MCOs; then PM validation was completed according to the 2012 CMS EQR Protocol 2 for the redesigned Medicaid waiver, called Centennial Care, for the four integrated, statewide MCOs.

The Assure team's approach to PMV is rooted in CMS EQR Protocol 2. Through more than a dozen years of PMV and ISCA experience, the Assure team has worked closely with state clients and MCOs to coordinate onsite, telephonic, or virtual meetings; lead informative discussions on new tools; and provide well-designed reports ensuring that organizations have knowledge of strengths and areas for improvement. Our QI professionals, information systems specialists, and healthcare data analysts have over 12 years of experience in conducting PMV for long-term support and services members.

2.1.5.5 Activities for TANF/CHAP and CHIP in Rural Counties

The awarded vendor may be asked to perform the following quality activities for expansion of Managed Care for the TANF/CHAP and CHIP populations into the rural counties. The awarded vendor may be asked to provide consulting to DHCFP's MCOs. Tasks may include:

A. Provide consulting for expansion performance measures applicable to the TANF/CHAP and CHIP populations;
B. Conduct an Information Systems (IS) Readiness Review on selected expansion MCO Vendor(s);
C. Provide technical assistance to the MCOs on the development of performance measures; and
D. Conduct a HEDIS Compliance Audit or validate the measures using the CMS Validating Performance Measures protocol on the contracted MCOs.

Subsection A: Consulting for expansion performance measures

Most of New Mexico consists of rural or frontier areas, including pueblo communities, where many Medicaid enrollees live. The Assure team has completed mandatory and optional protocols on the CHIP and TANF population as part of the overall Medicaid

population. Assure completed a readiness review for the CoLTS waiver MCOs, as described above.

<u>Subsection B: IS readiness review</u>

Assure completes regular ISCA reviews adhering to the requirements set forth in CMS EQR Protocol Appendix V. The Assure team sends an extensive questionnaire to the MCOs which then submit the completed questionnaire along with supporting documentation. Assure reviewers, analysts, and information technology go through the data to assess its completeness and adequacy. Once that analysis is finished, the Assure team follows the reporting method specified by the state Medicaid agency. The ISCA report can either be a standalone report or it can be incorporated into one of the other standard EQR reports.

Assure performed an ISCA readiness review in 2013 for the newly contracted CCOs under Oregon's revised waiver. We worked with the state Medicaid agency to define what would be included in the readiness review for the newly formed organizations. The ISCA review focused on the how the CCOs adapted their information systems and infrastructure to the new model of care and on their readiness for the full ISCA in the following year. Assure reviewed the CCOs' documentation related to their information systems, interviewed relevant staff members and partners, and identified strengths and recommendations to improve in certain areas in preparation for the ISCA.

Each CCO received feedback in its EQR report on strengths and areas for improvement. The readiness review covered:

1. ***Information system used for producing reports and performance measures***
2. ***Hardware***
3. ***Security, including a data center walk-through***
4. ***Data processing***
5. ***Enrollment systems***
6. ***Provider compensation (structure and monitoring)***
7. ***Vendor data processing***
8. ***Electronic health records***

Assure summarized the results of this review in the annual EQR technical report.

In Oregon, Assure completes onsite ISCA audits every other year. The audit includes a walk-through of CCO data centers. In alternate years, Assure conducts telephone interviews to follow up on the status of any findings from the full ISCA audit. Assure's ISCA tool includes a clear set of scoring criteria, including specific documents and content required to meet several different informational systems operational categories. Each of the 11 ISCA sections has subsections drilling down into the detail of

aspects such as programming languages, documentation of proprietary software, and documentation of data structures. The scoring criteria require specific documentation. For example, the scoring criteria for Data Integration Methods include:

a. ***The CCO has documented policies, procedures, or processes relevant to consolidating Medicaid data for calculating performance measurements.***
b. ***The CCO has documented policies, procedures, or processes relevant to how data extracts are performed to support calculating Medicaid performance measurements.***
c. ***All data structures involved in the process of evaluating Medicaid performance measures are fully documented.***
d. ***The CCO has documented policies, procedures, or processes relevant to handling of claim and encounter submission and processing lags when evaluating Medicaid performance measures.***
e. ***The CCO has documented policies, procedures, or processes relevant to how data integrity is maintained when consolidating Medicaid claim/encounter data for performance measures.***

The scoring categories include:

- ***Fully Met: The CCO meets all criteria.***
- ***Substantially Met: The CCO meets criteria A, B, C, and either D or E.***
- ***Partially Met: The CCO meets criteria A, B, and C.***
- ***Not Met: The CCO does not meet the minimum criteria of Partially Met.***

<u>Subsection C: Technical assistance to MCOs on development of performance measures</u>

The Assure team has many years of experience providing technical assistance to MCOs on the development of performance measures. We have helped MCOs adopt validated measures, modify existing measures, and develop new measures according to the guidelines provided by the state Medicaid agency. We have expertise in behavioral health, addictions, dental health, long-term care and child-focused measures, in addition to measures that consider health equity goals of the state.

<u>Subsection D: Conduct a HEDIS Compliance Audit or validate the measures using the CMS Validating Performance Measures protocol on the contracted MCOs.</u>

The Assure team has many years of experience working with state Medicaid programs to evaluate the accuracy and the extent to which Medicaid-specific performance measures followed HEDIS specifications for the calculation of performance measures, and applying the CMS Protocol for Validating Performance Measures. Assure staff have led more than a hundred HEDIS audits for MCOs in California, Montana, Florida, Washington, and Oregon; sixty Value Based Pay for Performance (VBP4P) audits in California; and 30 CMS data validation audits in California and Arizona. The ISCA team

first assesses an organization's ability to comply with 42 CFR §438.242. Then, the PMV process assesses the state's production of performance measures.

2.1.5.6 Additional Technical Assistance or Consultative Services

At the discretion of the DHCFP, the EQRO may be asked to provide additional technical assistance or consultative services related to EQR activities. All requests for technical assistance or consultative services shall be transmitted in writing from the DHCFP to the EQRO. Each request, at a minimum, will include the following:

A. A description of the major functions, tasks, and activities required;
B. The timeline/due date for any reports or identified deliverables;
C. Specifications as to the medium and/or format of the desired deliverable;
D. A listing of the EQRO's project requirements; and
E. Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or projects expected.

The EQRO will submit to the DHCFP, for approval, its cost proposal for completing the technical assistance or consultative project according to the scope of work detailed in the DHCFP's request.

Assure will respond to each request from DHCFP for technical assistance and consultative services with a detailed cost proposal and a draft work plan covering specific tasks, responsible parties, and dates of completion of deliverables for completing the scope of work. We will collaborate with the state, MCOs, and other stakeholders as appropriate to finalize the plan and execute the technical assistance. Our expert team has successfully performed a wide variety of technical assistance and is ready to respond to DHCFP's requests.

Recent examples of Assure's ability to quickly respond to requests for technical assistance and consultative services include:

- ***At the request of the Oregon Health Authority (OHA), Assure is conducting a review of hospital discharges of enrollees hospitalized with severe and persistent mental illness to evaluate Oregon's status for a part of the Oregon Performance Plan required by the U.S. Department of Justice. After establishing the review details and criteria, Assure developed a review tool and database, hired subject matter experts, coordinated access to hospital records for nine facilities, and completed the first review cycle in three months (about 650 discharges). This project will continue through 2018.***
- ***In April 2017, the Assure team provided an in-person training at OHA's request on Delivery System Network reporting (Network Adequacy) for all Oregon CCOs. This included all planning and implementation (including coordination of site location, invitations, materials, speakers, agenda, etc.).***

- ***At OHA's request, over the past two years, Assure has reviewed the request of three CCOs to increase their contracted member capacity. We developed the review criteria in consultation with OHA, and have been performed these reviews in a timely manner upon request. In addition, Assure has reviewed two CCOs in 2018 for network adequacy due to material changes. One review involved a significant change in subcontracting for the CCO's dental network; the other review involved to a significant change in member location due to the closure of another CCO and the need to transfer members.***

Examples of our technical assistance or consultative work are attached in Section VIII, Attachments 18 and 19 (Opioid Metrics for PIP Primary; Opioid Metrics for PIP Secondary).

2.2 Qualifications of External Quality Review Organizations

The following are mandatory requirements needed to successfully meet the minimum standards of this RFP. These items are not negotiable.

2.2.1 Vendor and Subcontractor Contract Requirements

The vendor and all subcontractors must meet all requirements of 42 CFR 438.354 and the mandatory DHCFP contract requirements as follows:

2.2.1.1 The vendor must have staff with demonstrated experience, knowledge and skills of:

A. Medicaid recipients, policies, data systems, and processes;

B. Managed care delivery systems, organizations, and financing;

2.2.1.2 Quality assessment and improvement methods; and

2.2.1.3 Research design and methodology, including statistical analysis

The following sections demonstrate how the Assure team meets competency requirements both through the staff we have proposed for the Nevada EQR SOW and through the institutional expertise available to the project through the HealthInsight enterprise. The sections include a summary of the Nevada review team's expertise and qualifications, followed by a review of Assure's qualifications for each specific area of the requirements of 42 CFR §438.354.

Staff Proposed for Nevada EQR SOW

Oversight

As the Board Chair for Assure, Sharon Donnelly, MS, is responsible for the success of the organization, providing overall direction and ensuring that all contract deliverables are timely, performed with excellence and with superior customer service. She has over 15 years of experience managing large scale projects across multiple states and organizations, 20 years of experience in health care quality improvement projects in Medicaid and Medicare, a background in statistics, analytics, and HEDIS auditing.

Dr. Jerry Reeves is the HealthInsight Nevada Medical Director as well as HealthInsight's Corporate Vice President of Medical Affairs. As the medical director for Assure's work in Nevada, he brings significant experience as a practicing physician and Chief Medical Officer of several health benefit organizations, such as Culinary Health Fund, Humana Inc. and Sierra Health services. He has been providing medical and health benefit consulting services in Nevada and throughout the United States for 18 years.

The Assure EQR team is led by Margaret White, RN. BSN, MSHA, CHC, the organization's director of EQR activities. Ms. White has more than 20 years of experience in health

care operations, patient care, physician and outpatient revenue cycle, physician coding, internal auditing, and monitoring and health care compliance, with five years' experience in specifically managing EQR programs.

Her team includes a full complement of individuals to meet the mandatory qualifications. Table 14 provides a snapshot of the team's capabilities followed by brief summaries of the individual team members meeting competency requirements set forth in 42 CFR §438.354 as well as support for these activities.

Table 14. Assure Team Staff Experience and Knowledge Domains.

HealthInsight Assure Professional Staff *Nevada Staff +Key Staff	Support		Medicaid Recipients				Managed Care			Qual-ity		Research		EQR Activities											
	Project Mgt/Coordination	Report Writing/Editing	Recipients	Politics	Data Systems	Processes	Delivery Systems	Organizations	Financing	Assessment	Improvement Methods	Design and Methodology	Statistical Analysis	PIP	PMV	Compliance	Network Adequacy	EDV/Revenue	ISCA	Quality of Care Surveys	PM Calculation	QRS	QAPIS	HEDIS	CAHPS
Bondarenko*	✓									✓	✓														
Buice+			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓					✓				
Caramella+			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓											
Cederlind*	✓																								
Donnelly*	✓	✓		✓		✓	✓				✓	✓	✓	✓								✓		✓	
Fanning			✓	✓		✓		✓		✓	✓					✓	✓						✓		
Fredericksen			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓									
Gadbois+			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓			✓	✓	✓				
Gehringer			✓			✓		✓																	
Griskell*+	✓									✓	✓														
Hallvik			✓	✓	✓	✓		✓		✓	✓	✓	✓		✓			✓		✓	✓			✓	✓
Land*+		✓								✓															
Martin		✓					✓			✓	✓														
O'Neal*+					✓						✓			✓	✓						✓				
Peterman			✓	✓	✓	✓	✓	✓		✓	✓			✓	✓	✓								✓	✓
Priloutskaya+				✓	✓					✓	✓	✓	✓				✓							✓	
Reeves		✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓								✓		✓	
Romero			✓	✓		✓	✓	✓		✓	✓	✓		✓	✓			✓							
Siegel			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓												
VanDomelen					✓	✓							✓						✓	✓					
White+			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Williams+					✓		✓				✓			✓	✓						✓				
DataStat (Sub)																								✓	✓

The Review Team

- ***Allen Buice, CPHQ, PMP,*** ***has 12 years of experience in the health care industry and extensive Medicaid managed care consulting experience delivering cost-effective, high-quality health care solutions. He has eight years of experience as a project manager and Medicaid compliance lead, leading multidisciplinary teams to conduct audits of the contracted organizations and providers.***

  Role for Nevada EQR: ***Compliance Lead and Compliance Reviewer***

- ***Joyce Caramella, RN, CHPQ,*** ***has performed over 18 years of process and QI work for clinic systems and health plans. She has been project lead for HEDIS review for Medicaid, Medicare, and commercial lines of business. Most recently she worked on integrating and coordinating services for contracted medical, dental, and mental health plans for the largest Oregon Medicaid CCO. Additionally, she has 10 years' experience with grievance, appeals, and hearings oversight for 17 contracted partners of a Medicaid plan.***

  Role for Nevada EQR: ***PIP Reviewer***

- ***Linda Fanning, LCSW, CPHQ,*** ***spent three years as the Oregon Health Authority's Medicaid policy analyst for all Federally Qualified Health Centers, Rural Health Clinics, Indian Health Services, and Tribal 638 clinics. She has experience coordinating and communicating state and federal policy, billing and reimbursement, rate development, active participation in an alternative payment methodology pilot project, advocating for and supporting tribal communities, and participating in government-to-government meetings.***

  Role for Nevada EQR: ***Compliance Reviewer***

- ***Charity O'Neal, RN, BSN (Nevada)*** ***has 13 years of cumulative experience in patient care, quality improvement, chart review/analysis, and case management. She currently works for HealthInsight Nevada on a CMS Innovation Center project to reduce avoidable hospital readmissions from Nevada nursing homes by helping nursing home staff recognize changes in patient conditions before an event occurs. She provides education to nursing home staff and helps them improve current practices. Her varied positions in QI, oncology, home health, and case/utilization management provide a solid foundation for QI and EQR activities.***

  Role for Nevada EQR: ***Nurse Reviewer***

- ***Nancy Siegel, MPH, PA-C,*** ***has more than six years' experience working with MCOs and CCOs on performance improvement activities in various settings: conducing***

audits of and providing technical assistance for managed care PIPs, program evaluation, data collection, and training facilitation, with a focus on compliance and quality improvement.

Role for Nevada EQR: ***PIP Reviewer***

- ***Galina Priloutskaya, PhD, has more than 20 years of sustained experience in health care management, population health and quality improvement, using standardized statistical methods to perform high-level analyses linking outcomes to improved health, health care and lower costs, and calculating quality measures. She is an NCQA certified HEDIS compliance auditor and CMS certified data validation auditor. She has performed HEDIS, P4P, and data validation audits on a contractual basis with NCQA certified licensed organizations since 2005. She has led more than a hundred audits for MCOs, 60 Value based pay for performance (VBP4P) audits, and 30 CMS data validation audits. NCQA certified HEDIS auditor, doctorate in economic science, Master of Management Information Systems and Computer Science, MS degree in Economic and Industrial Management Academy of Management, present CHCA, Certified HEDIS/P4P Auditor NCQA, Certified Data Validation Auditor CMS, National QIO Knowledge of CMS Development Program, Medicare Part D Training CMS, SAS Training SAS Institute, and Annual HEDIS Certification Training.***

  Role for Nevada EQR: ***Certified HEDIS Auditor***

- ***Colleen Gadbois, MPA, has 10 years of experience in health care in various roles, including quality, compliance, and health care information technology. Medicaid data processer with accuracy and timeliness, Medicaid policy analyst with the State of Oregon, and has knowledge of Medicaid recipients, policies, data systems, and processes, experience with EQR compliance piece, has knowledge and experience related to managed care delivery systems, organizations, and financing.***

  Role for Nevada EQR: ***ISCA Reviewer***

The Support Team: Project management, coordination, and administrative support staff provide support for the review specialists

- ***Linda Griskell, MHA, Project Manager (Nevada), is a project manager for HealthInsight Nevada, leading two QI teams addressing care transitions and adult immunizations. She engages hospital leaders and community stakeholders to review processes and identify opportunities for improvement. She has worked with hospital and physician groups across the country for more than 20 years, consulting and providing analytic expertise.***

  Role for Nevada EQR: ***Project Manager***

- ***Margarita Bondarenko, MHA,*** ***has coordinated QI initiatives for HealthInsight Nevada since 2014, focusing on improving immunization rates and screenings for cardiac measures in high-risk patients, and helping physicians prepare for meaningful use of electronic health records, physician quality reporting, and the value modifier. She has expertise in privacy and security and HIPAA compliance.***

  Role for Nevada EQR: ***Project Coordinator***

- ***Ellen Gehringer, BA,*** ***has over eight years of experience managing consumer surveys, including annual mental health consumer surveys for the State of Oregon. Responsibilities include survey design, quality control of data entry, technical assistance to survey respondents, facilitation of interpreter services, and assistance with final reports.***

  Role for Nevada EQR: ***Project Coordinator***

- ***Kristin Cederlind*** ***has over 25 years of experience in supporting executives, program managers and project teams with detailed understanding of policies, procedures and office interactions. Responsible for scheduling business meetings, reporting, and customer management. For the last four years, she has provided support for HealthInsight Nevada's operations, board and committee meetings and customer service related to technical assistance provided by HealthInsight staff.***

  Role for Nevada EQR: ***Project Assistant***

Analytics and Communications Support

- ***Sara Hallvik, MPH,*** ***manages the analytic team, providing oversight of analytic systems and tasks under state, federal, and private contracts. She has served as the senior healthcare analyst on mental health and physical health contracts in Oregon and Washington, as well as grants from the National Institute of Health (NIH), Bureau of Justice Assistance (BJA), and the Agency for Healthcare Research and Quality (AHRQ). She has expertise as a SAS coder, designing and executing statistical analysis plans for a variety of topics, including encounter data validation, chart reviews and inter-rater assurance, performance measure calculation, and survey design and analysis. Ms. Hallvik also has expertise working with linked data sets (including PDMP, Hospital Discharge, Vital Records, and MMIS), and is well versed in SAS for data cleaning and statistical analysis on large relational datasets. Ms. Hallvik has expertise in data presentation and reporting to a variety of audiences, and understands the nuances and analysis aims of both quality improvement and research projects. Ms. Hallvik has previous experience in statistical analysis design, execution, and reporting in public health and community assessment projects, and has implemented quality improvement***

strategies across large systems of care. Her analytical work has supported several peer-reviewed publications related to PDMP research which Ms. Hallvik co-authored.

***Role for Nevada EQR:* Senior Data Analyst**

- ***Jared VanDomelen* designs and builds survey forms and data collection processes, including data entry quality control and inter-rater reliability checks. He performs accurate and rapid data entry and often works with sensitive information, including protected health information (PHI) and personally identifiable information (PII) of Medicare and Medicaid recipients with diabetes, hypertension, mental illness or other targeted diagnoses. Jared has expertise in Excel automation, used in survey projects to manage follow-up with survey respondents, refining mailing lists for subsequent survey distributions and monitoring response rates. His eye for detail and ability to learn new programs and processes quickly has supported project teams on a variety of topics.**

  ***Role for Nevada EQR:* Data Specialist**

- ***Greg Martin, MA Journalism,* has 40 years of experience as an editor, writer, and researcher of technical publications. He oversees HealthInsight Oregon's communications program and ensures fulfillment of all communications-related objectives of the company's contracts with diverse clients. His experience with HealthInsight and its predecessor organization in Oregon since 2005 has given him a thorough understanding of Medicaid EQR, managed care delivery systems and policies, quality assessment and improvement methods, and health care performance measurement.**

  ***Role for Nevada EQR:* Report Writer and Editor**

- ***Jennifer Land, BS Journalism (Nevada)*, has 15 years of experience writing, editing, and designing for newspapers with the last four years at HealthInsight Nevada. She professionally edits, designs, and brands reports and publications, and serves as HealthInsight Nevada's communications manager. Her experience with QI projects and methods has given her a thorough understanding of that arena.**

  ***Role for Nevada EQR:* Report Writer and Editor**

The individuals listed above comprise the Assure team assembled to provide Nevada EQR services. For more details on the team's expertise, please see their resumes provided in Section VII.

A. Medicaid recipients, policies, data systems, and processes;

The Assure team's extensive experience with Medicaid managed care and FFS programs in New Mexico, Oregon, and Washington has given us an in-depth understanding of Medicaid recipients, policies, data systems, and processes. These engagements include but are not limited to the items listed in table 14A:

Table 14A. Experience with Medicaid Managed Care and FFFS Programs

Period	Contract Description
1988–2004	***Utilization review (UR) for Nevada Medicaid (DHHS-DHCFP).***
1993–2014	***EQRO for Washington physical health managed Medicaid programs***
1996–present	***UR and quality review of mental health services for Title XIX Medicaid enrollees who receive psychiatric hospital care and for adolescents in residential care in Oregon***
2005–present	***EQRO for New Mexico physical and behavioral health, long-term supports and services and children's care for the Medicaid programs***
2008–2014	***EQRO for Washington mental health managed Medicaid programs***
2012–present	***EQRO for Oregon mental, physical, and dental health managed Medicaid programs***

In these and other capacities we have performed tasks including but not limited to:

- ***Surveys of Medicaid recipient experience-of-care and health status, including satisfaction with mental health services and special analyses of racial and ethnic subpopulations, children with special health care needs, long-term supports and services, and other special need populations***
- ***focused quality-of-care studies on topics such as immunizations, well-child care, perinatal care, levels of care for nursing home patients, and adult residential mental health treatment services***
- ***performance measure calculation and reporting***
- ***validation of MCO, RSN, and state-produced performance measures***
- ***capability assessments of state and MCO/RSN information systems***
- ***validation of state and MCO/RSN PIPs***
- ***conduct of statewide PIPs***
- ***validation of state Quality Strategies***
- ***Medicaid program evaluations***
- ***annual EQR reporting of quality, access, and timeliness of care provided by managed care contractors***

B. Managed care delivery systems, organizations, and financing;

The Assure team has many years of experience conducting detailed monitoring and auditing of many aspects of MCO operations, including:

- ***direct surveys of delivery system providers***
- ***analysis of contracting and financial arrangements for evidence of fraud, abuse, or conflicts of interest***
- ***provider credentialing***
- ***review of QAPI programs***
- ***review of grievance systems***
- ***ISCA reviews***

Several members of Assure's staff assigned to this project, including Joyce Caramella and Allen Buice, are former employees of managed care plans with extensive involvement and experience in program operations and administration. Other team members have collaborated extensively with or been employed by managed care plans in QI, oversight, contract negotiation, and other capacities.

These examples of the depth of our experience in all facets of managed care demonstrate our sound understanding of managed care, which can help facilitate working relationships with the health plans.

2.2.1.2 *Quality assessment and improvement methods*

Assure is the current Medicaid EQRO for Oregon and New Mexico, and our parent company, HealthInsight Management Corp., is the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Oregon, Nevada, New Mexico and Utah. HealthInsight has more than 40 years of combined experience in health care quality assurance (QA) and QI. Our organization helped to develop some methods and approaches that have become standard QA procedures, and we have long advocated for the adoption of effective QI methods by states to improve performance levels. The Assure team has used many approaches to evaluate health plan performance by assessing the plans'

- ***abilities and resources to operate an efficient and effective QI program and conduct quality studies on a continuous basis***
- ***QI program structure, accountability, and expertise***
- ***use of appropriate mechanisms to identify important clinical and nonclinical areas for improvement and to set meaningful priorities***
- ***use of practice guidelines to assess provider performance***
- ***use of HEDIS and other indicators to monitor the process and outcomes of care***

- ***use of appropriate quality measurement tools, data collection, and statistically valid analysis to track QI***
- ***corrective action plans to determine if they are appropriate, being monitored for effectiveness, and if results of actions are being monitored and tracked***
- ***follow-up studies to determine if there is demonstrated improvement in care and services for health plan members***

The Assure team specializes in QI that focuses on the sharp end of the delivery system, where care is delivered. We are equally adept at facilitating systemic changes that affect larger organizational structures. Among our most effective approaches to systems improvement are those in which we have formed strong partnerships with other agencies and have facilitated collaborative efforts among providers and practitioners, payers, and others.

The Assure team has a long history of developing and successfully implementing innovative QI initiatives. Our rapid cycle program for Oregon hospitals was one of the first collaborative initiatives implemented by a QIO. We continued to build on that program by initiating the Children's Preventive Healthcare Initiative in Washington and the Diabetes Collaborative in Oregon, both of which have been successful in their efforts to improve care.

2.2.1.3 Research design and methodology, including statistical analysis

Over the 40 years that HealthInsight has conducted data-intensive research, measurement, and evaluation, our team has developed advanced research competencies. Our analysts have advanced academic training and practical experience in qualitative and quantitative research design. Assure's senior analysts are well versed in health care research designs and methodologies applied to survey design, focus groups, key informant interviews, comparative analysis, systematic pattern analysis, and program evaluation. Our analytic staff have experience turning large data sets (claims, electronic health record data, etc.) into useful analytic files and reports. All analytic staff are skilled in relational database design and manipulation and in the use of statistical software packages such as SAS.

Our team brings:

- ***expertise in physical health, mental health, and chemical dependency managed delivery systems, organizations, and financing models, including Medicaid, Medicare, and commercial lines of business***
- ***EQR of MCOs delivering medical, mental health, and dental care***
- ***expertise in physical health/behavioral health integration and medical homes***
- ***company-wide grounding in EQR, QA, and QI***
- ***team members with Certified Professional in Healthcare Quality credentials***

- ***team members with Certified in Health Care Compliance credentials***
- ***well-developed processes for requesting, cleaning, and analyzing Medicaid data obtained from states and from managed care plans***
- ***information technology capacity and expertise to handle large data sets***
- ***staff with advanced degrees and experience in statistical analysis and qualitative and quantitative study design***
- ***utilization review experience for Medicaid, Medicare, and a variety of other non-Medicaid settings***
- ***data encryption and HIPAA-compliant procedures meeting strict Federal Information Security Management Act (FISMA) standards***
- ***expertise designing and producing reports to provide baseline benchmarks for setting future performance goals for MCOs and transparently identifying variations in health plan performance and outcomes***

2.2.2 Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities

Below we describe Assure's physical, technological, and financial resources, which have been sufficient for us to carry out EQR and EQR-related activities for many years.

Physical resources

Assure team staff from Nevada, New Mexico, and Oregon will work on the Nevada contract. Operational activities will take place in all three offices. Nevada operations are housed at 6830 W. Oquendo Road, Suite 102, Las Vegas, NV 89118.

Staff work together as a team regardless of location and participate in meetings through video and teleconference mechanisms that are used for collaboration across all HealthInsight offices. Northern Nevada staff work remotely and are available to meet in person with the state representatives housed in the capital.

These offices have ample workspace for all project activities, a secure storage room for confidential material, and state-of-the-art communication and computer technology. Remote staff are fully supported with the technology and security requirements.

Technological resources

Assure maintains the equipment to receive, store, manipulate, and analyze large amounts of data, including research, claims, encounter, and patient and provider demographic data. Assure follows rigorous protocols for handling large amounts of confidential data in paper and electronic form. The company's information systems and written confidentiality and data security policies and procedures are HIPAA- and HITECH-compliant and are subject to rigorous FISMA audits by CMS.

As noted above, Assure is compliant with both HIPAA and the HITECH Act through our ongoing security program. We annually review our 17 security policies to ensure compliance and to update them as new regulations and guidance are published. The 17 security policies cover administrative, physical, and technical safeguards from NIST SP800-53ver4.

Our security program includes ongoing training and education of all organizational employees on security topics, including CMS Information Security training, protection of PHI/PII, phishing awareness, and reporting of suspected incidents.

Ensuring the protection of sensitive data is of critical importance to Assure for the purpose of maintaining a continuing trust among our partners and clients. We have put in-place a layered control environment to help prevent misuse or disclosure of sensitive data.

- ***Elements of the layered control environment include encryption of data, management of user privileges, secure data transfer, secure remote access, backups, secure destruction of sensitive data, IDS/IPS, SIEM, firewalls, third-party 24/7 managed security services monitoring (MSSP), disaster recovery/ business continuity program, incident response, annual penetration testing, and Business Associate Agreements with business partners. Access to restricted files is controlled by user access privilege management.***
- ***Restricted physical access is controlled at different points. Main entrance access is control by man traps, card access, and visitor sign-in logs; restricted areas such as computer rooms and file storage areas are controlled by card access. Card access is granted by access requisitions. All endpoints (servers and workstations) are protected by active endpoint protection and monitored 24/7 by our MSSP. Workstations employ disk encryption and have a pre-set time-out; passwords expire at defined intervals and are complex in design. Physical destruction of media occurs via secure shredding services.***

Assure's electronic data servers are secured in a locked room with separate environmental controls, accessible only to the system administrators. Servers are protected by an uninterruptible power source, allowing the servers to be shut down smoothly and preventing data corruption due to sudden loss of power. The IT staff performs data backups daily and encrypted backup tapes are stored at a secure offsite storage facility. IT staff evaluate our hardware capabilities every six months.

Our application and database servers are connected through redundant Cisco ASA5510 firewall appliances, providing encrypted Virtual Private network connectivity and network security. All information contained on these servers is completely protected by these firewalls, enabling Assure to comply with all HIPAA and HITECH regulations and standards. Assure uses McAfee Endpoint Protection to monitor all servers and work stations.

Financial resources

Financial Statements

Please refer to Section VIII, Attachments 20, 21 and 22 for copies of our audited financial statements for the prior two fiscal (2015/2016 & 2016/2017) years and Interim Statement for the period ending 12/31/2017.

HealthInsight, Assure's parent company, has seen steady organizational and financial growth since 1974. Strong fiscal resources that can sustain expansion and growth, and enable us to weather economic downturns or adverse financial events, further assure the delivery of services that HealthInsight offers as an EQRO contractor. Our current financial position is strong. We have no debts, mortgages, or long-term liabilities. Our fund balance reserves are adequate to meet current and prospective working capital needs. As of June 30, 2017, the Current Ratio for HealthInsight Management Corporation (i.e., the ratio of Current Assets to Current Liabilities) was 4.7:1. Generally, a current ratio of 2:1 is considered to represent strong and viable status. Cash and cash equivalents total $8.241 million.

Excess operating funds are invested in marketable debt and equity portfolios for long-term income growth, while maintaining asset liquidity. As a further fiduciary safeguard, we have maintained on an ongoing basis a line of credit reserve through our banking relationship. This pre-approved line of credit, currently equal to $750,000, would provide additional funding resources to cover any temporary cash flow needs. We also carry the appropriate levels of insurance coverage, including Professional Liability/Errors and Omissions ($3 million coverage), Directors' and Officers' liability ($1 million coverage), and General Property and Business Liability coverages ($2 million coverage).

Adequate Accounting System

As a 501(c)(3) nonprofit corporation, HealthInsight files an annual IRS Form 990. Because we perform a significant amount of work for government agencies, we also undergo an annual OMB Circular A-133 audit performed by an independent external auditing firm. Since HealthInsight is a federal government contractor, we also undergo regular incurred-cost financial audits by the Defense Contract Audit Agency (DCAA). The DCAA audit findings also verify that HealthInsight conducts financial data collection and reporting in compliance with government standards, including OMB Circular A-122, Federal Acquisition Regulations (FAR) and Cost Accounting Standards (CAS). The DCAA has approved our accounting system and accounting procedures as adequate in all respects and in compliance with government standards. As of 2015, HealthInsight became fully CAS-covered and therefore submitted a CAS Disclosure

Statement and new overhead, fringe and G&A rates that were subsequently approved by the cognizant government office within CMS.

Our board of directors oversees our contract with a qualified CPA firm for audit services and a full, annual audit opinion. The board oversees an annual, independent audit of the company's financial reporting and procedures. These independent audits have consistently rendered an unqualified opinion that indicates that our financial statements are sound in every material respect and comply with generally accepted accounting principles (GAAP). The independent CPA firm that performs this annual external financial audit is hired by and reports directly to the HealthInsight board of directors on all audit report issues.

HealthInsight is not aware of any pending judgments or expected litigation or of any other real or potential financial reversals that might materially affect the viability or stability of our organization. HealthInsight's current net worth (unrestricted net assets) of $12.72 million exceeds 10% of the total annual cost and fee of this proposal, as well as all other current and proposed contracts combined.

2.2.3 Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

Assure employs approximately 58 full and part-time employees across the western United States to support our EQRO and related review activities. Our staff includes a mix of clinical quality review specialists, registered nurses, mental health specialists, quality and performance improvement specialists, medical directors, clinical reviewers, coding professionals, case managers, care coordinators, health IT consultants, project managers, information management and technology professionals, data analysts, communication professionals, and administrative support staff. The Assure team also has experience in overseeing work assigned to EQR subcontractors and consultants, as evidenced by the successful use of subcontractors on EQR engagements in current and past contracts. In addition, a HealthInsight senior contracts manager ensures financial management and compliance.

Other HealthInsight operations include an additional 167 staff across the western United States, for a total of 225 staff supporting quality improvement and EQR activities.

The Assure team for this SOW maintains various relevant professional certifications and educational credentials that show their commitments to quality improvement. These certifications and credentials, which demonstrate both clinical and nonclinical skills, are shown in the following table.

Table 15. EQR Staff Credentials and Certifications.

Educational Credentials	Professional
• ***Master of Business Administration (MBA)*** • ***Master of Public Health (MPH)*** • ***Master of Science in Nursing (MSN)*** • ***Master of Social Work (MSW)*** • ***Master of Science (MS)*** • ***Master of Science in Healthcare Administration (MSHA)*** • ***Bachelor of Arts (BA)*** • ***Bachelor of Science (BS)*** • ***Bachelor of Science in Nursing (BSN)*** • ***Bachelor of Fine Arts (BFA)*** • ***Master of Education (MEd)*** • ***PhD in economic science***	• ***Project Management Professional (PMP)*** • ***Registered Nurse (RN)*** • ***Licensed Clinical Social Worker (LCSW)*** • ***Certified Professional in Healthcare Quality (CPHQ)*** • ***Certified in Healthcare Compliance (CHC)*** • ***Certified Physician Assistant (PA-C)*** • ***NCQA Certified HEDIS Compliance Auditor*** • ***CMS Certified Data Validation Auditor*** • ***Registered Health Information Technician (RHIT)*** • ***Certified Coding Specialist (CCS)*** • ***Certified Professional Coder (CPC)***

2.2.4 Independence. The EQRO and its subcontractors must be independent from the MCO, PAHP, or CMO entities. To qualify as "independent":
2.2.4.1 A State agency, department, university, or other State entity:
2.2.4.2 May not have Medicaid purchasing or managed care licensing authority; and
2.2.4.3 Must be governed by a Board or similar body the majority of whose members are not government employees.

Assure is not a state agency, department, university, or other state entity; we do not have Medicaid purchasing or managed care licensing authority; and we are governed by a board whose members are not government employees.

2.2.5 Contract Restrictions

As described in (described in §438.354(c)(2)) an EQRO may not:

2.2.5.1 Review any MCO, PIHP, PAHP, or PCCM entity or a competitor operating in the State, over which the EQRO exerts control or which exerts control over the EQRO (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through:

A. Stock ownership;
B. Stock options and convertible debentures;
C. Voting trusts;
D. Common management, including interlocking management; and
E. Contractual relationships.

Assure understands and will comply with the regulations stated above. Assure was created in 2017 as a separate entity with a board and leadership removed from other HealthInsight Management Corp. programs to ensure that all EQRO independence requirements are met.

2.2.5.2 Deliver any health care services to Medicaid beneficiaries;

Assure does not deliver health care services to Medicaid beneficiaries.

2.2.5.3 Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PAHP, or CMO entity services, except for the related activities specified in §438.358;

Assure understands and will comply with this statute.

2.2.5.4 Review any MCO, PAHP or CMO entity for which it is conducting or has conducted an accreditation review within the previous 3 years; or

Assure understands and will comply with this regulation.

2.2.5.5 Have a present, or known future, direct or indirect financial relationship with an MCO, PAHP, or CMO entity that it will review as an EQRO.

Assure does not currently, and understands it may not in the future, have a direct or indirect financial relationship with a Nevada MCO, PAHP, or CMO that it will review as an EQRO. Assure was created in 2017 as a separate entity with a board and leadership removed from other HealthInsight Management Corp. programs to ensure that all EQRO independence requirements are met. Assure has a compliance officer and a commitment to ongoing review to ensure all independence requirements are always met.

2.2.6 Vendor Contract Manager

The vendor must designate a contract manager to work with the assigned DHCFP program specialist or contract monitor(s).

Margaret White will be the contract manager who will work with the assigned DHCFP program specialist or contract monitor(s).

2.2.7 Subcontract with an NCQA Certified CAHPS Vendor

The awarded vendor is, or will subcontract with, a National Committee for Quality Assurance (NCQA) certified Consumer Assessment of Health Plans Survey (CAHPS) vendor, if this optional activity is assigned.

Assure will subcontract with DataStat, an NCQA certified CAHPS vendor, if this optional activity is assigned. Additional information about DataStat is included in Section VIII.

2.2.8 Subcontract with an NCQA-Certified HEDIS Compliance Auditor

The awarded vendor is or has on staff, or will subcontract with, an NCQA- Certified Health Employer Data Information Set (HEDIS) Compliance Auditor.

Assure has an NCQA-Certified HEDIS Compliance Auditor on staff. Galina Priloutskaya holds a Doctorate in Economic Science, Masters of Management Information Systems and Computer Science, Masters of Science in Economic and Industrial Management Academy of Management, present CHCA, Certified HEDIS/P4P Auditor NCQA, Certified Data Validation Auditor CMS, National QIO Knowledge CMS Development Program, Medicare Part D Training CMS, SAS Training SAS Institute and Annual HEDIS Certification Training. Ms. Priloutskaya has 20 years of sustained experience using standardized statistical methods to perform high-level analyses linking outcomes to improved health, health care, and lower costs; calculating quality measures from claims data; evaluating statistical validity and reliability; calculating risk adjustment; and assessing result stratification. She is experienced in developing and refining model/demonstration design and operations, designing and conducting surveys, and other data collection activities.

2.3 Vendor Operating Structure and Staffing

2.3.1 Adequate Staffing

The vendor must assure DHCFP that the organization is adequately staffed with experienced, qualified personnel. The vendor shall provide such assurances as follows:

2.3.1.1 Provide DHCFP with an updated organizational chart whenever a significant change in the organization occurs. The organizational chart must depict each functional unit of the organization, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with all subcontractors. The organizational chart must also identify key personnel and senior level management staff and clearly delineate lines of authority over all functions of the Contract. The names of key personnel must be shown on the organizational chart;

The Assure team will be staffed by seasoned professionals residing and working in Nevada, New Mexico, and Oregon. Nevada staff will work from HealthInsight's Las Vegas office or, if residing in northern Nevada, will telecommute.

HealthInsight Assure Team

Figure 11 on the following page depicts Assure's operational organization for Nevada EQR services. Key personnel are depicted in bold and each staff member's functional role is indicated. Individuals living and working in Nevada are italicized.

We shall provide DHCFP with an updated organizational chart whenever a significant change occurs.

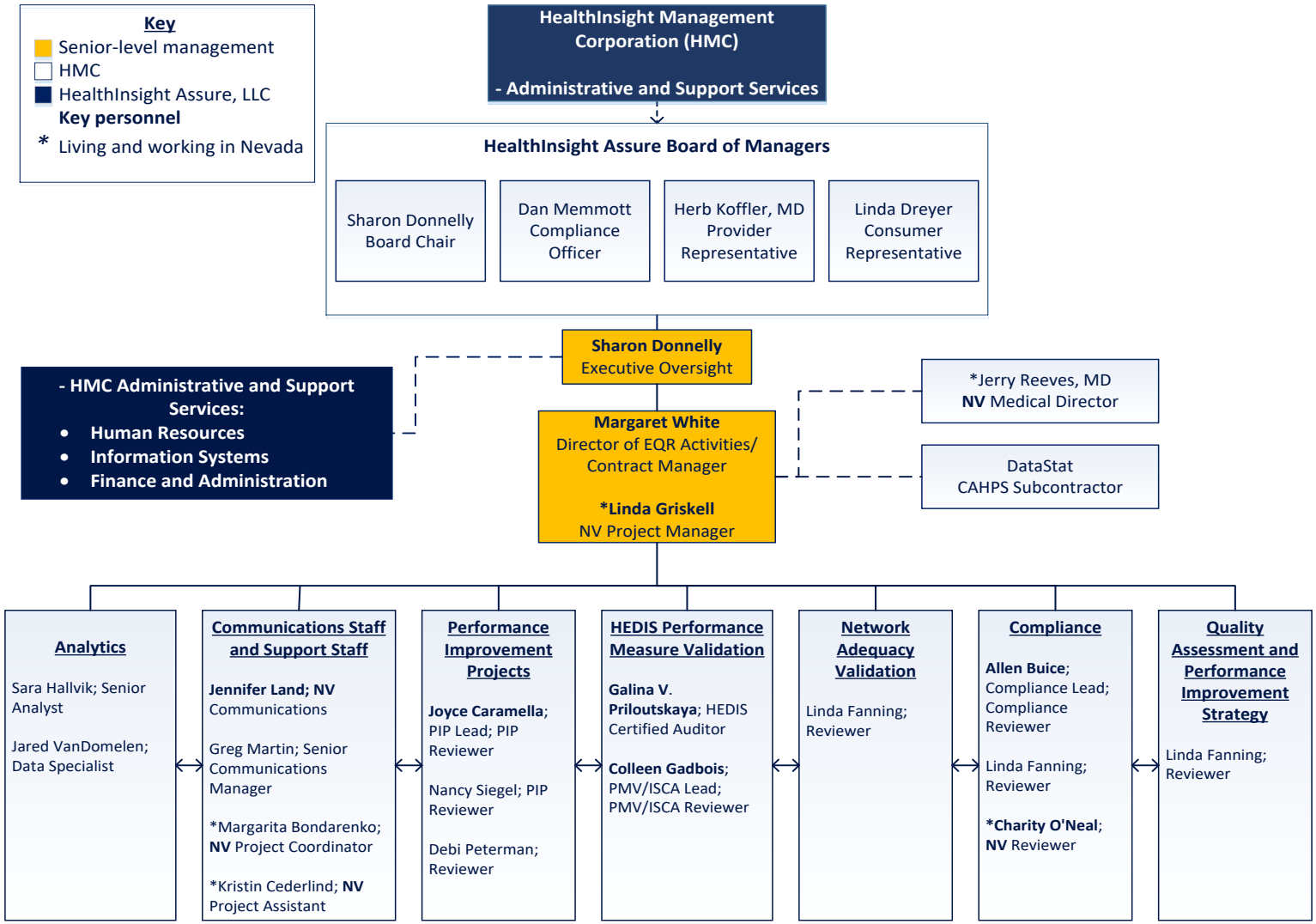

Figure 11. HealthInsight Assure Management Structure.

Leadership Team

The core Assure leadership team includes Sharon Donnelly, MS, Assure's senior vice president and chair of the Assure board of managers. She provides overall direction of Assure contracts and operations, and works closely with the board to ensure efficient and effective management. She will be a key staff member and executive officer and will oversee subcontractors for Nevada EQR services.

The leadership team also includes our EQR director, Margaret White, RN, BSN, MSHA, CHC, who directs all Assure operations. She is responsible for design and management of our EQR lines and for ensuring the success of the contracts she manages, overseeing project staff and operations and ensuring that Assure customers are satisfied with the services and deliverables they receive. Ms. White will be a key staff member and serve as the Nevada EQR Director and Contract Manager.

Table 16 presents the Assure team members and summarizes their roles, expertise, and background.

Table 16. Assure Team Members for Nevada External Quality Review Services.

Nevada External Quality Review Team		
Name Project Role	**Organizational Role**	**Education and Training**
Project Oversight and Management Staff		
Sharon Donnelly, MS Executive Oversight	Senior Vice President, Development and Chair of the HealthInsight Assure Board of Managers	Master of Science, Statistics, Bachelor of Science, Industrial Statistics, advanced leadership training from Great Basin Public Health Leadership Institute
	Sharon Donnelly advances strategic initiatives across HealthInsight's multi-state corporation and provides overall direction of HealthInsight Assure contracts and operations, working closely with the HealthInsight Assure board to ensure efficient and effective management She has over 15 years in managing large scale projects across multiple states and organizations, 20 years of experience in health care quality improvement projects in Medicaid and Medicare, Background in statistics, analytics and HEDIS auditing, Currently supports payment and delivery system reform	
Margaret White, , RN, BSN, MSHA, CHC; Contract Manager for Nevada EQR	Director of the External Quality Review Organization for HealthInsight Assure; Performance improvement methods; program evaluation; data collection; training facilitation; quality improvement/assessment; research design and methodology; health care compliance	Masters of Science, Healthcare Services, Bachelor of Science, Nursing, Associate of Applied Science, Licensed Registered Nurse, Certified in Healthcare Compliance Healthcare Compliance Association, Health Information Technology Pro. Certification, Six Sigma Green Belt Training, Lean Training

Nevada External Quality Review Team		
Name **Project Role**	**Organizational Role**	**Education and Training**
	Director of the External Quality Review Organization for HealthInsight Assure, highly accomplished hands-on leader, corporate compliance professional, strategic planner and experienced project manager with 20+ years of experience in the health care operations, patient care and health care compliance, achievements include contributing to superior performance through expert alignment of large programs and the management of multiple, complex projects that meet corporate objective, in health care operations, patient care and health care compliance and auditing	
Jerry Reeves, MD, Medical Director	Corporate Vice President of Medical Affairs of HealthInsight and Nevada Medical Director, based in Las Vegas, NV office	PhD and board certified in Pediatrics, Pediatric Hematology-Oncology, and in Medical Management. Dr. Reeves has authored more than 50 publications, been an editor for three professional journals, and served on the faculty of three medical schools.
	Nationally recognized physician, responsible for clinical oversight and guidance for the work performed. Dr. Reeves is very involved in the community, working with numerous providers and stakeholders to improve care in Nevada. He chairs the Nevada Partnership for Value-Driven Health Care (NPV), HealthInsight Nevada's regional health improvement collaborative and AHRQ-designated Chartered Value Exchange. NPV priorities include improving the effectiveness and safety of care that Nevada patients receive through the implementation of interoperable health information technologies, data sharing, and incentive programs that promote better health, better care, and lower cost. Dr. Reeves also chairs Nevada's multi-stakeholder Improving Diabetes and Obesity Outcomes (iDo) Council.	
Nicole O'Kane, PharmD Clinical Director	Clinical Director	Clinical and pharmaceutical expertise; quality assessment; performance improvement methods; research design and methodology; data evaluation and reporting
	Dr. O'Kane provides a broad range of clinical, pharmaceutical and data evaluation expertise to the company's quality improvement and research contracts, with a focus on improving the quality, safety and value of health care. She works closely with practitioners, purchasers, community-based organizations, professional associations and policymakers to design and measure patient-centered models and interventions that improve the safety and effectiveness of medical treatments. Her expertise includes the evaluation of medical practice patterns and the analysis and continuous quality reporting of medical claims and electronic health record data to drive value-based improvements. These initiatives focus on the needs of people who require complex medication combinations, such as elders who have a diagnosis of chronic pain, diabetes or heart disease.	
Jody Carson, RN, MSW, CPHQ; EQR Team Lead	EQR Director; Performance improvement methods; program evaluation; data collection; training facilitation; quality improvement/ assessment; research design and methodology; health care compliance	Bachelor of Nursing, MSW

Nevada External Quality Review Team		
Name **Project Role**	**Organizational Role**	**Education and Training**
	Experienced health care professional whose career spans over 40 years and includes clinical experience as a psychiatric nurse, social worker, program management, and quality improvement (QI) evaluation and education for Medicaid and Medicare managed care health plans. Ms. Carson has provided strong project and contract management for QI contracts in Oregon and Washington. She supervised all aspects of external quality reviews of the Medicaid regional support networks in Washington and coordinated care organizations in Oregon, which provide medical, mental health and dental managed care. Ms. Carson led the development of HealthInsight Assure's methodology to ensure that QI processes and projects adhere to federal regulations and to state contracts and regulations for managed care organizations.	
Linda Griskell, MHA Project Manager	Project Manager	Master of Healthcare Administration
	Experienced project manager for HealthInsight, currently leading two Nevada quality improvement teams addressing care transitions and adult immunizations. A significant portion of this work includes engaging with hospital leaders and community stakeholders to review current processes and identify new opportunities. She has worked with hospitals and physician groups across the country for more than 20 years in various analytic and consulting capacities. She has a bachelor's degree in sociology with an emphasis on health care market studies and reducing disparities, and a master's in health care administration from the University of Nevada, Las Vegas	
Pablo Garcia, MBA; Contracts Management Support	Senior Grants & Contracts Manager	Bachelor's degree in Accounting and a Master's degree in Business Administration (MBA)
	Pablo Garcia is the Senior Grants and Contracts Manager for HealthInsight. Responsibilities include contract solicitation response, negotiations, renewals, closeouts, development of financial modeling and contract risk assessment analyses to ensure achievement of corporate financial goals. He manages the accurate preparation, review, approval, and implementation of assigned contract proposals, amendments and extensions. He also works with senior leadership to ensure that HealthInsight is in compliance with legal and contractual requirements, client specifications and government regulations.	
Analytics Staff		
Galina V. Priloutskaya, PhD, MBA, CHCA; HEDIS Certified Auditor	Corporate Director of Analytics; CHCA, Certified HEDIS/P4P Auditor NCQA, Certified Data Validation Auditor CMS, National QIO Knowledge CMS Development Program, Medicare Part D Training CMS, SAS programmer	Doctorate in Economic Science, Masters of Management Information Systems and Computer Science, Masters of Science in Economic and Industrial Management Academy of Management, present CHCA, Certified HEDIS/P4P Auditor NCQA, Certified Data Validation Auditor CMS, National QIO Knowledge CMS Development Program, Medicare Part D Training CMS, SAS Training SAS Institute and Annual HEDIS Certification Training.

Nevada External Quality Review Team		
Name **Project Role**	**Organizational Role**	**Education and Training**
	NCQA certified HEDIS compliance auditor and CMS certified data validation auditor. She has been performing HEDIS, P4P and data validation audits on contractual basis with the NCQA certified licensed organizations since 2005. She led over hundred audits for managed care organizations, sixty Value based pay for performance (VBP4P) audits and thirty CMS data validation audits. Dr. Priloutskaya participated in multiple CMS and NCQA workgroups and technical expert panels (TEP) to develop national measurement strategy and improve HEDIS/VBP4P reporting. Recently Dr. Priloutskaya went through the training to perform URAC pharmacy accreditation audits and will be performing pharmacy audits in 2018.	
Sara Hallvik, MPH; Senior Analyst	Analytic Service Manager, SAS coding, senior healthcare analyst on EQRO contracts in Oregon, Washington, and New Mexico	Master of Public Health biostatistics and epidemiology, Bachelors in History and Spanish
	Expertise in data collection, management, and quantitative analytics, expertise with survey data and large relational databases, including claims and state registries, extensive experience supporting quality improvement initiatives, auditing and evaluation projects, and research grants, responsible for the planning and execution of encounter data validation, record sampling; inter-rater reliability calculation; and survey administration, management, analysis, and reporting.	
Jared VanDomelen; Data Specialist	Data Specialist	Associate in General Studies
	Jared VanDomelen designs and builds survey forms and data collection processes, including data entry quality control and inter-rater reliability checks. He performs accurate and rapid data entry and often works with sensitive information, including PHI and PII from Medicare and Medicaid members with diabetes, hypertension, mental illness, or other targeted diagnoses. Jared has expertise in Excel automation, which has been used in past survey projects to manage follow-up with survey respondents, refine mailing lists for subsequent survey distributions, and monitor response rates. His eye for detail and ability to learn new programs and processes quickly has supported many project teams on a variety of topics.	
EQR Activity Staff		
Joyce Caramella, RN, CPHQ; PIP Lead; PIP Reviewer	Project Manager	Bachelors in Management & Organizational Leadership, Certified Professional Healthcare Quality, National Association of Healthcare Quality, Certified Nephrology Nurse Nephrology Nursing Certification Commission
	36 years of experience as a registered nurse specializing in nephrology and oncology, 18 years as a certified health care professional focused on all aspects of quality improvement with managed care and coordinated care organizations (CCOs), their contracted partners, and physicians for medical, dental and mental health plans for Medicaid and Medicare Advantage, including 10 years as a HEDIS project manager	

Nevada External Quality Review Team		
Name **Project Role**	**Organizational Role**	**Education and Training**
Linda Fanning, LCSW, CPHQ; Reviewer	Project Manager	Master of Social Work, Licensed Clinical Social Worker, Certified in Healthcare Compliance
	34 years of experience connecting communities through social service and health care activities in both public and private sector, Clinical Quality Improvement Specialist responsible for Medicaid compliance reviews of Oregon coordinated care organizations, previously the Oregon Health Authority's Medicaid policy analyst for all federally qualified health centers, rural health clinics, Indian Health Services and Tribal 638 clinics. Manage planning, coordination, review, assessment and evaluation of external quality review activities of Oregon Medicaid CCOs for compliance with federal standards.	
Nancy Siegel, MPH, PA; PIP Reviewer	Program Manager	Master of Public Health, Bachelors in English/Communications, Physician Assistant certification, Oregon Board of Medical Examiners
	Experience performing annual reviews of performance improvement projects conducted by Medicaid managed care organizations, Certified Physician Assistant, 5 years of experience managing research studies and clinical trials, coordinate planning with Oregon Health Authority on coordinated care organization (CCO) PIPs related activities, develop tracking and monitoring tools and processes for CCOs, state and internal use, technical assistance to CCOs in Oregon regarding study design, intervention implementation, performance evaluation and report writing, analyze individual PIPs for validity and adherence to federal and state standards and good quality improvement (QI) methodology, and write quarterly summaries to Oregon Health Authority	
Allen Buice, CPHQ, PMP; Compliance Lead; Compliance Reviewer	Project Manager, EQR Compliance Lead	Master of Arts, Project Management Professional, Certified Professional in Healthcare Quality National Association of Healthcare Quality, Certified Medicaid Professional Certification Medicaid Learning Center'
	Lead multidisciplinary teams to conduct audits of the Medicaid managed care contracted organizations and providers, develop, designs and writes reports to the state Human Services Department, audit findings on managed care organizations (MCOs) regulatory compliance, quality improvement efforts, efficacy of those efforts, and recommendations for improvement, analyze health care metrics	
Colleen Gadbois, MPA; PMV/ISCA Lead; PMV/ISCA Reviewer	Project Manager	Master of Public Health
	Medicaid data processes, accuracy, and timeliness, Medicaid policy analyst with the State of Oregon and have knowledge of Medicaid recipients, policies, data systems, and processes, experience with EQR compliance piece have knowledge and experience related to Managed care delivery systems, organizations, and financing.	

Nevada External Quality Review Team		
Name **Project Role**	**Organizational Role**	**Education and Training**
Debi Peterman, MSN, RN; EQR Reviewer	Quality Improvement Manager for HealthInsight Assure	Master of Science in Nursing, Registered Nurse
	A registered nurse with over 25 years of experience, since 2009, Ms. Peterman has been reviewing documentation from managed care organizations (MCOs) for evidence of compliance with state contracts and applicable federal regulations	
Elaine Chavez, BSN, RN	Project Manager, Department of Corrections Medical Records Review	Registered Nurse with a Bachelor of Science Nursing degree
	32 years of experience in healthcare, previous Director of Nursing with upper level clinical and case management experience includes behavioral health, juvenile and adult corrections, long-term care, infection control, quality improvement, Project Echo Hepatitis C-Corrections. Under her guidance for a long-term care facility, the facility achieved a 5-star deficiency-free audit for four years	
Andrea (Andy) Romero, RHIT, CCS, CPC; EDV Reviewer	Project Manager - Physician and hospital coding; project management; case review; higher education; health care quality improvement; health information technology	Certified Professional Coder, AAPC, Certified Coding Specialist American Health Information Management Association, Registered Health Information Technician
	Over 35 years of experience in the health care field, 16 years of experience in quality improvement work, 3 years of experience in external quality review (EQR) work, in depth experience in resource allocation, process improvement, quality improvement, auditing, technical writing and data analysis. She is knowledgeable of New Mexico Medicaid Regulations, Centennial Care, the CMS Protocols for Medicaid EQR and the federal regulations as they pertain to public health, specifically managed care.	
Charity O'Neal, BSN; EQR Reviewer	Nurse Reviewer, Nevada	Bachelors of Applied Science in Nursing, Associates of Applied Science Degree
	Clinical Care Coordinator, Education to RNs, LPNs, CNAs, Patient care, Implemented Data Sets, Chart audit	
Kelly Williams, RN; EQR Reviewer	Registered Nurse, Nurse Case Manager, reviewer	Nursing Associates Degree, knowledge of Mysis and Centricity Business Systems, ONS Chemotherapy and Biotherapy Certified, ONS Safe Handling of Hazardous Drugs, member of the Nevada Nurses Association.
	Clinical Care Coordinator, Responsible for staff education at five long term nursing facilities with a special focus on Infection Control, Pneumonia, CHF, UTI, Pressure Ulcers and Dehydration in the elderly population, participates in patient care conferences to create a complete patient profile and treatment plan. Works in partnership with facility physicians/APRN's ensuring communication of care plans and treatment goals.	

Nevada External Quality Review Team		
Name Project Role	**Organizational Role**	**Education and Training**
Communications and Project Support Staff		
Greg Martin, MS; Senior Communications Manager	Director of Communications and Public Policy	Master of Science
	40 years of experience as an editor, writer, and researcher of technical publications. Formerly Acumentra Health's Director of Communications and Public Policy, Mr. Martin oversees corporate communications and public relations, supervises the communications staff, and ensures fulfillment of all communications-related objectives of the company's contracts with diverse clients. His experience with Acumentra Health since 2005 has given him a thorough understanding of Medicaid managed care delivery systems and policies, quality assessment and improvement methods, and health care performance measurement.	
Jennifer Land, BS; Nevada Communications	Senior Communications Specialist, HealthInsight Nevada	Bachelors of Science, Journalism
	Provides communications support to multiple teams working on Federal contracts to carry out quality improvement initiatives in hospitals, nursing homes, home health agencies, and physician offices.	
Ellen Gehringer; Project Coordinator	Project Coordinator, Nevada	Bachelors of Arts, Ethnic Studies
	More than 8 years of progressive experience managing consumer surveys, including the annual mental health consumer survey for the Oregon Health Authority (OHA). Responsibilities include survey design, quality control of data entry, technical assistance to survey respondents, facilitation of interpreter services and assistance with final reports. During a special study on adult residential care in Oregon, she managing weekly assignments for the field reviewers. For 2 years she managed the Health Professional Services contract with OHA, which included design of the database and procedures to produce weekly mandatory reporting to the state. Ellen is also responsible for producing monthly, quarterly and annual reports to OHA as a member of HealthInsight Oregon's mental health utilization review team.	
Kristin Cederlind Project Assistant	**Project Assistant**	
	Over 25 years of experience supporting executives, program managers and project teams with detailed understanding of policies, procedures and office interactions. Responsible for scheduling business meetings, reporting, and customer management. For the last four years, she has provided support for HealthInsight Nevada's operations, board and committee meetings and customer service related to technical assistance provided by HealthInsight staff.	
Other HealthInsight Experts		
Staff Name	**Organizational Role/Expertise**	
Mike Silver, MPH Consulting as needed	Senior Vice President of Improvement Science and Consultation - Patient safety and medical errors; human factors psychology; organizational safety management principles; process reliability; health care quality improvement; intervention design; program evaluation; research design and methodology; statistical analysis	

Nevada External Quality Review Team		
Name **Project Role**	**Organizational Role**	**Education and Training**
Susan Yates Miller, MPA Consulting as needed	QIO Director - Health care quality improvement; quality assessment, data evaluation and reporting; program evaluation; training facilitation and technical assistance; health care transformation; HEDIS; program administration.	
Anne Timmins, BChD, MPH Consulting as needed	QI Operations Director - Health care quality improvement; public health; patient safety; statistical analysis; technical assistance to health care providers; program administration; collaborative management	
Jackie Buttaccio, BSHSM, CPHQ Consulting as needed	Regional Quality Director - Healthcare quality improvement; QI methods; quality assessment; program evaluation and administration; project management	
David Cook, MBA, C(ASCP)cm, CPEHR Consulting as needed	Operations Director - Health care quality improvement; meaningful use and quality reporting; health information technology; program managemen	

2.3.1.2 Organizational, Management and Administrative Systems

The vendor must have in place the organizational, management, and administrative systems capable of fulfilling all contract requirements; and

Assure is a wholly owned subsidiary of HealthInsight Management Corp. (HealthInsight), created to house our EQR programs which had previously been operated separately in New Mexico and Oregon. Our combined units have worked together to build efficient processes to serve our clients in a cost-effective manner and to provide excellent oversight of programs critical to Medicaid clients and others in the communities we serve. Through an administrative services agreement, HealthInsight provides Assure with administrative support for human resources, accounting, information technology and security, communications and analytics, as illustrated in Figure 11 above.

Assure has a well-established, robust Continuous Internal Quality Improvement Plan (CIQIP) for anticipating and managing risk to assure contract success. CIQIP uses team charters, gap analyses/reality trees, performance dashboards, customer satisfaction questionnaires, after action reviews, root cause analyses, and monthly leadership review. Assure uses CIQIP tools to closely track deliverables and process measures through internal dashboards aligned with contract goals and evaluation measures. Dashboards are reviewed monthly to assess internal and external goals. Upon award of the EQRO contract, Assure will compare tools and processes to align and finalize the CIQIP.

These tools help us to manage the following processes:

- ***<u>Budget and cost controls:</u> We aggressively manage our budget to ensure that we are operating within budget by contract and by task. We have developed a set of financial tools that we use to review real-time financial data based on the high drivers of expense. Categories continuously monitored for financial performance include labor, travel, subcontractor and other direct costs.***
- ***<u>Internal quality assurance:</u> Assure maintains internal teams for quality assurance. These teams are responsible for identifying gaps in knowledge and creating training materials and educational information to ensure that our staff has the knowledge, skills and expertise to deliver services in a consistent, standardized approach that incorporates best practices.***
- ***<u>Project schedule management:</u> Per the requirements of a contract, we develop work plans for individual tasks that include detailed timelines and aggressive performance goals, tied directly to the contract deliverables. Work plans are reviewed weekly with staff and management to ensure that adequate resources are allocated to support the specified activities.***
- ***<u>Resource management, including staffing matrices by task/subtask:</u> Prior to the start of a contract, we conduct an in-depth review and analysis of each task and the skills that would be necessary to successfully execute the deliverables associated with the task. As a result of this review, we develop a staffing plan that ensures that each task has sufficient staff with the right skills and experience to ensure successful project completion. Staff with unique skills (e.g., health IT) are leveraged across tasks and across service areas.***
- ***<u>Progress reviews and performance monitoring:</u> Project performance is monitored weekly through a variety of tools, including the IQC dashboards and Key Performance Indicator dashboard.***
- ***<u>Risk management:</u> We have developed a comprehensive dashboard with Key Performance Indicators that is reviewed monthly and tracked on a red/yellow/green status indicator. Root cause analyses are completed on metrics classified as "red" to identify the barriers and challenges contributing to the poor performance and possible solutions to remedy the problem.***
- ***<u>Change management:</u> We recognize that successful change management starts with leaders who support and facilitate change by providing the vision for change and the strategy to sustain change. Our change management strategy has three parts:***
    1. ***Use data to create a sense of urgency and need.***
    2. ***Incorporate PDSAs as the process to lead, inspire, and guide change.***
    3. ***Promote real-time transparent communication through visibility walls and weekly huddles.***

As engaged leaders, our role during change is to identify and allocate resources to best support change activities, including motivating staff and removing barriers to transformational efforts.

2.3.1.3 Subcontractor Oversight and Accountability

The vendor is accountable for and must oversee all subcontractor functions.

HealthInsight's contracts management staff have processes in place to monitor subcontracts and ensure they operate in accordance with state and federal requirements. Assure anticipates only one subcontractor for the optional CAHPS survey activity, should that work be requested. A teaming agreement is in place for DataStat, which has reviewed the DHCFP contract elements that will be flowed down and has completed the vendor information requested in this RFP.

2.4 Implementation

2.4.1 Detailed Work Plan and Timeline

The vendor shall develop and submit to DHCFP for approval, no later than one month after notification that the vendor has been awarded the Contract, a detailed work plan and timeline for performing the obligations set forth in the Contract for the first contract year.

Work plans are the core of our processes. Work plans communicate expectations and identify resources and project deliverables. The Assure team has years of experience creating, monitoring, maintaining, and revising work plans in collaboration with state Medicaid agencies, and uses the Project Management Institute guidelines on good project management, which includes written, current work plans with specific deliverables, milestones, identified resources, and subtasks for each deliverable.

The Assure team is flexible with different types of work plans that meet the needs of our customers. We can provide online access to current work plans, deliver Excel spreadsheet or Adobe PDF formats, online versions via SmartSheet, and are willing to revise our work plans as work progresses on a project.

2.4.2 Updates to Work Plan and Timeline

Provide DHCFP with updates to the initial work plan and timeline, identifying adjustments that have been made to either and describing the vendor's current stage of readiness to perform all Contract obligations. All such updates shall be reviewed and approved by the DHCFP.

We will stay in communication with our state contact and keep them informed of our progress, any changes to the work plan and timeline, and our readiness to perform contract obligations. We understand that all updates will be reviewed and approved by the DHCFP.

2.4.3 Deliverables and Modifications

Unless otherwise agreed to by the DHCFP, submit to the DHCFP, within a minimum of ten (10) working days of the service start date, all deliverables to permit any DHCFP identified modifications. The DHCFP will have a maximum of twenty (20) working days upon receipt in which to respond with modifications to the vendor. If the DHCFP does not respond by the twentieth work day after receipt of the deliverable, the DHCFP's approval of the submission will be assumed to be granted.

The Assure team will submit all deliverables as requested above. If the DHCFP does not respond by the 20th work day after receipt, we understand that we may assume that approval was granted.

However, the Assure contract manager or other specified contact typically maintains communications with our customers to make sure we are providing deliverables that are useful, actionable, and professional. We would likely confirm the status with our DHCFP contact.

2.5 Presentation of Findings

The awarded vendor must obtain DHCFP's approval prior to publishing or making formal public presentations of statistical or analytical material that includes information about enrolled recipients. This material must protect specific individual recipient privacy and confidentiality to the extent required by both federal and state law and regulation.

We will comply with DHCFP's process for approval before publishing or making formal public presentations. We will request, in writing, permission to publish information about enrolled recipients before publishing the information and will follow any specific guidelines or restrictions DHCFP may place on the publication of the material.

2.6 HIPAA Compliance Requirements

2.6.1 Vendor Representations

The vendor represents and warrants that:

2.6.1.1 It will conform to all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations no later than the compliance date of each of those requirements or regulations;

Assure represents and warrants that it will conform to all applicable HIPAA regulations no later than the compliance date of each of those requirements or regulations. HealthInsight has a corporate privacy and security officer who is responsible for ensuring compliance across the organization. More details about our internal privacy policies are provided in Section 2.2.2.

2.6.1.2 It will ensure compliance with all HIPAA standards for themselves and any Business Associate(s), including transaction, code sets, identifier, privacy, confidentiality, and security standards, by the effective date of those rules;

Assure represents and warrants that it will ensure compliance with all HIPAA standards for ourselves and Business Associates as described in Section 2.6.1.2 above.

2.6.1.3 As a Business Associate, the Vendor and all subcontractors will comply with the Business Associate Addendum, ("BAA") found in Attachment J that is made a part of the contract.

Assure represents and warrants that it and all subcontractors will comply with Section 2.6.1.3 above. Both Assure and any subcontractors we may engage will sign a BAA during the contracting process.

Section VI– Company Background and References

Vendors shall place their written response(s) to ***Section 3, Company Background and References*** in ***bold/italics*** immediately following the applicable RFP question, statement and/or section. This section shall also include the requested information in ***Section 3.2, Subcontractor Information***, if applicable.

3. Company Background and Experience

Section 3.1.9 below presents HealthInsight's corporate background and history, and describes Assure's qualifications to provide the services described in this RFP.

3.1 Vendor Information

Assure is a new division of HealthInsight Management Corp. (HMC). Before Assure was created, HMC's affiliate organizations in New Mexico and Oregon performed EQR services. To establish independent direction and governance for EQR and other quality assurance work, HMC formed Assure as a separate division of HealthInsight in 2017 with appropriate separations in place to ensure independence requirements are met for our existing and future customers. Below, we provide the vendor information for both HMC and Assure where we believe it would be necessary to gain a full picture of the organization's background.

3.1.1 Vendors shall provide a company profile in the table format below.

Question	**Response**
Company name:	***HealthInsight Assure, LLC, a division of HealthInsight Management Corp. (HMC), a private, nonprofit organization***
Ownership (sole proprietor, partnership, etc.):	***Assure: LLC*** ***HMC: Private, nonprofit corporation***
State of incorporation:	***Utah (both)***
Date of incorporation:	***Assure: March 1, 2017*** ***HMC: 1974***
# of years in business:	***Assure: 1*** ***HMC: 43***

Question	Response
List of top officers:	***Sharon Donnelly, Assure board chair*** ***Linda Dreyer, Assure board consumer representative*** ***Herb Koffler, MD, Assure board provider representative***
Location of company headquarters, to include City and State:	***Murray, Utah***
Location(s) of the office that shall provide the services described in this RFP:	***Las Vegas, Nevada*** ***Portland, Oregon*** ***Albuquerque, New Mexico***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***Four employees currently in Nevada will be assigned to this work. Twenty-five additional employees with QI expertise also work from our Nevada office.***
Number of employees nationally with the expertise to support the requirements in this RFP:	***58 Assure employees*** ***225 total staff, when including the Quality Improvement and support expertise of other HealthInsight affiliates***
Location(s) from which employees shall be assigned for this project:	***Las Vegas, Nevada*** ***Portland, Oregon*** ***Albuquerque, New Mexico***

3.1.2 A Nevada-based business may apply for a five percent (5%) preference on its proposal. This preference may apply if a business has its principal place of business within Nevada. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. To claim this preference a business must submit a letter with its proposal showing that it qualifies for the preference.

A significant portion of the work and the majority of goods produced for this contract will be produced in Nevada. Therefore, as indicated in the letter attached letter, we are requesting consideration for the 5% preference. Please see Section VIII, Attachment 24 for our 5% preference letter.

3.1.3 Registration as a foreign corporation

Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

Assure was incorporated in Utah and has registered with the State of Nevada as a foreign corporation. Our business license is attached in Section IV, attachment 7.

Note that Assure is a division of HealthInsight Management Corp., also registered to do business in Nevada. Some responses below include information on both organizations, where indicated.

3.1.4 Licensure by Secretary of State

The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	**Response**
Nevada Business License Number:	***NV20171682698***
Legal Entity Name:	***HealthInsight Assure, LLC***

Is "Legal Entity Name" the same name as vendor is doing business as? -

Yes	✔	No	

If "No", provide explanation.

3.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

HealthInsight Assure and HealthInsight Nevada are both affiliates of HealthInsight Management Corp. While Assure does not have any past or current contracts with the State of Nevada, the other two entities do. Current and past contracts are listed in the table below for HealthInsight Nevada and HealthInsight Management Corp.

Yes	✔	No	

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

The following contracts span from 2002 through 2019. We held contracts prior to 2002, including the utilization review contract that ended in 2004 (last contract entered below). The original contract began in 1988 when Nevada Peer Review (original name of HealthInsight Nevada) was formed.

Table 17. Contracts with Nevada State Agencies

Question	Response
Name of State agency:	***Department of Health & Human Services*** ***Division of Public & Behavioral Health*** ***Bureau of Health Care Quality and Compliance***
State agency contact name:	***Leticia Metherell, RN, CPM, Program Manager*** ***775-684-1045*** ***lmetherell@health.nv.gov***
Dates when services were performed:	***April 1, 2017–March 28, 2019***
Type of duties performed:	***The HealthInsight Reducing Injury and Improving SafEty (RISE) program is a QI initiative designed to help acute care hospitals improve fall-related care processes and outcomes and minimize risk and harm to patients.***
Total dollar value of the contract:	***$286,756 ($0.494)***
Question	**Response**
Name of State agency:	***Department of Health & Human Services*** ***Division of Public & Behavioral Health*** ***Chronic Disease Prevention and Health Promotion (CDPHP)*** ***Bureau of Child, Family and Community Wellness (CFCW)*** ***1st Tier Subcontractor: HealtHIE Nevada (State Health Information Exchange)***
State agency contact name:	***Eric Fortenbury*** ***Grants and Project Analyst 2*** ***775-684-5929*** ***efortenbury@health.nv.gov***
Dates when services were performed:	***November 1, 2014 – June 29, 2015***

Question	Response
	July 1, 2015 – June 29, 2016 ***July 1, 2016 – June 29, 2017*** ***June 30, 2017 – June 29, 2018***
Type of duties performed:	***To promote awareness of high blood pressure and physician screening and referral to diabetes self-management education (DSME) programs.***
Total dollar value of the contract:	***2017-2018: $38,715*** ***HealthInsight Award: $21,715*** ***2016-2017: $70,314*** ***HealthInsight Award: $52,514*** ***2015-2016: $60,000*** ***HealthInsight Award: $41,000*** ***2014-2015: $185,000*** ***HealthInsight Award: $141,000***
Question	**Response**
Name of State agency:	***Department of Health & Human Services*** ***Division of Public & Behavioral Health*** ***Civil Monetary Penalty Fund Grant Award*** ***Bureau of Health Care Quality and Compliance***
State agency contact name:	***Jeanne Hesterlee, Health Facility Inspection Manager*** ***775-684-1054*** ***mhesterlee@health.nv.gov***
Dates when services were performed:	***May 1, 2016 – April 30, 2018***
Type of duties performed:	***HealthInsight assists nursing facilities in providing individualized, person-centered care, and improving fall-related care processes and outcomes.***
Total dollar value of the contract:	***$821,323 (S0.482)***
Question	**Response**
Name of State agency:	***Department of Health & Human Services*** ***Health Division*** ***Bureau of Health Care Quality and Compliance***
State agency contact name:	***Richard Whitley, Administrator, Health Division*** ***775-684-1030*** ***rwhitley@health.nv.gov***

Question	Response
Dates when services were performed:	***March 13, 2013 – February 28, 2015***
Type of duties performed:	***Provide Independent Informal Dispute Resolution (IIDR) to review deficiencies from surveys that result in civil money penalties for the department.***
Total dollar value of the contract:	***$1,750 ($250/case) (S0.441.NV)***
Question	**Response**
Name of State agency:	***Department of Health & Human Services*** ***Division of Mental Health and Developmental Services*** ***Agency of Rural Services Mental Health***
State agency contact name:	***Richard Whitley, Administrator, Health Division*** ***775-684-1030*** ***rwhitley@health.nv.gov***
Dates when services were performed:	***April 22, 2013 – June 30, 2013***
Type of duties performed:	***Provide Root Cause Analysis Training*** ***HealthInsight developed the Incident Investigation and Root Cause Analysis training program as a regional, multi-setting, two-day workshop designed to increase the capacity of local healthcare organizations through informed and disciplined analysis of safety-critical events and system redesign.***
Total dollar value of the contract:	***$8,166 (S0.446)***
Question	**Response**
Name of State agency:	***Southern Nevada Health District***
State agency contact name:	***Lawrence Sands, DO, MPH, Chief Health Officer*** ***702-759-1000*** ***snhdpublicinformation@snhdmail.org***
Dates when services were performed:	***July 1, 2006 – June 30, 2008*** ***July 15, 2008 – September 30, 2009*** ***July 1, 2009 – June 30, 2010***
Type of duties performed:	***Lead Poisoning Prevention: Education and outreach on lead poisoning awareness and prevention***
Total dollar value of the contract:	***2006-2008: $27,500*** ***2008-2009: $12,500*** ***2009-2010: $12,500*** ***$52,500 (S0.393, S0.400, S0.415)***

Question	Response
Name of State agency:	***Division of Health Care Financing and Policy*** ***Nevada Covering Kids and Families Initiative***
State agency contact name:	***Betsy Aiello*** ***775-684-3756*** ***baiello@health.nv.gov***
Dates when services were performed:	***July 1, 2006 – September 30, 2006*** ***July 1, 2006 – June 30, 2008***
Type of duties performed:	***Fiscal agent for Covering Kids and Families Program***
Total dollar value of the contract:	***2006: $17,759*** ***2006-2008: $399,888*** ***$417,467 (80.601.02, 80.601.03)***
Question	**Response**
Name of State agency:	***Aging and Disability Services Division*** ***State Health Insurance Assistance Program (SHIP)***
State agency contact name:	***General Contact*** ***775-687-4210*** ***adsd@adsd.nv.gov***
Dates when services were performed:	***October 1, 2003 – September 30, 2004*** ***October 1, 2004 – September 30, 2005*** ***October 1, 2005 – September 30, 2006*** ***October 1, 2006 – September 30, 2007***
Type of duties performed:	***Fiscal agent for State Health Insurance assistance Program (SHIP)***
Total dollar value of the contract:	***2003-2004: $38,869*** ***2004-2005: $46,693*** ***2005-2006: $52,850*** ***2006-2007: $50,208*** ***$188,620 (G0.501, G0.503, G0.504)***

Question	Response
Name of State agency:	***The Office of Nevada Attorney General***
State agency contact name:	***General Contact*** ***702-486-3420*** ***AgInfo@ag.nv.gov***
Dates when services were performed:	***February 01, 2003 – June 30, 2005***
Type of duties performed:	***Quality Case Reviews***
Total dollar value of the contract:	***$50,000 ($0.319)***

Question	Response
Name of State agency:	***Clark County Health District***
State agency contact name:	***General Contact 702-759-1000*** ***snhdpublicinformation@snhdmail.org***
Dates when services were performed:	***August 1, 2004 – October 31, 2004***
Type of duties performed:	***Lead Poisoning 2006: Funding to participate in planning for lead poisoning campaign.***
Total dollar value of the contract:	***$3,791.60 ($0.342)***

Question	Response
Name of State agency:	***Division of Health Care Financing*** ***Nevada Medicaid***
State agency contact name:	***General Contact*** ***877-638-3472***
Dates when services were performed:	***July 1, 2002 – March 31,2003***
Type of duties performed:	***Surveillance and Utilization Review - protect the integrity of Nevada Medicaid from provider fraud, waste, abuse, and improper payments.***
Total dollar value of the contract:	***$2,592,740 (M0)***

3.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	✔

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person shall be performing or producing the services which you shall be contracted to provide under this contract, you shall disclose the identity of each such person in your response to this RFP, and specify the services that each person shall be expected to perform.

3.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

Does any of the above apply to your company?

Yes		No	✔

If "Yes", please provide the following information. Table can be duplicated for each issue

Question	Response	
Date of alleged contract failure or breach:		
Parties involved:		
Description of the contract failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

being identified.

3.1.8 Vendors shall review and provide if awarded a contract the insurance requirements as specified in Attachment D, Insurance Schedule for RFP 3491.

The insurance requirements have been reviewed and will be provided upon award.

3.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. (5 page limit)

Our mission is to serve as a primary agent in focusing community energy to achieve significant and continuing improvement in the health of the community and in the quality and effectiveness of health care.

HealthInsight is a private, nonprofit community-based organization dedicated to improving health and health care, composed of locally governed affiliates in Nevada, New Mexico, Oregon, and Utah. HealthInsight also has operations in Seattle, WA, and Glendale, CA, supporting End-Stage Renal Disease Networks in the western United States. The HealthInsight enterprise holds contracts and grants in key areas of health care improvement, including initiatives with the Center for Medicare and Medicaid Innovation to improve care in nursing homes and contracts to provide learning system development, training and technical assistance support to health care innovation programs. This support includes environmental scans, lessons-learned synthesis, knowledge product development, collaborative learning facilitation, and direct technical assistance to innovations projects. HealthInsight operates a community health information exchange in Nevada and has launched Utah Healthscape, a comprehensive health care quality data-reporting website for providers, health plans, and the public. HealthInsight is a recognized leader in quality improvement; transparency and public reporting; health information technology programs; health care system delivery and payment reform efforts; and human factors science research and application.

Most relevant to this current proposal are the federal Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and state External Quality Review Organization (EQRO) contracts. (For a more comprehensive description of our work, see Section VIII, Attachment 25, HealthInsight Corporate Summary.)

HealthInsight Management Corp. (HealthInsight)

HealthInsight Management Corp. and its state affiliates hold the Medicare QIN-QIO contracts for Nevada, New Mexico, Oregon, and Utah. HealthInsight (originally known as Utah Professional Review Organization) was incorporated in 1974 and has held federal contracts to support Medicare QI activities since 1984. As the regional QIN-QIO, HealthInsight's staff of over 200 health care and support professionals work with health care providers and communities on multiple data-driven quality initiatives to improve patient safety, reduce harm, engage patients and families, and improve clinical care. As the parent company for its affiliates, HealthInsight provides financial,

administrative, information systems, data analytics, communications and human resources services to support operations.

HealthInsight state affiliates in New Mexico and Oregon have performed EQR activities, beginning with a contract in Washington, since 1993.

HealthInsight Assure. ***HealthInsight Assure, LLC (Assure) is a newly formed division of HealthInsight Management Corp. HealthInsight created Assure in 2017 to provide independent direction and governance of HealthInsight's existing EQR contracts and related quality assurance lines of business. Previously, HealthInsight's independently governed state-based affiliates in New Mexico and Oregon performed EQR work in those states.***

Assure has QIO-Like status (See Section IV, Attachment 6) and meets all qualifications to perform EQR work. Currently, Assure holds EQRO contracts for Oregon and New Mexico.

Our services for these states include:

- ***reviewing and assessing health plans' compliance with federal and state regulatory and contractual standards***
- ***validating health plan performance measures***
- ***validating managed care plans' performance improvement projects***
- ***validating Medicaid encounter data***
- ***conducting yearly in-person trainings for managed care plan staff***
- ***conducting and reporting the results of large-scale Medicaid consumer satisfaction***
- ***surveys, including surveys of children and their families***
- ***publishing annual technical and analytical reports on results of our EQR work***

Figure 12 below presents a corporate organization chart showing Assure within the organizational structure.

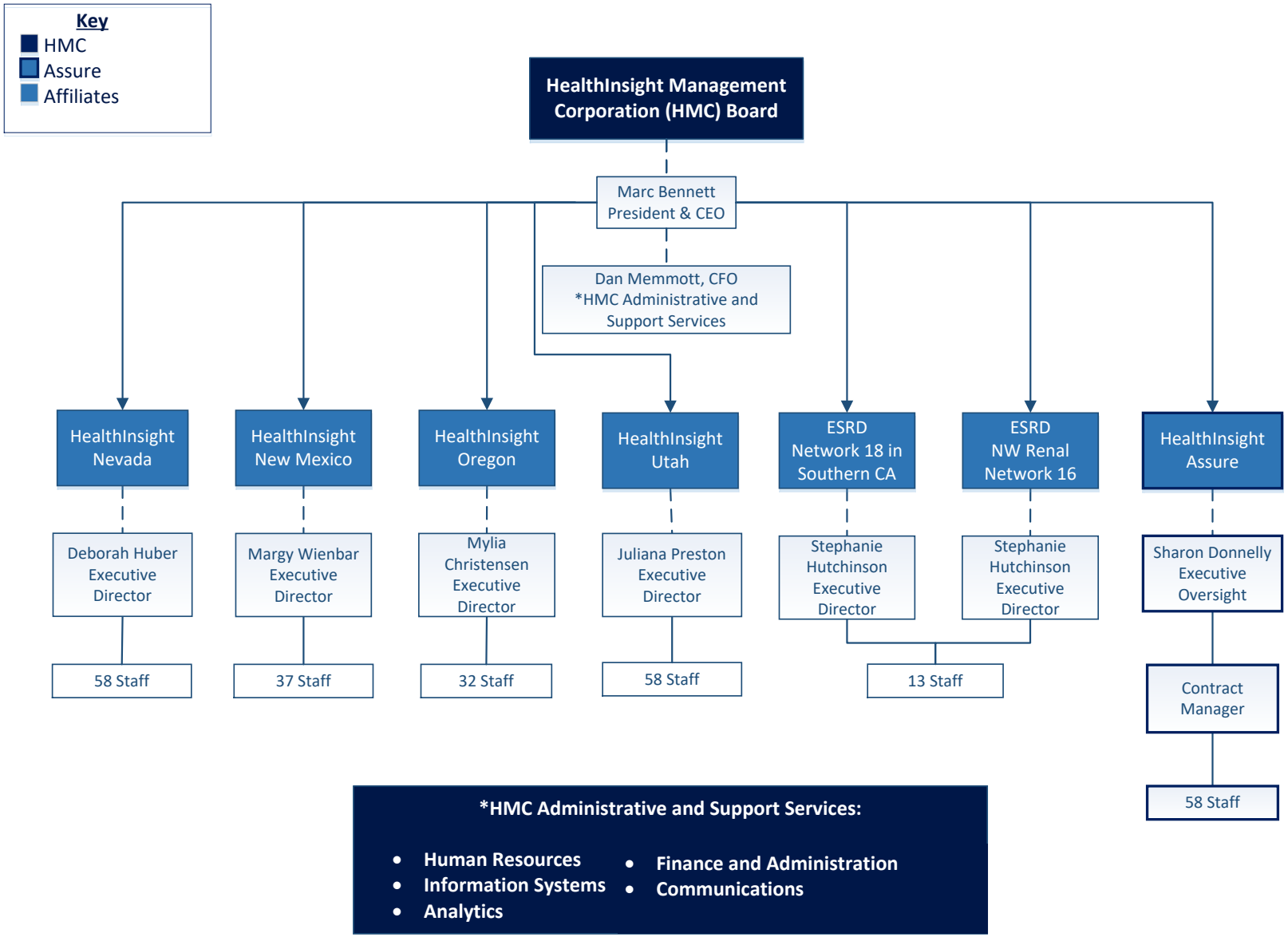

Figure 12. HealthInsight Management Corp. Organizational Chart.

Qualifications and Experience

Throughout this proposal we have included detailed information about our capabilities, staff experience, and expertise with EQR, and descriptions of how we meet all of the statutory requirements.

Below we highlight HealthInsight's corporate history, including relevant milestones and major QI contracts.

Table 18. HealthInsight Corporate History and Milestones

Years	Topic/Contract	Description
1984-1999	CMS Peer Review Organization (PRO) 1st through 5th Statements of work	***HealthInsight Utah, formerly the Utah Professional Review Organization, begins serving as Utah's Peer Review Organization under the Medicare PRO program as (UPRO).***
		HealthInsight New Mexico, formerly New Mexico Medical Review Association, begins serving as New Mexico's PRO.
		HealthInsight Oregon, formerly Acumentra Health and Oregon Medical Professional Review Organization (OMPRO), begins serving as Oregon's PRO.
1988	Nevada Peer Review	***Nevada Peer Review joins UPRO and the organization is subsequently (1994) renamed HealthInsight.***
1992–2014	Washington EQRO	***HealthInsight Oregon (Acumentra Health and OMPRO) becomes External Quality Review Organization (EQRO) for the Washington Medicaid program.***
1993	Workers Compensation	***HealthInsight New Mexico (NMMRA) begins administering the New Mexico Workers Compensation Utilization Review Program.***
1999–2019	QIO, CMS 6th–11th Statements of Work	***HealthInsight Oregon (Acumentra Health and OMPRO), New Mexico (NMMRA), Utah and Nevada are awarded QIO contracts***
2004	Oregon EQRO	***HealthInsight Oregon (Acumentra Health) becomes EQRO under contract with Oregon Health Authority.***
2005	New Mexico EQRO	***HealthInsight New Mexico (NMMRA) becomes EQRO under contract with New Mexico Human Services Dept.***
2008	URAC	***HealthInsight Oregon (Acumentra Health) receives URAC CORE accreditation.***
2009	URAC	***HealthInsight Nevada receives URAC CORE accreditation.***
2010	Beacon Communities Cooperative Agreement (CA)	***This was an Office of the National Coordinator for Health Information Technology CA to accelerate the adoption of electronic health records and using them to improve care***
2011	Network for Regional Healthcare Improvement (NRHI)	***HealthInsight Utah, HealthInsight New Mexico and HealthInsight Nevada are designated a Regional Health Improvement Collaborative and join NRHI.***
2012	Hospital Engagement Network (HEN)	***HealthInsight Nevada and New Mexico are awarded subcontracts from state hospital associations to conduct HEN activities with participating hospitals to reduce healthcare acquired conditions.***

Years	Topic/Contract	Description
2012	Admissions and Transitions Optimization Program (ATOP)	***HealthInsight Nevada is awarded the ATOP cooperative agreement by the Center for Medicare and Medicaid Innovation to improve processes and care within nursing facilities to reduce avoidable hospitalizations.***
2012-2017	Prescription Drug Monitoring Program (PDMP) Grant	***HealthInsight Oregon and partners completed a five-year NIH grant to assess whether state PDMPs can serve as an effective tool to improve patient care/outcomes.***
2013	Qualified Entity	***HealthInsight certified as a Qualified Entity by CMS.***
2013	QIO Medication Navigation	***HealthInsight New Mexico is awarded contract to explore the efficacy of using a telephonic health advice line to answer medication questions.***
2015	Task F.1: Adult Immunization (11SOW Task Order2)	***Staff focus on improving assessment and documentation of Medicare beneficiary immunization status, increasing immunization rates and reducing disparities.***
2015	Task G.1: Behavioral Health (11SOW Task Order 3)	***This task is focused on improving the identification of depression and alcohol use disorder in primary care and care transitions for behavioral health conditions.***
2015	SIE IMPAQ	***HealthInsight works with IMPAQ International on the CMS Strategic Innovation Engine contract to create widespread acceptance and application of QI in health care.***
2015	Expanding Participation in Self-Management Education Programs	***HealthInsight Oregon works with Oregon Public Health Division (PHD) to align activities with Oregon's existing self-management education initiative***
2015	End Stage Renal Disease (ESRD) NW 16 and 18	***HealthInsight provides health care QI services to improve care for persons living with ESRD.***
2015	ATOP 2: Payment Reform	***HealthInsight Nevada tests whether a new payment model for long-term care facilities and practitioners, together with clinical and educational interventions will improve quality while lowering Medicare/Medicaid spending.***
2016	Patient Flow ECHO (11SOW Task Order 6)	***Staff train medical practices to use the ECHO model and increase staff capacity for change and readiness to participate in emerging alternative payment models.***
2016	Hospital Improvement Innovation Network (HIIN)	***HealthInsight is awarded HIIN contract by CMS to work with hospitals to achieve a 20% decrease in overall patient harm and a 12% reduction in 30-day hospital readmissions from the 2014 baseline.***
2016	11SOW Task Order 7 *"Partnership to Advance Tribal Health"*	***HealthInsight New Mexico partners with CMS Center for Clinical Standards and Quality and Indian Health Services to address the need for expert health care QI services in 26 American Indian/Alaska Native health care facilities..***
2017	NRHI THRIVE QPP-SURS	***HealthInsight provides direct technical assistance and support services to ensure successful participation of clinicians during the transition of Medicare payments from a fee-for-service system to Quality Payment Program.***

3.1.10 Length of time vendor has been providing services

Provide a brief description of the length of time vendor has been providing services described in this RFP to the public and/or private sector.

HealthInsight has provided quality improvement and/or assurance services since 1974. From 1988 through the early 21st century, HealthInsight Nevada provided utilization review services for Nevada Medicaid. When this activity was wrapped into the initial Medicaid Management Information System contract, another vendor succeeded HealthInsight in that work.

Assure and its predecessor organizations have provided EQR services since 1993, beginning with a contract for performance improvement projects and survey work with the State of Washington. Assure currently holds EQR contracts with the states of New Mexico and Oregon.

The table below describes the EQR contracts Assure has held over the last 35 years.

Table 19. Assure EQR Contract History

Period	Contract Description	Activities and Experience
1988-2004	*Utilization review for Nevada Medicaid (DHHS-DHCFP)*	*Experience working with Medicaid programs in NV began in 1988 with Utilization Review. We have a 30-history working with Nevada Medicaid and other NV state agencies.*
1993-2014	*EQRO for Washington physical health managed Medicaid programs*	- *Performance Measure Validation (PMV),* - *compliance with standards,* - *Performance Improvement Project (PIP) validation,* - *surveys (adult and child; special populations),* - *focus studies,* - *quality strategy review*
1996-present	*UR and quality review of mental health services for Title XIX Medicaid enrollees who receive psychiatric hospital care and for adolescents in residential care in Oregon since 1996*	- *Utilization review for individuals up to age 21 or 65 and over to ensure medically appropriate services at an appropriate level of care and length of time.* - *Includes children and adolescents who are under tribal authority and children in Department of Human Services custody.*

Period	Contract Description	Activities and Experience
		- *Also review individuals ages 18 to 21 and 65 and over who are in certified treatment programs within the Oregon State Hospital.*
2005-present	*EQRO for New Mexico physical health, behavioral health, long-term supports and services and CHIP for the Medicaid programs*	- *Performance Measure Validation* - *Compliance with Standards* - *PIP Validation* - *Encounter Data Validation* - *Calculation of PMs* - *Focus Studies*
2008-2014	*EQRO for Washington mental health managed Medicaid programs*	- *Compliance,* - *PIP validation,* - *PMV,* - *EDV,* - *focus studies,* - *quality strategy review*
2012-present	*EQRO for Oregon mental, physical and dental health managed Medicaid programs*	- *Compliance,* - *PIP validation,* - *conducting PIPs,* - *validation of PM with ISCA,* - *member survey,* - *focus study*

3.1.11 Financial information and documentation to be included in accordance with Section 8.5, Part III – Confidential Financial Information.

We have not designated any information as confidential and have provided the information requested in this section below and attached as indicated.

3.1.11.1 Dun and Bradstreet Number

HealthInsight Assure DUNS #: ***081 106 627***

HealthInsight Management Corp DUNS #: ***073 096 190***

3.1.11.2 Federal Tax Identification Number

HealthInsight Assure: ***81-5464494***

HealthInsight Management Corp: ***87-0303872***

3.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement

B. Balance Statement

The last two years of financial statements and current year interim are attached in Section VIII as Attachments 20, 21 and 22. The Assure statements are incorporated into the HealthInsight Management Corp. financial statements

3.2 Subcontractor Information

Subcontractors are defined as a third party, not directly employed by the contractor, who shall provide services identified in this RFP. This does not include third parties who provide support or incidental services to the contractor.

3.2.1 Does this proposal include the use of subcontractors?

Yes	✔	No	

If "Yes", vendor shall:

3.2.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor shall perform services.

Assure will not use any subcontractors for the mandatory work.

If DHCFP requests optional activities requiring an NCQA Certified CAHPS vendor, we will contract with DataStat. Vendor information for DataStat is completed in Section 3.2.1.3.

3.2.1.2 If any tasks are to be completed by subcontractor(s), vendors shall:

A. Describe how the work of any subcontractor(s) shall be supervised, channels of communication shall be maintained and compliance with contract terms assured;

HealthInsight's contract management and accounting staff is experienced at monitoring contract compliance. All invoices are approved for payment by the project manager supervising the vendor before payment is made.

All vendors report to a specified project manager who supervises the activities and performance of the vendor. The project manager receives the invoice from the vendor and only approves said invoice if the work is satisfactory and on schedule. Any issues are promptly discussed and addressed with the vendor. Once the payment is approved, it is forwarded to the contracts manager for payment. The contracts manager tracks and manages the income and expenditures for each contract and subcontract.

B. Describe your previous experience with subcontractor(s).

The Oregon Health Authority has contracted directly with DataStat to perform CAHPS survey work. In addition, DataStat was recommended to us by another EQRO. A description of their experience appears in section 3.2.1.3 below.

3.2.1.3 Provide the same information for any proposed subcontractors as requested in Section 3.1, Vendor Information.

Assure has sufficient staff to complete all of the mandatory and most of the optional activities. If we are asked to provide services that require a certified CAHPS vendor, we will subcontract with DataStat. We have signed a teaming agreement with DataStat to enable expedient contracting once a scope of work is identified.

DataStat has provided the following overview of its experience and performance.

DataStat: Experience and Performance

DataStat has a long history and solid record of results as a top-tier survey research organization, conducting health care, academic, pharmaceutical, and other types of survey research projects. Our clients include institutions such as Harvard Medical School, the Centers for Disease Control and Prevention, the RAND Corporation, the MacArthur Foundation, the National Institute of Mental Health, NCQA, the Centers for Medicaid and Medicare (CMS), and the Department of Defense, in addition to many state agencies and health plans. Our client list represents the leading organizations in health services research, and the projects we work on frequently receive national attention.

Projects we have conducted over the years vary widely in size and scope: from a single academic organization, for example, field testing a single instrument among several hundred selected respondents using a uni-modal protocol, to hundreds of health care organizations and hundreds of thousands of respondents, state- or nation-wide, using a multi-modal protocol and requiring a multitude of aggregate or individualized custom graphical reports. Typically, we work with the quality improvement or health care improvement staff within a health care organization, who then disseminate survey results to other key personnel, such as board members or directors, within their organization as well as to key stakeholders in their larger health care community.

DataStat plays a major role as well in CAHPS and HEDIS research projects, dating back to the beginning of CAHPS when we partnered with the Picker Institute in the early testing and development of these instruments. We continue to participate in CAHPS development efforts and annually conduct many CAHPS, HEDIS, as well as Hospital

Outcomes Surveys (HOS) and other studies and surveys on behalf of our health plan clients, CMS, and state Medicaid partners.

Our expertise with CAHPS surveys comes from years of partnering with designers of CAHPS tools and protocols, ranging from the development of tools for non-English languages, to field testing new materials and protocols, such as the health literacy module designed for use in health plan, hospital, and provider settings.

DataStat is authorized by NCQA to process 500 CAHPS samples and 200 HOS samples per year. We conduct CAHPS, HEDIS, and HOS survey projects for hundreds of clients each year. Over time, we have increasingly specialized in large-scale state-level projects, such as CAHPS surveys for Utah, New York, Ohio, Minnesota, Washington State, Hawaii, and California. Sample sizes for these projects range from 50,000 or so, to well over 100,000, which means that we handle sample frames that are several orders of magnitude larger. Most of these projects run concurrently, with all materials and data collection tools produced and managed in-house.

Summaries of key projects are described below.

- ***Tri-State Children's Health Improvement Collaborative (T-CHIC). In 2012-13, DataStat was chosen to conduct the Clinician and Group with Patient-Centered Medical Home (PCMH) Items CAHPS Survey for this demonstration project, incorporating practice sites in Oregon, West Virginia, and Alaska. The Oregon Health Authority provided coordination for the project and T-CHIC practices, and structured the project such that practices in Oregon outside the scope of the grant were able to join the project, field their samples alongside T-CHIC sites, and have the opportunity to participate in NCQA's PCMH Recognition Program. Quality Corporation, a not-for-profit group working to improve health care quality in Oregon, worked with DataStat to coordinate efforts with non-T-CHIC sites. DataStat worked directly with all practice sites to obtain sample frame data files. A total of 21 T-CHIC and 23 non-T-CHIC practice sites (N=27,000, approximately) participated in the survey, which used the adult and child versions of the PCMH CAHPS instrument, with some custom items. A two-wave mail only protocol was implemented in English and Spanish; a telephone follow-up was added for sites in Alaska, given the limits of mail delivery in remote areas there. About half of the sites elected to submit data to NCQA.***

- ***The California Managed Risk Medical Insurance Board. Children's Health Insurance CAHPS Member Satisfaction Survey. From 2000 through 2013, when California reorganized its administration of public health care programs, DataStat conducted an evaluation of member services provided by 27 California health plans under the California Healthy Families program, which was federally funded under the SCHIP program. Approximately 25,000 respondents were involved. The project was conducted in five languages with complex ethnic oversampling. We did extensive consumer report design work for this project, including focus groups of likely***

consumers, and prepared final reports in the 11 official languages supported by MRMIB.

- ***<u>State of Oregon – Oregon Medical Assistance Program.</u> Since 2001, DataStat has been chosen to implement the CAHPS surveys for the State of Oregon Medicaid, Fee-for-Service, and low-income medical assistance programs. Using an enhanced approach to recommendations by NCQA and the CAHPS Consortium, we use a multi-wave mail plus telephone follow-up mixed methodology to collect the experiences of these beneficiaries.***

- ***<u>State of Utah – DHS Office of Healthcare Statistics.</u> DataStat has worked with the State of Utah since the early 1990's surveying the adult and child Medicaid populations. Utah was one of the very early adopters of the CAHPS survey, and began using it in telephone surveys in 1995. DataStat has enjoyed a long and successful relationship with OHCS and the Medicaid plans in Utah.***

- ***<u>New York State Department of Health (NYSDOH) – CAHPS Adult Medicaid Survey Project.</u> Since 2009, DataStat has been awarded the contract for conducting the CAHPS Adult Medicaid survey project for the NYSDOH. For each survey administration, about 35,000 enrollees are sampled across 15-20 managed care organizations. The project uses the current year CAHPS adult Medicaid survey instrument, with additional custom items, for approximately 64 total questions. We implement a mixed-mode protocol consisting of four mailing waves and a telephone follow-up; some years have included a $5 check incentive mailed to respondents who completed a survey. Project data are reported to the National CAHPS Benchmarking Database.***

- ***<u>New York State Department of Health – Adult and Child PCMH CAHPS Survey Project.</u> DataStat was selected to conduct the Clinician and Group with PCMH CAHPS Survey for the NYSDOH. The 2013 project was a pilot consisted of adult and child samples (N=6,000) drawn from PCMH and non-PCMH practices, and used a mixed-mode (3 wave mail plus phone) data collection in English and Spanish. Analysis compared experience of care in PCMH and non-PCMH practices.***

  In 2015, Data was selected to conduct 5 consecutive years of data collection in conjunction with Public Consulting Group and focused on the Delivery System Reform Incentive Payment Program (DSRIP). The DSRIP survey project surveys the adult populations enrolled in 25 NYSDOH Preferred Provider Systems (PPS); N=37,500. The DSRIP project uses the 2015 C&G CAHPS survey instrument, with some modifications, for approximately 47 total questions, and a mixed mode (mail and telephone) survey protocol in English and pre-identified Spanish. Custom state and PPS-level reports were developed and delivered along with the dataset.

Subcontractor Vendor Information

3.1.1 Vendors shall provide a company profile in the table format below.

Subcontractor Response:

Question	Response
Company name:	***DataStat Inc.***
Ownership (sole proprietor, partnership, etc.):	***Corporation***
State of incorporation:	***Michigan***
Date of incorporation:	***March 8, 1988***
# of years in business:	***29 years***
List of top officers:	***James Jeffery, President*** ***Kim Wheeler, COO / CFO***
Location of company headquarters, to include City and State:	***Ann Arbor, Michigan***
Location(s) of the office that shall provide the services described in this RFP:	***Ann Arbor, Michigan***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***Approximately 100:*** • ***25 professional staff*** • ***75-80 staff in mail, phone, scanning facilities***
Number of employees nationally with the expertise to support the requirements in this RFP:	***Same***
Location(s) from which employees shall be assigned for this project:	***Ann Arbor, Michigan***

3.1.2 A Nevada-based business may apply for a five percent (5%) preference on its proposal. This preference may apply if a business has its principal place of business within Nevada. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. To claim this preference a business must submit a letter with its proposal showing that it qualifies for the preference.

Subcontractor Response:
DataStat's principal place of business is in Michigan; we do not qualify for this preference.

3.1.3 **Please be advised**, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

DataStat will register with the State of Nevada if needed prior to execution of a contract.

3.1.4 The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

DataStat will obtain a business license with the State of Nevada if needed prior to execution of a contract.

3.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Subcontractor Response:

Yes		No	***X***

3.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Subcontractor Response:

Yes		No	***X***

3.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

Does any of the above apply to your company?

Subcontractor Response:

Yes		No	***X***

3.1.8 Vendors shall review and provide if awarded a contract the insurance requirements as specified in ***Attachment D, Insurance Schedule for RFP 3491.***

DataStat currently has in place the types and levels of insurance coverage, as described in Attachment D, Insurance Schedule for RFP 3491, and will submit documentation of such upon award of a contract.

3.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

Please see Section VIII Attachment 23 DataStat Capabilities 2018

3.1.10 Provide a brief description of the length of time vendor has been providing services described in this RFP to the public and/or private sector.

CAHPS®[1]-specific Experience:

- ***29+ years' experience in complex and large scale survey research***
- ***Primary contributor to CAHPS Consortium pilots and development***
- ***Conducted more complex CAHPS projects than any other vendor, from stand alone to state-wide***
- ***Certified by NCQA for 10+ years for health plan CAHPS (500 samples), and for PCMH CAHPS***
- ***Certified by CMS for MA&PDP CAHPS, ACO CAHPS, QHP and MIPS CAHPS surveys***
- ***Consistently achieve optimal response rates and superior levels of data quality***
- ***16+ years' experience in AHRQ CAHPS Benchmark Database and NCQA reporting requirements***

3.1.11 Financial information and documentation to be included in accordance with ***Section 8.5, Part III – Confidential Financial Information***.

3.1.11.1 Dun and Bradstreet Number: ***19-267-8969***

3.1.11.2 Federal Tax Identification Number: ***38-2791120***

3.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement
B. Balance Statement

[1] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

HealthInsight Assure has received the financial statements from DataStat, which they deemed confidential. Assure will provide them as a confidential file once DHCFP requests services requiring their expertise.

3.2.1.4 Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

HealthInsight Assure acknowledges and agrees, and DataStat has agreed to comply once they are engaged for this work.

3.2.1.5 Vendor shall notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in Section 3.2, Subcontractor Information. The vendor shall receive agency approval prior to subcontractor commencing work.

Assure acknowledges and agrees to notify DHCFS if we intend to use additional subcontractors.

3.3 Business References

3.3.1 Vendors shall provide a minimum of three (3) business references from similar projects performed for private and/or public sector clients within the last three (3) years.

As previously described, Assure is a new corporation that combines the EQR departments of HealthInsight Oregon and HealthInsight New Mexico. The references requested below represent relevant QIO and EQR experience of HealthInsight.

The business references are included in Table 20, below.

Table 20. Business References

Organization Name Contract Name and Number	Name of Contact Email and Phone Number
Oregon Health Authority External Quality Review Organization (EQRO) Services Contract Number: 142877	*Allison M. Tonge* *ALLISON.M.TONGE@dhsoha.state.or.us* *(503) 947-2340*
New Mexico Human Services Division External Quality Review Organization (EQRO) Services Contract Number: PSC 15-630-8000-0015	*Kathy Leyba* *Katherine.Leyba@state.nm.us* *(505) 827-7715*
Centers for Medicare & Medicaid Services Quality Innovation Network-Quality Improvement Organization (QIN-QIO) Indefinite Delivery / Indefinite Quantity (IDIQ) Contract for New Mexico, Nevada, Oregon, and Utah IDIQ Contract Number: HHSM-500-2014-QIN-007I	*Maryanne B. Butcher* *Maryanne.butcher@cms.hhs.gov* *(20i6) 615-2376*
University of New Mexico Evidence Now Program Southwest Health Extension Partnership to Enhance Research Dissemination Sub Award Number: 3RX42	*Danelle Callen* *DCallan@salud.unm.edu* *(505) 272-3448*

3.3.2 Vendors shall submit Attachment E, Reference Questionnaire to their business references.

Reference questionnaires have been submitted and requested.

3.3.3 It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in Section 7, RFP Timeline for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.

We anticipate that the Purchasing Division will receive at least three references on or before the deadline.

3.3.4 The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

Noted.

3.4 Vendor Staff Resumes

A resume shall be completed for each proposed key personnel responsible for performance under any contract resulting from this RFP per Attachment F, Proposed Staff Resume.

Resumes for 18 staff who will provide significant support to DHCFP and the Nevada MCOs to support the EQR work in Nevada have been supplied in Section VII.

Section VII – Attachment F – Proposed Staff Resumes

Resumes have been provided for the following individuals who will support the Nevada external quality review activities. Key staff are noted by an asterisk* and staff residing in Nevada are indicated by a black circle•

Name	***Role***	
Oversight and Management		***Section Page***
1. Sharon Donnelly*	***Executive oversight***	***2***
2. Margaret White*	***Contract Manager, Director of EQR Activities***	***5***
3. Jerry Reeves, MD•	***Medical Director***	***8***
4. Linda Griskell*•	***NV EQR Project Manager***	***11***
Review and Support Staff (in alphabetical order)		
5. Margarita Bondarenko*•	***NV Project Coordinator***	***13***
6. Allen Buice*	***Compliance Lead and Reviewer***	***16***
7. Joyce Caramella*	***PIP Lead and Reviewer***	***18***
8. Kristin Cederlind•	***Project Assistant***	***20***
9. Jared VanDomelen	***Data Specialist***	***22***
10. Linda Fanning	***Compliance and QAPI Reviewer***	***24***
11. Colleen Gadbois*	***PMV and ISCA Lead and Reviewer***	***28***
12. Sara Hallvik	***Senior Analyst***	***30***
13. Jennifer Land*	***Report Writer and Editor***	***32***
14. Greg Martin	***Senior Report Writer and Editor***	***34***
15. Charity O'Neal*•	***Nurse Reviewer- Compliance***	***36***
16. Debi Peterman	***PIP Reviewer***	***39***
17. Galina Priloutskaya*	***HEDIS Auditor***	***42***
18. Nancy Siegel	***PIP Reviewer***	***45***

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Sharon Donnelly, MS***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Senior Vice President and HealthInsight Board Chair***		
# of Years in Classification:	***6***	**# of Years with Firm:**	***21***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

As a Senior Vice President of Strategy at HealthInsight and as HealthInsight Assure's senior vice president and chair of the HealthInsight Assure board of managers, Sharon Donnelly advances strategic initiatives across HealthInsight's multi-state corporation and provides overall direction of HealthInsight Assure contracts and operations, and works closely with the HealthInsight Assure board to ensure efficient and effective management.

Ms. Donnelly manages development of programs with multiple partners, especially in the area of transforming primary care practices, across Nevada, New Mexico, Oregon and Utah, and in other western states. She participates in the regional health improvement collaboratives (RHICs) and supports them in project development, strategy and data transparency initiatives. She currently chairs the Utah Health Data Committee's Best Use Subcommittee which prioritizes future collection and use of data and recently chaired Utah's HIT State Innovation Model (SIM) planning group. She is also an advisor to Oregon Health & Sciences University's workforce development project to update and expand the Office of the National Coordinator's (ONC) Health Information Technology (HIT) curriculum.

Ms. Donnelly's interests in practice transformation include: using data to inform system and individual change; facilitating HIT adoption and meaningful use, along with work process redesign, in order to improve patient care; supporting development and interfacing with regional health information networks; payment reform and transparency initiatives; and building outpatient practice reporting and recognition programs. Ms. Donnelly leads the CMS task order for the Transforming Clinical Practices Initiative, designed the Utah Beacon and Regional Extension Center programs and was the initial project director for the HealthInsight HIT Regional Extension Center for Utah and Nevada. She has experience as a HEDIS auditor and in design, execution and analyses of Medicaid quality improvement projects under a previous external review contract in Utah.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

1996-present HealthInsight, Salt Lake City, Utah. Senior Vice President and Assure Board Chair
<u>HealthInsight Assure Board Chair 2017-Present</u>
<u>Senior Vice President, Strategy (2012–Present)</u>
<u>Vice President, Development (2009–2012)</u>

- Strategic planning to identify a priority agenda of opportunities to develop into projects to improve health care in various settings of care and states.

- Coordinating multi-state strategic agenda.
- Leading corporate effort to drive Board goals to strategic priorities, integrated across states.
- Cultivating relationships with state and national partners to pursue our strategic agenda.
- Managing ongoing relationships with internal and external customers.
- Design projects and write proposals to cultivate work with new partners in addition to handling existing contracts.
- Develop, facilitate, and participate in collaborative efforts with health care providers and educators, health care systems, managed care organizations, Departments of Health, academic researchers, quality improvement organizations from other states, regional networks, federal and state agencies, and pharmaceutical companies (including Salt Lake MSA Beacon Community).
- Multi-state project director for Transforming Clinical Practice Initiative for CMS QIN-QIO task order across four states (2016-2019).
- As project director for two-state HealthInsight Regional Extension Center (2010-2014), managed projects across multiple entities and states: provided management support including: relationship development and proposal writing, project development and design, budget planning and tracking, analyses of effectiveness of interventions, and presentation of project results.
- Ongoing customer relationship management.
- Support service and product development and marketing of product lines.

Strategy Director of Health Information Technology (HIT) 2006-2009

- Manage projects across multiple entities and states: provide management and analytic support including: background research and grant/proposal writing, project development and design, budget planning and tracking, analyses of effectiveness of interventions, and written and oral presentation of project results.
- Implementation of quality improvement and health information technology (HIT) initiatives.
- Create strategies for identifying opportunities to improve health care in various settings.
- Design projects and write proposals to cultivate work with new partners in addition to handling existing contracts.
- Delegate and coordinate work performed by project team members.
- Facilitate understanding of HIT adoption, health information exchange, process redesign, measurement, statistics, quality improvement and applied human factors within project teams and with collaborators.

Project Manager/Health Care Analyst 1996–2006

- Facilitate use of electronic decision control tools and community intervention models to significantly decrease antibiotic misuse across two rural states.
- Manage state-wide provider education program that reversed the trend of prescription drug deaths in Utah.
- Manage CDC and CMS projects across multiple entities and states: provide management and analytic support.
- Created Utah's first manual of Certified Self-Management Training Programs, Data Collection and Reporting Tools for the Diabetes Program.
- Delegate and coordinate work performed by junior analysts and project team members.
- Facilitate understanding of measurement, statistics, quality improvement and applied human factors within project teams and with collaborators.
- Design and analysis of Medicaid project to improve Asthma outcomes.
- Use customer input to design and program data collection and reporting tools.
- Perform HEDIS audits of health plans.

1993-1996 Statistics Department, University of Tennessee, Knoxville, TN. Instructor and Consultant

- Consulted with researchers, staff, and physicians at UT Medical Research Center on a wide variety of research projects and management initiatives. Responsibilities included: designing studies, writing and reviewing grant proposals, calculating sample size, designing data collection procedures and data management and verification systems, performing statistical analyses, and interpreting and presenting results.
- Taught undergraduate courses: Statistical Computing, Introduction to Statistics, Statistical Methods, and Sampling Techniques. Designed and taught a research methods course for the Ronald McNair Achievement Program for promising minority undergraduates.

2008-2010 Computer Center, University of Tennessee, Knoxville, TN. Statistical Consultant

- Consulted on experimental design, data management, programming, and statistical analysis.
- Developed course materials and taught computer applications.
- Consulted on software and operating systems for microcomputers and mainframes.
- Wrote newsletter articles, help files and other documentation.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- University of Tennessee, Knoxville, TN. Master of Science, Statistics, 1992
- University of Tennessee, Knoxville, TN. Bachelor of Science, Industrial Statistics, 1990

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- None to report

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Marc Bennett, President and CEO, HealthInsight.
   Phone number: 801-892-0155, Fax number: 801-892-0160,
   E-mail address: MBennett@healthinsight.org

2. Stephanie Hutchinson, Executive Director, ESRD Alliance- HealthInsight.
   Phone number: 206-923-0714, Ext. 103, Fax number: 206-923-0716,
   E-mail address: SHutchinson@healthinsight.org

3. Marci Scott-Weis, Chief Operating Officer, Qualis Health.
   Phone number: 206-288-2305, Fax number: 206-368-2419,
   E-mail address: MarciS@qualishealth.org

4. Mike Silver, Senior VP, Improve Science and Consultation, HealthInsight.
   Phone number: 801-892-6639, Fax number: 801-892-0160,
   E-mail address: MSilver@healthinsight.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Margaret A. White, RN, BSN, MSHA, CHC***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Director, External Quality Review Organization***		
# of Years in Classification:	***5***	**# of Years with Firm:**	***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Margaret White is the director of the External Quality Review Organization (EQRO) for HealthInsight New Mexico. She is a highly accomplished hands-on leader, corporate compliance professional, strategic planner and experienced project manager with 20+ years of experience in the health care operations, patient care and health care compliance. Her experience is demonstrated by achievements contributing to superior performance through expert alignment of large programs and the management of multiple, complex projects that meet corporate objectives. Ms. White is skilled in operational processes, clinical quality assurance, internal and external auditing, ethical cultures, successful communication structures, revenue cycle management, and organizational productivity through precise development, implementation, and management of policy, communication and training programs. She is a creative decision-maker and problem-solver focused on developing effective solutions and exceeding project goals while ensuring the continuous delivery of top quality services. Ms. White is results-oriented with outstanding communications and team building attributes.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2013-present HealthInsight New Mexico, Albuquerque, NM. Director, EQRO

- Oversees an operations area that consists primarily of providing Medicaid external quality review as well as providing services under other independent review contracts that may be in place from time to time.
- Fulfills all contract and grant requirements and deliverables for assigned projects.
- Supervises project managers and related project staff to meet contractual programmatic obligations and commitments and may serve as lead on selected projects as needed
- Develops, implements and assesses the Quality Management Program and internal quality control program
- Manages the EQR budget and related contract budgets; works in concert with the chief executive officer (CEO), finance director, chief operating officer and medical director, as appropriate, in the development of budgets for both existing contracts/grants and new business opportunities
- Provides liaison, direction and technical assistance to EQR-related subcontractors; reviews the outcomes of performance monitoring and provides feedback to subcontractors

- Interprets program guidelines, policies and procedures applicable to the fulfillment of contracts
- Works with the corporate medical director and contracted Medicaid medical director to provide for properly credentialed and licensed peer reviewers and physician advisors involved in medical decision making
- Provides oversight for the design of external quality review organization work plans and use of consultants, peer reviewers and physician advisors
- Oversees the preparation of reports and recommendations based on information from national practice guidelines and quality improvement design
- Participates in strategic planning efforts as appropriate and assists in developing proposal responses to new business opportunities
- Assists in development of and/or gives formal presentations to healthcare-related audiences as appropriate
- Updates contact information in HealthInsight New Mexico's Contact Management Database as appropriate
- Understands and adheres to HealthInsight's Code of Business Conduct and Ethics, Corporate Compliance Program and related policies and procedures
- Develops and maintains positive relationships with internal and external customers
- Participates in HealthInsight New Mexico's internal quality improvement activities as appropriate

2010-2012 ABQ Health Partners, Albuquerque, NM. Senior Director, Revenue Cycle

- Reported to the CFO and oversaw the Revenue Operations Department, which served over 300 providers in 24 clinics with more than $18,000,000 in charges billed each month and 70,000 claims prepared monthly.
- Managing a staff of 50 with 3 Directors who worked in tandem with an external Billing Service to train providers and clinic staff, code medical records, respond to patient billing inquiries, appeal denials, post payments and resolve credit balances.
- Synchronous management of local and long-distance Revenue Cycle Teams, monitoring and reporting key performance indicators, providing financial and operating analyses of revenue cycle data for the Executive Management Team and implementing the revenue cycle quality assurance program.

2008-2010 Healthcare Information Services, Willowbrook, IL. Director, Billing, Reimbursement and Compliance Officer

- Provided leadership to the Radiology Division and mentoring to the Management Team by performing as an agent of change during a period of expansion for the company;
- Directed Billing, Coding, Call Center, Collections, and Compliance/Auditing Departments for all clients in the Division;
- Oversaw the day-to-day operations of the Division which served 6 hospital-based radiology groups and 11 free-standing imaging centers with over $16,000,000 in charges billed each month and more than 65,000 claims prepared monthly.

2002-2008 Tenzing, Loves Park, IL. Director, Quality Improvement Manager and Compliance Officer

- Orchestrated expert completion of compliance plan objectives in accordance with federal guidelines and best practices;
- Acted as an independent entity to ensure that compliance issues/concerns within the organization were being appropriately evaluated, investigated and resolved;
- Monitored complex, inter-departmental company projects by designing each project's plan and scope and ensuring efficient, productive communication between stakeholders and adherence to project deadlines;
- Acted as a liaison with legal counsel on compliance and reimbursement issues.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- University of St. Francis Joliet, IL. Masters of Science, Healthcare Services Administration, 2006
- Saint Anthony College of Nursing, Rockford, IL. Bachelor of Science, Nursing, 1998
- Rockford Business College, Rockford, IL. Associate of Applied Science, Paralegal, 2001

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Licensed Registered Nurse, 2016
- Proficiency Level Quality Certification Program, 2017
- Certified in Healthcare Compliance, 2016
- Health Information Technology Pro., 2012
- Six Sigma Green Belt Training, 2012
-

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Gary Logsdon, Contract Manager, New Mexico Human Services Department, Phone number: 515-309-1345, E-mail address: Gary.Logsdon@state.nm.us

2. Joann Sanchez, Project Manager, Partnership to Advance Tribal Health (PATH), HealthInsight, Phone: 505-998-9753, Fax number: 505-998-9899, E-mail address: josan101@gmail.com

3. Todd Trautwein, Director of Revenue Cycle, Davita, Phone number: 505-620-3515

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jerry Reeves, MD***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Corporate Vice President Medical Affairs, HealthInsight***		
# of Years in Classification:	***20***	**# of Years with Firm:**	***8***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Dr. Jerry Reeves is Corporate Vice President of Medical Affairs of HealthInsight in Nevada, Utah, Oregon, and New Mexico, where he is responsible for clinical oversight and guidance for the quality improvement and patient safety work performed. Dr. Reeves is very involved in the community, working with numerous providers and stakeholders to improve care. He chairs the Nevada Partnership for Value-Driven Health Care (NPV), HealthInsight Nevada's regional health improvement collaborative and AHRQ-designated Chartered Value Exchange. NPV priorities include 1. Expanding community health improvement collaboratives, 2. Improving care coordination, 3. Engaging consumers in better self-management of their conditions, and 4. Expanding Nevada's clinical work force. Dr. Reeves also chairs Nevada's multi-stakeholder Improving Diabetes and Obesity Outcomes (iDo) Council.

Outside of HealthInsight, Dr. Reeves consults nationally on health benefits design, wellness and health management services for health plan sponsors and coalitions. He is Principal and Medical Director of wellPORTAL LLC, a patient centered medical home network and Medical Director of Health Services Foundation promoting health and well-being among union health plan members.

Dr. Reeves previously served as Chief Health Officer for Consumer Owned and Operated (CO-OP) Plans in South Carolina and Tennessee, Chief Medical Officer of Hotel Employees and Restaurant Employees International Union (HEREIU) Welfare Funds, CEO and Chairman of WorldDoc Inc., Chief Medical Officer of Humana Inc. and Sierra Health Services Inc., and as Chief of Clinical Medicine at USAF Headquarters in Europe. He served two terms on the Board of Health of the State of Nevada and as Associate Dean, Managed Care, for University of Nevada School of Medicine. He is board certified in Pediatrics, Pediatric Hematology-Oncology, and in Medical Management. He has more than 20 years of experience delivering primary and specialty care. He has authored more than 50 publications, been an editor for three professional journals, and served on the faculty of three medical schools.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2010-2018 HealthInsight, Las Vegas, Nevada. Corporate Vice President Medical Affairs

- Responsible for clinical oversight and guidance for the quality and patient safety work performed.

- Chairs the Nevada Partnership for Value-Driven Health Care (NPV), HealthInsight Nevada's regional health improvement collaborative and AHRQ-designated Chartered Value Exchange.
- Chairs Nevada's multi-stakeholder Improving Diabetes and Obesity Outcomes (iDo) Council. **Charter:** Promote, track, and continually improve results of diabetes screening, prevention and control interventions for Nevadans with, or at high risk for, diabetes and obesity through effective collaborations among public and private employers, payers, health care providers, educators, and community stakeholders, respecting the cultural diversity of our community. Brief Description

2008-2018 wellPORTAL LLC, Las Vegas, Nevada. Principal and Medical Director
Principal and Medical Director of this network of patient centered medical homes

2001-2018 Health Innovations LLC, Las Vegas, Nevada. Principal
- Providing medical and health benefit consulting services in Nevada and throughout the United States to large and small companies and to large and small union health trusts

2011-2015 Community Health Alliance of Tennessee. Chief Health Officer
- Develop and implement an integrated healthcare delivery network enhancing the practice of evidence based medicine, medical home primary care and chronic disease management for this consumer owned and operated not-for-profit health plan.

2011-2015 Consumers' Choice Health Plan of South Carolina. Chief Health Officer
- Develop and implement an integrated healthcare delivery network enhancing the practice of evidence based medicine, medical home primary care and chronic disease management for this consumer owned and operated not-for-profit health plan.

Selected Previous Experience

- Hotel Employees and Restaurant Employees International Union (HEREIU) Welfare Funds. Chief Medical Officer
- Culinary Health Fund. President of Las Vegas Operations
- Humana Inc. Senior Vice President/ Chief Medical Officer
- Sierra Health Services Inc. Senior Vice President/ Chief Medical Officer
- USAF Headquarters in Europe. Chief of Clinical Medicine
- Nevada State Board of Health. Board Member

EDUCATION
Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Baylor University, Waco Texas. Degree, Bachelor of Arts, 1967
- Baylor College of Medicine, Houston Texas. Doctor of Medicine (MD), year completed, 1971
- David Grant USAF Medical Center, Travis AFB, CA. Residency (Pediatrics), 1971-1974
- University of Colorado School of Medicine, Denver, CO. Fellowship (Pediatric Hematology-Oncology), 1976

CERTIFICATIONS
Information required should include: type of certification and date completed/received.

- Diplomat, American Board of Pediatrics, No. 19416
- Diplomat, American Board of Pediatrics Subspecialty Board on Pediatric Hematology-Oncology, No. 293
- Nevada State Board of Medical Examiners, 0121 (Since 1988)
- Diplomat, American Board of Medical Management

- Arizona Board of Medical Examiners, No. 24931 (1997- 2006)
- Kentucky Board of Medical Examiners, No. 34053 (1998- 2006)
- California Medical Board, No. C35093

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Insert here a **minimum of three (3) references** with the above/below information.

1. Marc Bennett, CEO, HealthInsight, Phone: 801-892-0155, Fax: 801-892-0160, MBennett@healthinsight.org
2. Leslie Johnstone, VP Operations, HealthInsight Nevada, Phone number: 702-777-8370 Fax: 702-385-4586, LJohnstone@healthinsight.org
3. Steven Phillips, MD, Geriatric Specialty Care, Medical Director, Phone: 702-398-1981, gcnreno@gmail.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Linda Griskell, MHA***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Project Manager***		
# of Years in Classification:	***20***	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Linda Griskell is a project manager for HealthInsight and leads two Nevada quality improvement teams addressing care transitions and adult immunizations. A significant portion of this work includes engaging with hospital leaders and community stakeholders to review current processes and identify new opportunities. She has worked with hospitals and physician groups across the country for more than 20 years in various analytic and consulting capacities. She has a bachelor's degree in sociology with an emphasis on health care market studies and reducing disparities, and a master's degree in health care administration from the University of Nevada, Las Vegas.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2015-Present HealthInsight, Las Vegas Nevada. Project Manager

- Current Nevada state lead for a care transitions program, aimed at reducing hospital readmissions and preventable admissions while also reducing adverse drug events.
- Current Nevada state lead for an adult immunizations program, aimed at improving adult immunizations rates and protecting the Medicare population against vaccine preventable diseases.
- Former state lead for Meaningful Use and EHR Incentive Program task, aimed at moving providers toward value based payment programs.

2001-2015 HealthGroup West, LLC, Las Vegas Nevada. Senior Consultant

- Develop strategic plans for hospitals, health systems, and practices to identify growth opportunities.
- Specialize in oncology, cardiovascular, orthopedics, general surgery, ambulatory, and ER services.
- Improve access to care by adding new services, physicians and locations to communities.
- Work with quality improvement teams to identify measure and report quality and safety outcomes.
- Identify cost reduction strategies and reduce spending and waste while creating value for patients.
- Conduct community needs assessments, physician workforce studies, and medical staff surveys.

- Develop needs assessments and volume projections for new or existing services and de novo hospitals.

2013-2013 Matt Smith Physical Therapy, Las Vegas Nevada. Internship for Graduate School
- Work with COO to develop a new prior authorization department.
- Provide research, analysis, and planning tools for centralizing insurance authorization.

1996-2001 John Goodman & Associates, Las Vegas Nevada. Executive Assistant
- Work with consultants and analysts in daily functions, planning documents, presentations.
- Review and edit all company business planning documents and correspondence

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- UNLV, Las Vegas, NV. Master of Healthcare Administration, 2013
- UNLV, Las Vegas, NV. Bachelor of Arts, Sociology; Minor in Psychology, 2004

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- None to report

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Jackie Buttaccio, Quality Improvement Director, HealthInsight,
   Phone number: 702-933-7322, Fax number: 702-385-4586,
   E-mail address: JButtaccio@healthinsight.org

2. Deepthi Rajeev, Director Patient Safety and Innovation, HealthInsight,
   Phone number: 801-892-6654, Fax number: 801-892-0160,
   E-mail address: DRajeev@healthinsight.org

3. Donna Thorson, Senior Project Manager, HealthInsight,
   Phone number: 702-933-7327, Fax number: 702-385-4586,
   E-mail address: DThorson@healthinsight.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Margarita Bondarenko***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Project Coordinator***		
# of Years in Classification:	***3***	**# of Years with Firm:**	***3***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Margarita Bondarenko is a Project Coordinator for HealthInsight and has coordinated quality improvement initiatives since 2014. She has worked primarily with home health agencies and physician practices focusing on areas such as improving immunization rates and screenings for cardiac measures in high risk patients; and helping physicians prepare for meaningful use of electronic health records, physician quality reporting and the value modifier. She has particular expertise in privacy and security and HIPAA compliance from her graduate and undergraduate studies in health care administration. Prior to HealthInsight she was an Ethics and Compliance intern at Sunrise Hospital and a Compliance Specialist at Boys Town Nevada where she executed and managed provider licensing with Medicaid and conducted internal audits of Nevada facilities. Ms. Bondarenko has a particular interest in shared decision making within the Primary Care Medical Home model of care, and was published by Patient Experience Journal in 2015. She earned her Master of Health Care Administration in 2016 from the University of Nevada Las Vegas and is certified in Public Policy Leadership by the Greenspun College of Urban Affairs.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2014-Present HealthInsight, Las Vegas, Nevada. Project Coordinator

- Work with Nevada Home Health agencies to improve immunization rates and screenings for cardiac measures in high risk patients.
- Collaborate on the planning, development, implementation, evaluation and improvement for care coordination/care transitions with Nevada Home Health Agencies, as well as developing intervention materials.
- Work with physician offices throughout Nevada by developing a strategic plan to address changes in reimbursement from CMS, with a focus on preparing offices on meaningful use of electronic health records, physician quality reporting system, and value modifier.
- Manage web-based access projects for HealtHIE Nevada Health Information Exchange for Home Health Agencies.
- Collaborated on writing successful grant proposals from Center for Medicaid and Medicare Services.
- Developed and conduct Privacy and Security program and auditing for HealtHIE Nevada Health Information Exchange.
- Work on EHNAC accreditation for HealtHIE Nevada Health Information Exchange.

2016-2016 University of Nevada, Las Vegas, Nevada. Graduate Teaching Assistant

- Taught undergraduate Health Care Administration Pre-Practicum and Practicum courses.
- Developed Blackboard course for practicum program.
- Collaborated and implemented student placement for undergraduate practicum in the following settings:
    - Hospital
    - Hospice
    - Insurance
    - Skilled Nursing Facility
    - Physician office
- Conducted performance evaluations and reviews of practicums for over 80 students per semester.
    - Implemented program improvement strategies
- Built relationships across internal and external resources.

2014-2015 University of Nevada, Las Vegas, Nevada. Graduate Research Assistant

- Taught undergraduate Health Care Administration Courses:
    - Quantitative Methods in Health Care Administration
    - Strategic Planning
- Worked on a variety of research projects alongside faculty in the area of patient experience. Conducted literature reviews, data analysis, composition, and editing.

2014-2014 Sunrise Hospital, Las Vegas, Nevada. Ethics and Compliance Intern

- Prepared and executed Hospital Portal for Policies and Procedures software implementation and developed training for software users.
- Coordinated with Office of Research Compliance to develop Pediatric Research policy and supporting documents for the Institutional Review Board (IRB).
- Participated in biannual disaster drill scenario composition and evaluation.

2013-2014 Boys Town Nevada, Las Vegas, Nevada. Compliance Specialist

- Executed and managed provider licensing with Medicaid, and conducted internal audits of facilities and patient paperwork.
- Coordinated care of youth in collaboration with clinical/behavioral staff and oversaw youth medication documentation.
- Developed a Medicaid Manual for use by Clinicians and Billing Specialist and provided training on commonly used billing codes to ensure correct reimbursement.

2013-2014 University Medical Center of Southern Nevada, Las Vegas, Nevada. HIPAA Project Intern

- Created HIPAA policy manual.
- Developed Protected Health Information (PHI) and Mobile Devices policy.
- Performed audit for HIPAA compliance.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- University of Nevada, Las Vegas. Master of Health Care Administration, 2016
- University of Nevada, Las Vegas. Bachelor of Science, Health Care Administration, 2014

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Public Policy Leadership, General Government, 2017

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Chris Cochran, Professor; Chair, Department of Health Care Administration, University of Nevada Las Vegas, Phone number: 702-895-1400, Fax number: 702-895-5573, E-mail address: chris.cochran@unlv.edu

2. Michele Klem, Quality Assurance Specialist, State of Nevada, Phone number: 702-668-4200, Fax number: 702-668-4280, E-mail address: michele.klem@boystown.org

3. Jackie Buttaccio, Quality Improvement Director, HealthInsight, Phone number: 702-933-7322, Fax number: 702-385-4586, E-mail address: JButtaccio@healthinsight.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Allen Buice, CPHQ, PMP***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Project Manager***		
# of Years in Classification:	***12***	**# of Years with Firm:**	***8***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Allen Buice is a project manager at HealthInsight New Mexico. He has 12 years of experience in the health care industry and extensive Medicaid managed care consulting experience delivering cost effective, high quality health care solutions. Mr. Buice has eight years of project management experience including expertise in work plan development, resource allocation, process improvement, quality improvement, time estimation, budgeting, auditing, technical writing, quality metrics, contract management, data analysis and risk management. He is also knowledgeable of NCQA/HEDIS audit requirements, New Mexico Medicaid Regulations, Centennial Care, the CMS Protocols for Medicaid external quality review (EQR) and the federal regulations as they pertain to public health, specifically managed care. He is credentialed as both a CCPHQ and a PMP. He participates in the health care quality improvement discussion at the national level through the National Association of Healthcare Quality and the National Medicaid Director's Association. He has previously held positions as a provider contract specialist at Lovelace Health Plan and a contractor for Capital One's Global Finance division though Kelly Services. Mr. Buice earned his Master of Arts from Union Theological Seminary.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2009-present HealthInsight New Mexico, Albuquerque, NM. Project Manager, Medicaid Compliance

- Lead multidisciplinary teams to conduct audits of the Medicaid managed care contracted organizations and providers
- Report to the state Human Services Department audit findings on managed care organizations (MCOs) regulatory compliance, quality improvement efforts, efficacy of those efforts, and recommendations for improvement
- Analyze healthcare quality metrics
- Provide recommendations for improvement and follow-up on the success of those recommendations
- Consult with counterparts at MCOs to initiate quality improvement efforts and developed measurement criteria to gauge their success
- Give public presentations regarding our audits, processes and findings
- Increase efficiency by reducing redundancy in processes
- Develop and implement software based solutions for improve the quality of our audits
- Attend state-level advisory meetings for the Medicaid program
- Remain current on changes to the Medicaid program including the New Mexico Medicaid Centennial Care redesign and upcoming reauthorization.

- Write reports for public information on audit findings and recommendations
- Work in partnership with executive leadership at external organizations, and at the state level
- Write policies and procedures for conducing internal activities
- Develop Process Maps for implementing HealthInsight corporate strategy

2007-2009 Lovelace Health Plan, Albuquerque, NM. Provider Contract Specialist

- Managed and audited provider contract data and rate schedules for commercial, Medicare, Medicaid (Salud), and State Coverage Insurance products in the Network Operations Department.
- Audited entered data for accuracy for all lines of business
- Interfaced daily with providers to resolve issues pertaining to existing provider contracts and the development of new contracts
- Interfaced daily with claims personnel to resolve issues pertaining to claims payment according to the terms of provider contracts
- Orchestrated the development and implementation of an archival system for secure management of provider contract information
- Headed an interdisciplinary team to develop improvement plans for our internal processes

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Union Seminary, Richmond, VA. Master of Arts 2005
- Presbyterian College, Clinton, SC. Bachelor of Arts 2002

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Project Management Professional, 2012
- Certified Professional in Healthcare Quality, 2010
- Certified Medicaid Professional Certification, 2017

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Margaret White, Director of External Quality Review, HealthInsight Assure,
   Phone number: 505-938-9125, Fax number: 505-998-9899,
   E-mail address: mwhite@healthinsight.org

2. Denise Anderson, Healthcare Quality Analyst, Blue Cross Blue Shield of New Mexico,
   Phone number: 505-816-2234, E-mail address: denise_anderson@bcbsnm.com

3. Marta Larson, Senior Director of Healthcare Quality, United Healthcare,
   Phone number: 505-239-3755, E-mail address: mlarson01@uhc.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Joyce Caramella, RN, CPHQ***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Project Manager***		
# of Years in Classification:	***18***	**# of Years with Firm:**	***7 Mos.***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Joyce Caramella currently manages the PIP reviews in HealthInsight Oregon, proving technical assistance and training for Oregon CCO PIPs. She leads special studies, currently a study on SPMI member hospital discharges for the OHA, and is part of the compliance review team, following CMS protocol for EQR on-site reviews for 16 Oregon CCOs. Ms. Caramella has more than 38 years' experience as a registered nurse. After 20 years of bedside nursing in a variety of specialty areas; she began work in Quality Improvement for a large national health plan serving commercial and Medicare members. Obtaining CPHQ certification 2002, she now has 18 years of experience leading process and quality improvement teams, creating sustainable improvements in clinical care and service. Clinical expertise includes oncology, nephrology (all CRRTs) and immunizations. She remains a volunteer with the Multnomah County Health Corp reserve, ready to serve in regional emergencies.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2017-present HealthInsight, Portland, OR. Project Manager

- Manages the PIP validation team for the EQRO contract with the Oregon Health Authority (OHA). We coordinate, write, and provide training and technical assistance for the statewide PIP project for 16 CCOs servicing Oregon Medicaid members. The CCO staff develop, implement, and evaluate the interventions. In addition, we validate and prior feedback to the OHA for 3 additional PIPs for each Oregon CCO, reviewing quarterly progress reports and submitting written summary/analysis to OHA. Currently managing a focus study for OHA involving discharge planning for enrollees discharged from acute psychiatric facilities who were admitted with serious persistent mental illness. This is part of the Oregon Performance Plan metrics for the US DOJ. Assists with the EQRO Compliance reviews for 16 CCOs and 1 MHO, doing documentation review, on site interviews, evaluation and report writing for the OHA.

2014-2017 Health Share of Oregon, Portland, OR. Clinical Quality Assurance Specialist

- Process improvement work for the state's largest coordinated care organization (CCO) to integrate and coordinate services for contracted medical, dental, and mental health plans for large Medicaid coordinated care organization
- Grievance, appeals and hearings oversight for 17 contracted partners for Medicaid plan

- Analyze and reports quarterly data for Oregon Health Authority
- Trained and collaborated contracted partner staff, developed audit tools, audits for compliance and care coordination

2012-2014 CareOregon, Portland, OR. Health Outcomes Supervisor
- HEDIS project lead – hired, trained, supervised HEDIS staff
- Planned, implemented and coordinated process improvement activities at plan and clinic levels to improve outcome measures for Medicaid/Medicare Advantage plan

2007-2012 CareOregon, Portland, OR. Quality Improvement Coordinator
- Grievance process design and implementation and staff training
- Brought HEDIS review in-house; project lead
- Prepared and presented peer review and adverse events to Quality Committee
- Worked on team to achieve NCQA accreditation for plan

2001-2007 Adventist Medical Group, Portland, OR. Quality Improvement Coordinator for 20 primary and specialty clinics
- Led team of staff and physicians in two diabetes collaboratives
- Instigated data mining from EPIC EMR and data utilization for population management
- Led group visit start up for two primary care physician teams
- Prepared and presented physician performance reports at monthly physician meetings

1998-2001 PacifiCare of Oregon, Portland OR. Quality Improvement Specialist
- Brought HEDIS review in-house; project lead
- Worked on team to achieve NCQA accreditation for plan

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- George Fox University Newberg, OR. Bachelors in Management & Organizational Leadership
- Clackamas Community College, Oregon City, OR., 1979

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Certified Professional Healthcare Quality, 2002 - current
- Certified Nephrology Nurse, 1993 - 1997
- Certified Oncology Nurse, 1980 - 1983

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Jennifer Rees, Adult Acute Mental Health Specialist, Oregon Health Authority,
   Phone number: 503-757-3872, Fax number: 503-378-8467, E-mail: Jennifer.ress@state.or.us

2. Jenna Harms, Quality Manager, Yamhill Community Care Organization,
   Phone number: 503-376-7432, Fax number: 503-376-7436, E-mail: jharms@yamhillcco.org

3. Lisa Bui, Quality Improvement Director, Oregon Health Authority,
   Phone number: 971-673-3397, E-mail: lisa.t.bui@state.or.us

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Kristin Cederlind***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Administrative Assistant***		
# of Years in Classification:	***8***	**# of Years with Firm:**	***4***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Kristin Cederlind has over 25 years of experience in supporting executives, program managers and project teams with detailed understanding of policies, procedures and office interactions. Responsible for scheduling business meetings, reporting, and customer management. For the last four years, she has provided support for HealthInsight Nevada's operations, board and committee meetings and customer service related to technical assistance provided by HealthInsight staff.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2014-present HealthInsight Nevada, NV. Administrative Assistant

- Meeting coordination via Zoom for Nevada teams (including: HIE Operations, Outreach and Marketing, Finance Committee, ASP Meeting, Nevada Partnership for Value-Driven Healthcare (NPV) Steering Committee and Improving Diabetes and Obesity Outcomes (iDo) Committee)
- Supports the Nevada Board including meeting set up, correspondence and minutes
- Creates invoice records in CRM; past due invoice collections
- Coordinates travel arrangements for Nevada Executive Director
- Office 365 Power User Group

2009-2014 MountainView Hospital, Las Vegas, NV. Executive Assistant to Vice President of Quality

- Prepared documentation for Quality Council and Functional Team
- Assisted with State and The Joint Commission survey preparation and plans of correction
- Prepared spreadsheets and presentations for Peer Review Committee
- Created Power Point presentations for various physicians and hospital directors
- Responsible for maintaining over 2,000 house-wide and departmental policies and procedures; updated policy and procedure master list, posted live on line and attended Policy and Procedures Committee
- Received and screened executive correspondence, faxes and packages
- Ordered office supplies and equipment
- Notarized documents for hospital personnel and visitors

2009 Sundvick Legacy Center, Las Vegas, NV. Legal Assistant

- Organized attorney's office and files

- Answered multi-line VOIP phone system
- Prepared binders for clients (scanned trust agreements into computer)
- Prepared correspondence and documents for attorney's signature
- Prepared deeds for recording by Clark County Recorder's office
- Notarized documents for attorney and clients

1987-2009 Real Estate Services Group, Las Vegas, NV. Administrative Office and Commercial Real Estate Leasing Manager

- Leasing and property management of executive suites, office space and industrial space for owner/broker
- Prepared real estate contracts and correspondence
- Management of real estate syndications
- Leasing and property management calls and follow up
- Accounts Payable, Accounts Receivable and Payroll
- Management of office personnel
- Travel arrangements for owner/broker
- Notarized documents for owner/broker and clients

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- University of Nevada, Las Vegas, NV. 3 years of undergraduate studies in Real Estate and Finance (1985-1988)

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Commercial Real Estate License #21668
- Notary Public #92-0777-1

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Lizette Sundvick, Attorney at Law, Sundvick Legacy Center.
   Phone number: 702-384-3767, Fax number: 702-463-9710,
   E-mail address: Lizette@Sundvicklegacycenter.com

2. Chip Johnson, Owner/Broker, Real Estate Services Group.
   Phone number: 702-732-8860, Fax number: 702-938-1008,
   E-mail address: realestatecdj@yahoo.com

3. Deborah Huber, Executive Director, HealthInsight.
   Phone number: 702-933-7305, Fax number: 702-385-4586,
   E-mail address: dhuber@healthinsight.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jared VanDomelen***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Data Specialist***		
# of Years in Classification:	**2**	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Jared VanDomelen designs and builds survey forms and data collection processes, including data entry quality control and inter-rater reliability checks. He performs accurate and rapid data entry and often works with sensitive information, including protected health information (PHI) and personally identifiable information (PII) of Medicare and Medicaid recipients with diabetes, hypertension, mental illness or other targeted diagnoses. Jared has expertise in Excel automation, used in survey projects to manage follow-up with survey respondents, refining mailing lists for subsequent survey distributions and monitoring response rates. His eye for detail and ability to learn new programs and processes quickly has supported project teams on a variety of topics.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2015-present HealthInsight, Portland, OR. Data Specialist
- Design and format surveys using REDCap and StatPac.
- Assist in data analysis using SAS and Excel.
- Extract survey data with Excel using REDCap API to update response rates and mailing lists.
- Work with PHI and PII and apply appropriate safeguards.
- Collaborate with project team to set up data management system for Home and Community-Based Services survey.
- Enter survey data into Access, Excel and StatPac with high accuracy.

2015 Aerotek/Acumentra Health, Portland, OR. Data Entry
- Organized surveys returned via mail for data entry and storage.
- Entered survey data into Access with high accuracy.
- Searched online and entered personal/business information into Excel.

2014 Agile1/PacifiCorp, Portland, OR. Data Equipment Specialist
- Responsible for the timely processing of customer payments, including:
  - payment processing
  - mail sorting and extraction
  - data entry and completion of payment transactions
  - opening and processing customer payments

2012-2013 Adecco/Epiq Systems, Portland, OR. Data Entry

- Keyed class action and bankruptcy claim information.
- Transcribed voice-mails.
- Processed invoices.
- Used VDE Viking, OCR AnyDoc, Excel, Word and other applications.
- Trained co-workers on system fields and entry details.
- Tested/quality checked new systems prior to implementation.
- Developed scripts that increased input speed by an additional 50% to 1000%. Scripts included shortcuts and automation to maximize the use of keying efficiencies and minimize errors and repetitive input. Implemented and trained co-workers on the scripts.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Portland Community College, Portland, OR. Associate in general studies, 2010
- Art Institute of Portland, Portland, OR., 2007

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- None to report

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Sara Hallvik, Analytic Services Manager, HealthInsight,
   Phone number: 503-382-3916, E-mail address: shallvik@healthinsight.org

2. Ellen Gehringer, Project Coordinator, HealthInsight Assure,
   Phone number: 503-382-3937, E-mail address: egehringer@healthinsight.org

3. Jody Carson, EQR Director, HealthInsight Assure,
   Phone number: 503-382-3955, E-mail address: jcarson@healthinsight.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Linda Fanning, MSW, LCSW***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Project Manager***		
# of Years in Classification:	***34***	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Linda Fanning has more than 34 years of experience connecting communities through social service and health care activities in both public and private sector organizations. As a Project Manager for HealthInsight, she is responsible for Medicaid compliance reviews of Oregon coordinated care organizations (CCOs). During 2013–2015, she was the Oregon Health Authority's Medicaid policy analyst for all federally qualified health centers (FQHCs), rural health clinics (RHCs), Indian Health Services (IHS) and Tribal 638 clinics. In that role, she coordinated and communicated state and federal policy, billing and reimbursement, rate development, active participation in alternative payment methodology pilot project, advocating for and supporting tribal communities and participating in government-to-government meetings. Before joining OHA, she worked for a children's mental health agency, ChristieCare/Youth Villages, for 21 years in clinical, contracting, compliance, and program development roles. She is a licensed clinical social worker in Oregon and is Certified in Healthcare Compliance (CHC) through the Health Care Compliance Association.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2016-present HealthInsight, Portland, OR. Project Manager

- Manage planning, coordination, review, assessment and evaluation of external quality review (EQR) activities of Oregon Medicaid CCOs for compliance with federal standards
- Manage utilization review for youth and adults receiving mental health services in psychiatric residential treatment facilities and at the state hospitals, including clinical record review and treatment staff interviews for quality studies.
  - Assess, analyze and define operational processes and related policies, organization structure, personnel, supporting systems; identify areas for needed improvement and communicate written recommendations to various stakeholders.
  - Develop, implement and monitor project plans and timelines.
  - Interpret and apply federal regulations and state Medicaid regulations.
  - Design and oversee the EQR review of CCOs and document findings based on application of designated criteria.
  - Provide results to healthcare organizations and stakeholders.
  - Manage review of psychiatric clinical records according to contractual timing requirements and review guidelines; make determinations of the need for

treatment at the requested level of care for children, adolescents and geriatric clients.

2015-2016 Acumentra Health, Portland, OR. Clinical Quality Improvement Specialist

- Participates in the planning, coordination, review, assessment and evaluation of EQR activities of Oregon Medicaid CCOs for compliance with federal standards; leads/facilitates process improvement activities using QI techniques. Assists with utilization review for children and adults receiving mental health services in psychiatric residential treatment facilities and at the state hospitals. Performs clinical record review and treatment staff interviews for quality studies.

2013-2015 Oregon Health Authority, Medical Assistance Programs (MAP), Salem, OR. Operations & Policy Analyst 3

- Policy analyst for FQHCs, RHCs, IHS clinics and Tribal 638 health clinics.
- Analyze, interpret and apply state and federal laws, rules and policies.
- Research, analyze and develop recommendations on policy strategies to executive managers.
- Integrate budgetary and operational data; analyze for alignment with agency strategies.
- Oversee MAP enrollment process.
- Conduct rate setting and change-in-scope processes.
- Support clinics in understanding Medicaid billing and reimbursement
- Conduct stakeholder meetings.
- Support alternative payment methodology pilot in FQHCs and RHCs.
- Project manager for Tribal Uncompensated Care Program.
- Work with Office of Payment Accuracy and Recovery on billing concerns.
- Assist clinics in integrating physical and behavioral health.

2008-2013 Youth Villages, Inc., Marylhurst, OR. Contract Compliance Manager

- Ensured that all contracts were up-to-date, all contract requirements were met, and all licensing, certification and accreditation rules, regulations and standards were in compliance.
- Contract management of all contracts.
- Coordination of all licensing, certification and accreditation activities.
- Developed relationships with all MHOs and developing CCOs (quality, contracting and claims processes).
- Compliance work.
- Policy management.
- Strong understanding of all rules, regulations and standards including the Oregon Administrative Rules, Oregon Revised Statutes, Joint Commission standards.
- Accounts receivable, July 2009–July 2010 and April 2012–April 2013.
- HIPAA Privacy Officer 2003–2013.
- Participated in clinical on-call rotation.
- Provided Emergency Safety Intervention (ESI) services; trained in CPI,
- PART, ProAct.
- During merger of Youth Villages, Inc. and ChristieCare (finalized 6/1/2011), managed DMAP provider enrollment, all licensing, certification, accreditation, and updated all contracts.
- Supported organization in grievance process, notices of action, and reporting requirements.

2006-2008 ChristieCare, Marylhurst, OR. Program Development Manager

- Project Manager for implementation of Young Adults in Transition Group Home (Mosaic); Cedar Bough Psychiatric Residential Treatment Program for Native American/Alaska Native Youth.

- Developed and carried out organization project plans to implement complex programs.
- Led the project teams for implementation of programs
- Completed all licensing, certification and accreditation needs for new programs (in addition to ongoing programs)
- Contract management
- Successfully wrote and obtained a $25,000 grant from Alaska Mental Health Trust Authority to coordinate services between Alaska and Oregon youth in care
- Managed Treatment Foster Care and Intensive Community Based Services and Supports Program in Lincoln City
- Clinical on-call and ESI practitioner

2002-2006 ChristieCare, Marylhurst, OR. Quality Improvement Manager

- Ensured high quality clinical services through coordination of quality assurance and quality control activities
- Lead the QI Committee and Special Treatment Procedures Committee
- Trained employees and communicate QI activities and monitor the results organization.
- Established a meaningful and effective grievance process
- Developed contract management process for the organization. Monitored all regulatory and contractual reporting requirements. Responsible for all licensure, certification and accreditation.
- Led the Failure Modes Effects Analysis process for high-risk activities of Medication Management and Suicide Prevention
- Assisted in development of the Children's Receiving Center

1998-2002 ChristieCare, Marylhurst, OR. Program Manager

- Supervised graduate-level therapists and program supervisors for two secure Psychiatric Residential Treatment Service Assessment and Treatment programs
- Agency peer review liaison
- Program development
- Responsible for overall milieu treatment

1997-1998 ChristieCare, Marylhurst, OR. Program Services Coordinator

- Supervised graduate-level therapists and program supervisors for two secure psychiatric residential treatment service assessment and treatment programs

1996-1997 ChristieCare, Marylhurst, OR. Clinical Supervisor

- Supervised all graduate-level therapists in a psychiatric residential treatment facility

1992-1996 ChristieCare, Marylhurst, OR. Child and Family Therapist

- Multidisciplinary team member in assessment and evaluation program
- Case management
- Assistance with treatment recommendations and placement decisions
- Family therapy post-discharge

1989-1992 Emerald Terrace Nursing Center, Vancouver, WA. Director of Social Services

- Organized admissions
- All social work activities including: assessments care planning, clinical work and discharge planning
- Patient and family advocate
- Senior social worker for Unicare Corporation; provided education and training
- Coordination of Medicare and Medicaid

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Eastern Washington University, Cheney, WA. Master of Social Work, 1987
- Boise State University, Boise, ID. Bachelor in Social Work, 1982

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Licensed Clinical Social Worker #1807, 1992
- Academy of Certified Social Workers, National Association of Social Workers, 1992
- Certified in Healthcare Compliance (CHC), 2016

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Jody Carson, SPS Contract Director, HealthInsight, Phone number: 503-382-3955, Fax number: 503-279-0190, E-mail address: JCarson@healthinsight.org

2. Don Ross, Manager,Integrated Health Programs, Oregon Health Authority,
3. Phone number: 503-945-6084, E-mail address: Donald.ross@state.or.us

4. Laureen Oskochil (retired) Compliance Manager, Acumentra Health, Phone number: 503-839-1983, E-mail address: salty_51@yahoo.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Colleen Gadbois, MPAHA, PMP***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Information Systems Audit Manager***		
# of Years in Classification:	***10***	**# of Years with Firm:**	***6 months***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Collen Gadbois has over 10 years' experience in health care in a variety of roles including quality and compliance and health care information technology. She has a Master's degree in Public Administration and Healthcare Administration.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2017-present HealthInsight Assure, Portland, Oregon. Information Systems Audit Manager

- Responsible for all aspects of annual Information Systems Capabilities Assessment (ISCA).
- Developed an ISCA tool for use in assessing the ability of MCO and related businesses' IT systems to deliver health care and manage data, including performance metrics in accuracy, completeness and timeliness.
- Responsible for managing patient surveys.
- Participant in compliance activities.

2013-2017 Portland, Oregon. Consultant

- Bonneville Power Administration
  - Fulfilled project manager roles in Corporate Strategy and Transmission Divisions, managing complex projects and programs.
- The Vancouver Clinic
  - Manager of Medical Affairs. Managed nurses and non-nurses in six teams, including coding auditors, credentialing/licensure/privileging, physician peer review, service recovery/general customer service, employee health and patient injury.
  - Implemented service recovery and customer service metrics and tracking systems.
  - Completed medical chart reviews.
- Life Flight Network
  - Director of Quality and Compliance, managed nurse staff.
  - Oversaw compliance and quality programs and company-wide performance metrics.
  - Completed quarterly utilization and medical chart reviews.

- Wrote quarterly and annual quality report presented to board of directors.
- Developed company-wide HIPAA training.
- Responsible for customer service program.

1998-2013 Providence Health & Services, Portland, Oregon. Regional Manager

- Regional Manager from 2010–2013. Managed over 20 personnel in multiple locations. Consolidated similar services across multiple states to a single center of excellence facility. Implemented technology and other processes saving $1.4 million within one year after implementation and improving quality and efficiency. Responsible for a budget over $5 million.
- IT Project Manager, Process Engineer and Analyst roles from 1998–2009. Managed or worked on multi-state and other large projects in clinical and non-clinical areas. Completed IT audits. Completed medical chart reviews. Trained others on Lean, Six Sigma and change management techniques.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Portland State University, Portland, Oregon. Master of Public Administration and Healthcare Administration, 2010
- University of Oregon, Eugene, Oregon. Bachelor of Arts, Music and Telecommunications/Film (double major), 1994

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Health Care Information Systems and Privacy Professional, 2018
- Working toward PHQ certification, 2018
- Project Management Professional (PMP), 2015
- Prosci ADKAR change management training, 2015
- Certified Health Insurance Portability and Accountability Act Officer, 2013
- Crucial Conversations, 2011
- Lean (GE Healthcare/Providence), 2007
- Six Sigma (GE Healthcare/Providence), 2006
- WorkOut (GE Healthcare/Providence), 2007
- Process Management Professional (Process Management Specialists), 2004
- Certified Quality Improvement Associate (American Society for Quality), 2004

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Art Bahrs, Senior Information Security Engineer, Nike Inc.,
   Phone number: 503-709-9355, E-mail address: Arthur@Bahrs.us

2. Jody Carson, SPS Contract Director, HealthInsight Assure,
   Phone number: 503-382-3955, Fax number: 503-279-0190,
   E-mail address: Jcarson@healthinsight.org

3. Linda Fanning, Project Coordinator, HealthInsight Assure,
   Phone number: 503-382-3953, Fax number: 503-279-0190,
   E-mail address: Lfanning@healthinsight.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Sara Hallvik, MPH***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Senior Analyst***		
# of Years in Classification:	***5***	**# of Years with Firm:**	***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Sara Hallvik manages the Oregon analytic team, providing oversight of analytic systems and tasks under state, federal, and private contracts. She has served as the senior healthcare analyst on EQRO contracts in Oregon, Washington, and New Mexico, responsible for the planning and execution of encounter data validation (EDV); record sampling; inter-rater reliability calculation; and survey administration, management, analysis, and reporting.

She has expertise as a SAS coder, working with medical, behavioral, and pharmacy claims data for a variety of purposes, including EDV. Ms. Hallvik has previous experience in statistical analysis design, execution, and reporting in public health and community assessment projects, and has implemented quality improvement strategies across large systems of care.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2013-present HealthInsight, Portland, OR. Analytic Services Manager

- Supervise analytic team, providing oversight and management to tasks under state, federal, and private contracts
- Lead quantitative analyst for external quality review projects in multiple states
- Co-Investigator: Using High-Quality Data to Evaluate and Improve Prescribing Practices [BJA 2016-H2280-UT-PM (Fondorio, PI)]
- Lead Quantiative Analyst: Use of Prescription Monitoring Programs to Improve Patient Care and Outcomes [NIH R01-DA031208-01A1 (Dey, PI)]

2008-2013 Multnomah County, Department of County Human Services, Mental Health & Addiction Services Division, Quality Management Unit, Portland, OR. Senior Research & Evaluation Analyst

- Directed and performed data collection, management, analysis, and reporting in Quality Management Unit
- Facilitated outcomes informed care initiative in 24 community mental health centers and provided data analysis for associated projects

2006-2008 Kittitas County Public Health Department, Ellensburg, WA. Assessment Coordinator II and Health Promotion Manager

- Authored Key Health Indicator reports for personal and environmental health, standardizing assessment procedures for centralized data collection, analysis, reporting, and use

2005-2006 Richland County Public Health Department, Sidney, MT. AmeriCorps VISTA

- Engaged communities by facilitating Mobilizing for Action through Partnerships and Planning (MAPP) and Protocol for Assessing Community Excellence in Environmental Health (PACE-EH) processes

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Oregon Health & Science University Portland, OR. MPH, biostatistics and epidemiology, 2010
- University of Puget Sound Tacoma, WA. Bachelors of history and Spanish, 2005

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- None to report

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Jody Carson, EQR Director, HealthInsight Assure,
   Phone number: 503-382-3955, Fax number: 503-279-0190,
   E-mail address: jcarson@healthinsight.org

2. Christi Hildebran, Research Director, HealthInsight Oregon,
   Phone number: 503-382-3971, Fax number: 503-279-0190,
   E-mail address: childebran@healthinsight.org

3. Susan Yates Miller, Senior Program Director, HealthInsight Oregon,
   Phone number: 503-382-3922, Fax number: 503-279-0190,
   E-mail address: syatesmiller@healthinsight.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jennifer Land***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Communications Manager***		
# of Years in Classification:	***3 ½***	**# of Years with Firm:**	***3 ½***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Jennifer Land has more than 15 years of experience writing, editing and designing for newspapers and magazines, and most recently for the health care industry, lending her communications skills to HealthInsight, a quality improvement nonprofit organization. As a communications manager, she carries out many functions, including ensuring all materials are professionally edited, designed and branded, and serving as Nevada's communications representative. She maintains media relations for the company and distributes all e-newsletters, press releases and outward-facing communications.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2014-present HealthInsight Nevada, Las Vegas NV. Communications Manager

- Manage communications staff and projects, and serve as media and vendor liaison for HealthInsight Nevada
- Provide communications support to multiple teams working on federal contracts to carry out quality improvement initiatives in various health care settings
- Write proposals, press releases, news articles and newsletter summaries
- Design fliers, posters, brochures, ads, table tents, information packets, forms
- Edit and brand proposals, deliverables and PowerPoint slideshows
- Create and maintain multiple e-newsletters
- Purchase marketing materials and perform all print/product invoicing

2011-2014 Las Vegas Business Press, Las Vegas NV. Managing Editor

2011-2014 Las Vegas Review-Journal, Las Vegas NV. Assistant Business Editor

- Managed a staff of reporters and freelancers, conducted weekly budget meetings, assigned stories and organized content for a business-to-business magazine targeting small-business owners and entrepreneurs.
- Laid out news and feature stories, created cover story packages and conceptualized art-only covers.
- Line and content edited copy and wrote display type.
- Prepared content for Web maintained the magazine website and managed social media accounts.
- Assigned, organized and edited the Nevada 150 project, a yearlong series of more than 150 stories telling the state's history through its people, places and events.

2008-2011 Las Vegas Review-Journal, Las Vegas NV. Copy Editor/Page Designer

- Edited copy and wrote display type for the business section of a 150k-circulation metropolitan newspaper.
- Designed inside pages and occasional Sunday fronts.
- Pushed stories to Web.

2005-2008 The Villages Daily Sun. Universal Desk Editor

- Managed a staff of designers, conducted budget meetings, prepared weekly schedules and represented the production desk of a 35,000-circulation daily newspaper.
- Laid out stories and built fronts for A1, Local, Sports, Lifestyles and Travel.
- Edited local and wire copy, and wrote headlines, cutlines and all other forms of display type

2004-2005 Boca Raton News. Copy Editor/Page Designer

- Laid out and edited news and features stories for a 15,000-circulation tabloid.
- Handled prepress duties and performed final press checks.

2003-2003 High Springs Herald. Interim Managing Editor

- Managed a staff of reporters and photographers for a small weekly.
- Designed pages, edited copy and wrote display type.
- Wrote editorials, columns and occasional news stories.

2002-2002 The Independent Florida Alligator. Copy desk chief

- Edited news and sports articles while managing a staff of copy editors for an independent newspaper serving the University of Florida.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- University of Florida, Gainesville, FL. Bachelor of Science in journalism with magazine concentration, 2002

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- None to report

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Deborah Huber, Executive Director, HealthInsight,
   Phone number: 702-933-7305, Fax number: 702-385-4586,
   E-mail address: dhuber@healthinsight.org

2. Leslie Johnstone, Vice President of Nevada Operations, HealthInsight,
   Phone number: 702-777-8370, Fax number: 702-385-4586,
   E-mail address: ljohnstone@healthinsight.org

3. Jackie Buttaccio, QIO Director, HealthInsight,
   Phone number: 702-933-7322, Fax number: 702-385-4586,
   E-mail address: jbuttacio@healthinsight.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Greg Martin, MA***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Communications Manager/Senior Corporate Writer***		
# of Years in Classification:	***2***	**# of Years with Firm:**	***13***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Greg Martin has 40 years of experience as an editor, writer, and researcher of technical publications. His experience with HealthInsight Assure and previously with Acumentra Health since 2005 has given him a thorough understanding of Medicaid External Quality Review requirements, managed care delivery systems and policies, quality assessment and improvement methods, and health care performance measurement. He also oversees and develops content for the company's website, corporate newsletter, and collateral public relations materials. Previously, working for the Texas House of Representatives, he edited, designed, and produced public policy reports and journal articles aimed at legislators and a broad range of stakeholders. In the course of his career, he has produced reports covering issues related to health care, technology, fiscal policy, real estate, energy, and law, with a focus on research and statistical analysis.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2016-present HealthInsight, Portland, OR. Communications Manager/Senior Corporate Writer

- Managed internal and external communications activities for HealthInsight Oregon, as part of a multistate communications team reporting to corporate leadership in Utah; supervised three other communications staff members.
- Edited and wrote articles for flagship quarterly newsletter, and distributed the newsletter to stakeholders.
- Executed special writing assignments related to corporate marketing collateral, business proposals, stakeholder communications and more.

2005-2016 Acumentra Health, Portland, OR. Director of Communications and Public Policy

- As Communications Manager (from 2009) and Director of Communications and Public Policy (from 2013), oversaw diverse corporate communications, public relations, and contract fulfillment activities.
- Led redesign/repurposing of corporate website in 2013, including online integration of the corporate e-newsletter.
- Designed and produced Health Impact Statements describing the company's key contributions to health care quality for a general audience.
- Developed standardized reader-friendly formats for annual External Quality Review Technical Reports for Washington and Oregon Medicaid.

- Wrote/edited annual technical reports, HEDIS performance measure reports, white paper reports, and newsletters under Medicaid EQR contracts.

1999-2003 Texas House of Representatives, Austin, TX. Editor, House Research Organization
- Edited Daily Floor Report, analyses of all bills considered on House floor each day during legislative sessions.
- Wrote/edited special policy reports and monthly newsletter between sessions

1990-1998 Texas Comptroller of Public Accounts, Austin, TX. Editor
- Edited and wrote articles for flagship newsletter Fiscal Notes and other newsletters, policy reports, and press releases.

1984-1989 M/PF Research, Inc., Dallas, TX. Director of Publications
- Responsible for producing all client reports and marketing collateral products for real estate market research firm.

1981-1984 Society of Petroleum Engineers, Dallas, TX. Communications Supervisor/Editor

1977-1981 Harcourt Brace Jovanovich, Dallas, TX. Communications Supervisor/Editor

EDUCATION

Information required should include: institution name, city, state, degree and/or achievement and date completed/received.

- University of Texas, Austin, TX. Master in Journalism, 1976
- University of Oklahoma, Norman, OK, Bachelors in Language arts, 1973

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- None to report

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Dana Hawes, Corporate Communications Director, HealthInsight,
   Phone number: 801-892-6645, Fax number: 801-892-0160,
   E-mail address: dhawes@healthinsight.org

2. Christi Hildebran, Research Director, HealthInsight,
   Phone number: 503-382-3971, Fax number: 503-279-0190,
   E-mail address: childebran@healthinsight.org

3. Jessica Letteney, Senior Management Analyst, Portland Water Bureau,
   Phone number: 503-823-7242, E-mail address: jessica.letteney@portlandoregon.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Charity O'Neal, RN, BSN***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Clinical Care Coordinator***		
# of Years in Classification:	***7***	**# of Years with Firm:**	***6***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Charity O'Neal is a registered nurse with 13 years of cumulative experience in patient care, Chart Review/Chart analysis and case management. She currently works for HealthInsight on a Medicare Innovations Center funded project to reduce avoidable hospital readmissions from Nevada nursing homes by helping nursing home staff recognize changes in patient condition before an event occurs. She provides education to nursing home staff and helps them improve current practices. Her varied positions in oncology, home health, and case/utilization management provide a solid foundation for quality improvement and external quality review activities.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2011-present HealthInsight Nevada, NV. Clinical Care Coordinator
Admissions and Transitions Optimization Program I and II

- Data collection entry for Medicare Innovations Project (ATOP)
- Education to RNs, LPNs, CNAs, PT/OT
- Patient care
- Implemented Data Sets
- Implemented POLST
- Utilization management to help manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision
- Chart audit for ATOP 2 at HME-audited charts for qualifying events to help confirm if criteria is met for Medicare initiative

2008-2017 Nuclear Care Partners, Elko, NV. Case Manager, Chart Review Manager Supervisor over Chart Review

- Supervisor over Chart Review—Audited charts for 300 patients, assured charts meet criteria for DOL billing. Audited plans of care, orders, RN/CNA documentation and database for an accredited Home Care Agency
- Assisted the company in becoming accredited, worked with compliance
- Utilization Review-- critically examine patient medical records, paying close attention to the appropriateness of healthcare expenditures. Completed an appropriate review to compile an accurate account of the patient's clinical picture. Was responsible for relaying this information to Case Management and Compliance Department. This

review consisted of: patient's compliance, working diagnosis, supporting diagnostic findings, plan of care, and course or progression.
- Managed multiple patients on a weekly basis
- Implemented plans of care—set up care plans for patient care, managed care plans to meet patient needs and outcomes
- Supervises HHA
- Admissions, Re-certifications, Direct patient care
- Patient/Staff education
- Wound care
- Collaboration of care with primary MD

2007-2012 Genesis Home Health, Elko, NV. Nurse Supervisor/Registered Nurse/ Lead Nurse
- Nurse Supervisor
- Field Nurse/Oasis Nurse
- Chart reviewed Medicare charts that care provided met Medicare criteria
- Performed chart audits appeal for Medicare charts that were initially denied
- Manages multiple patients on a weekly basis
- Implements plan of care
- Supervised HHA, RNs, PT, OT, ST
- Admissions, Re-certifications, direct patient care
- Patient/staff education, DC planning
- Hospice/End of life care
- Chemotherapy certified
- Wound care and Ostomy care
- IV administration, blood draws, line maintenance
- Terminal care/pain management

2005-2011 Northeastern Nevada Regional Hospital, Elko, NV. Registered Nurse/Charge Nurse
- M/S/P Nurse, direct patient care, care plan management
- Assessments, medication management, IV infusions
- Wound care
- Safety precautions/education
- ACLS/PALS certified

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Great Basin College, Elko, NV. Bachelors of Applied Science in Nursing, 2015
- Great Basin College, Elko, NV. Associate Degree Nursing, 2004

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Active Nevada and California RN license
- CPR certified

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Amy Schmidt, MSW, ATOP Director, HealthInsight.
   Phone numbers: 702-933-7308, 702-810-0685, Fax number: 702-385-4586,
   E-mail address: aschmidt@healthinsight.org

2. Jean Lyon, PhD, APRN, ATOP Clinical Care Practitioner, HealthInsight.
   Mobile number: 775-530-144, E-mail address: jlyon@healthinsight.org

3. Katie Steele PA, Geriatric Specialty Group.
   Phone number: 775-340-3620, E-mail address: ksteele@gscnv.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Debra K. Peterman, MSN, RN***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Quality Improvement Manager***		
# of Years in Classification:	***9***	**# of Years with Firm:**	***9***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Debra Peterman is a quality improvement manager for HealthInsight New Mexico. Debi is a registered nurse with 25 years of experience in the fields of HIV, behavioral health, case management and quality management. Debi helped develop and implement a harm reduction program in rural/frontier New Mexico. The program provided many services such as linking to treatment centers, homeless shelters and medical care in alternative settings to the emergency department. The program also monitored blood pressure, provided vaccines, blood testing for HIV, and viral hepatitis for anyone in need.

Ms. Peterman has performed motivational interviewing and taught harm reduction techniques, including overdose prevention to injection drug users and their families. She participated in community assessment and HIV planning activities at the state and national levels as well as working on numerous HRSA demonstration projects, administering state and federal grants totaling over $10 million dollars. Since 2009, Debi has been reviewing documentation from managed care organizations (MCOs) for evidence of compliance with state contracts and applicable federal regulations, as a project manager and currently as the quality improvement manager.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2016-present HealthInsight New Mexico, Albuquerque, NM. Quality Improvement Manager

- Promoting and facilitating the achievement of improvements within the department
- Creating and maintaining the quality improvement/quality assurance program activities and documentation
- Managing department processes, policies and procedures
- Conducting medical record review activities
- Conducting review of MCO documentation for compliance to the state contract and applicable federal regulations
- Validating performance measures reported to the state by each MCO
- Validating performance improvement projects reported to the state by each MCO

2009-2016 HealthInsight New Mexico, Albuquerque, NM. Project Manager

- Managed the process of reviewing compliance of each MCO to the state contract and applicable federal regulations
- Managed the process of validating performance measures reported to the state by each MCO

- Managed the process of validating performance improvement projects reported to the state by each MCO
- Provided technical assistance to New Mexico MCOs to facilitate performance improvement
- Provided technical assistance to New Mexico Human Services Department (HSD) to facilitate the understanding of quality improvement principles

1998-2009 Alianza of New Mexico, Roswell, NM. Executive Director
- Provided overall direction and leadership of non-profit agency providing HIV treatment and prevention services
- Administered federal, state, local and foundation grants
- Participated in services planning at the state and national levels for HIV care and prevention
- Provided client education about HIV and viral hepatitis natural disease process
- Counseled clients about why and how to adhere to HIV treatment plan
- Provided direct nursing clinical services to persons living with HIV and their families
- Educated individuals and families about HIV disease, treatment, and prevention

1995-1997 New Mexico Rehabilitation Center, Roswell, NM. Unit Nurse
- Delivered direct patient care for acute drug and alcohol detoxification
- Provided one on one and group education during 21 day treatment program
- Delivered direct care for patients hospitalized for physical rehabilitation

1993-1996 Guidance Center of Lea County, Hobbs, NM. Case Manager
- Provided case management services for persons living with persistent severe mental illness
- Provided case management services for pregnant teenage women and
- their infants

1991-1993 New Mexico Junior College, Hobbs, NM. Nursing Student
- Completed nursing curriculum in accredited nursing school
- Attained registered nursing license

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- University of Phoenix, Albuquerque, NM. Master of Science in Nursing, 1999
- Eastern New Mexico University, Portales, NM. Bachelor of Science in Nursing, 1997
- New Mexico Junior College, Hobbs, NM. Associate of Arts in Nursing, 1993

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Systems Introduction, 2017
- Strategic Intervention Design, 2017
- Determinants of Health, 2016
- Human Factors, 2016
- Cyber-security, 2016
- Security Awareness Training, 2016
- Triple Aim for Populations, 2015
- Patient Safety, 2014
- Improvement Capability, 2014
- Motivational Interviewing, 1998
- Train the Trainer, 1996
- Registered Nurse License, 1993

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Kathleen Freebird, MSW, Reeves County Hospital District,
   Phone number: 505-369-9700, Fax number: 432-447-0033,
   E-mail address: Kfreebird@icloud.com

2. Jessica Clayton, RN Case Manager, BCBS,
   Phone number: 505-918-8043, Fax number: 505-291-3500,
   E-mail address: Jessica.clayton@aol.com

3. Gayla Pardee, Circulations Manager, Natrona County Public Library,
   Phone number: 307-797-5224, Fax number: 307-577-7323,
   E-mail address: jgcspardees@hotmail.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Galina Priloutskaya, PhD***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Corporate Director, Analytical Services***		
# of Years in Classification:	***20***	**# of Years with Firm:**	***17***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Dr. Priloutskaya has more than 20 years of sustained experience in health care management, population health and quality improvement using standardized statistical methods to perform high-level analyses linking outcomes to improved health, health care and lower costs, and calculating quality measures. She is an NCQA certified HEDIS compliance auditor and CMS certified data validation auditor. She has been performing HEDIS, P4P and data validation audits on contractual basis with the NCQA certified licensed organizations since 2005. She led over hundred audits for managed care organizations, sixty Value based pay for performance (VBP4P) audits and thirty CMS data validation audits. Dr. Priloutskaya participated in multiple CMS and NCQA workgroups and technical expert panels (TEP) to develop national measurement strategy and improve HEDIS/VBP4P reporting. Recently Dr. Priloutskaya went through the training to perform URAC pharmacy accreditation audits and will be performing pharmacy audits in 2018.

Dr. Priloutskaya has managed projects such as: designing health care cost and quality reports for providers, employers groups and consumers; launching national Medicaid/Medicare public reporting initiatives for nursing homes and home health agencies; and development and implementation of ambulatory and inpatient community public reporting. She is experienced in developing and refining model/demonstration design and operations; designing and carrying out surveys; and other data collection activities.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2013-Present HealthInsight, Albuquerque NM. Corporate Director of Analytic Services

- Directs the HealthInsight analytic staff on corporate projects or scopes of work, including development of corporate performance dashboards, national provider performance rankings, and Qualified Entity efforts; and provides support for the company quality award programs for hospitals, nursing homes, home health agencies and physician offices ; ensures preparation of performance reports for internal management and for funding sources
- Responsible for integration and coordination analytical services for federal, state and private contracts not limited to for Medicare and Medicaid , to assure efficiency and the delivery of high quality analytical services to external and internal customers
- Leads HEDIS, URAC , CMS data validation and Value Based P4P audits

2010-2013 HealthInsight, Albuquerque NM. Director of Analytic Services and Drug Safety

- Oversee HealthInsight New Mexico's analytical staff to integrate and synergize support for Medicare and Medicaid activities, reporting for Centennial Care project and public reporting for local initiative of Robert Wood Johnson Foundation's Aligning Forces for Quality to assure efficiency and the delivery of high quality analytical services to external and internal customers

2007-2010 HealthInsight Albuquerque NM. Director, Medicare Part D/Drug Safety and Senior Analyst

- Led drug safety projects in New Mexico; organized statewide Prescription Improvement Coalition (NMPIC) devoted to decrease of adverse drug events (ADE)
- Led HRSA Patient Safety and Pharmacy collaborative(PSPC) teams focused on decreasing ADEs in the high-risk population
- Led medication therapy management (MTM) pilot and served as a technical advisor for New Mexico state MTM Collaborative
-

2000-2007 HealthInsight, Albuquerque NM. Senior Analyst

- Participated in the CMS pilot on the public release of home health agencies data and worked on development national short-term and long-term strategies, including a communications strategy and rollout plans at the state and national levels.
- Led inpatient studies on use data from Health Outcome survey (HOS) and HCAHPS data in managed care and fee-for-service population

1999-2000 Cimarron Health Plan, Albuquerque NM. Data Analyst, HEDIS Project Manager

- Involved in research design and methodology projects, including statistical analysis and provider profiling using PRG (in-house provider grouping software) approaches to allow for effective evaluation and monitoring
- Provided analytical support for disease management strategies, selection and evaluation interventions
- Led HEDIS reporting and Implementation of the HEDIS reporting software – McKesson

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Albuquerque Technical Vocational Institute, Albuquerque, NM. Computer Science, 1999
- University of New Mexico, Albuquerque, NM. MBA, Management Information Systems, 1998
- Moscow Academy of Management, Moscow, Russia. PhD, Economic Science, 1994
- Economic & Industrial Management Academy of Management, Russia, 1979

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- CHCA, Certified HEDIS/P4P Auditor, NCQA, 2005-Present
- Certified Data Validation Auditor, CMS, 2010-2014
- Annual, HEDIS Certification Training, NCQA
- Home Health Agency National Pilot Public, CMS Reporting Training, 2004
- Nursing Home Public Reporting Training, CMS, 2003
- Washington State Diabetes Collaborative, Washington DOH, 2002
- Quality Advisor Training Institute for Healthcare Improvement, IHI, 2001
- DOQ-IT: National QIO Knowledge, CMS, Development Program, 2006
- Medicare Part D Training, CMS, 2005
- SAS Training, SAS Institute, 2005

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Suzan Mora Dalen, President , QMetrics,
   Phone number: 619-254-9094, E-mail address: smoradalen@qmetrics.us

2. Michael Campbell, MPP,CHHQ, CHCA, President, Indicina, LLC,
   Phone number: 202-256-9100, E-mail address: Michael.e.campbell@gmail.com

3. John Cousin, MPH, CHCA, Director, EQRO, QSource,
   Phone number: 615-244-2007, Fax number: 615-244-2018,
   E-mail address: jcousin@qsource.org

4. Paul Mertel, ph.D, CHCA, FACHE, ex Vice –President HDCData Corporation,
   Phone number: 717-576-6370, E-mail address: pmertel@yahoo.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***HealthInsight Assure***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Nancy A. Siegel, MPH, PA-C***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Quality Improvement Specialist***		
# of Years in Classification:	***5***	**# of Years with Firm:**	***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Nancy Siegel is a dedicated health care professional with a successful track record in conducting audits of and providing technical assistance to Medicaid managed care performance improvement projects, and managing clinical research studies and trials from start-up through implementation. Skilled in program evaluation, data collection and training facilitation, with a focus on compliance and quality improvement. Possesses clinical experience in a managed primary care setting and knowledge of EpicCare. Team-oriented individual known for building rapport and collaborating with diverse groups to achieve organizational goals.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2012-present HealthInsight, Portland, OR. Quality Improvement Specialist

<u>2012-present: State of Oregon</u>

- Coordinate planning with Oregon Health Authority on coordinated care organization (CCO) PIP-related activities.
- Develop tracking and monitoring tools and processes for CCOs, state and internal use.
- Provide technical assistance to CCOs in Oregon regarding study design, intervention implementation, performance evaluation and report writing on a quarterly and as-needed basis.
- Analyze individual PIPs for validity and adherence to federal and state standards and good quality improvement (QI) methodology, and write quarterly summaries to Oregon Health Authority.
- Make quarterly and annual recommendations for improving performance at the individual organization and state level.
- Develop and conduct trainings and learning collaboratives on QI tools and processes (including Plan-Do-Study-Act), best practices, current challenges and PIP-related topics.
- Collaborate with content experts to develop training and learning collaborative presentations, including how to develop measurement plans.

2012-2015: State of Washington

- Performed annual reviews of PIPs conducted by Medicaid managed care organizations (MCOs)
- Analyzed individual PIPs for validity, reliability and adherence to federal and state standards, and wrote narrative reports on individual MCO results. Made recommendations for improving performance at the individual organization and state level.
- Developed tracking and monitoring tools and processes for MCO and internal use.
- Developed and conducted trainings on Center for Medicare and Medicaid Services PIP protocol guidelines, QI methodology and processes (including Plan-Do-Study-Act) and PIP-related topics.
- Assist with additional tasks, such as encounter validation, as needed.

2006-2011 Kaiser Permanente Center for Health Research, Portland, OR. Project Manager

- Managed various phases of research studies and clinical trials, including a federally-funded oxygen treatment trial, a multi-site pharmaceutical trial for an investigational COPD medication, a clinical study of influenza in the elderly and a multi-site study of tobacco cessation strategies for people with ADHD.
- Created and presented regulatory documents, including clinical, compliance and HIPAA privacy procedures, to the Institutional Review Board for approval.
- Analyzed population and study data; developed timelines, recruitment and retention strategies, operating procedures, budgets; and managed study process and procedure modifications based on ongoing performance evaluation.
- Assumed clinical role as necessary, and conducted physical exams, managed study medications and performed study procedures.
- Supervised up to seven employees, including managing the hiring process, professional development, performance management and staff scheduling.

2006 Oregon Community Health Information Network (OCHIN), Portland, OR. Graduate Intern

- Evaluated and revised staff surveys on the implementation of and training around the use of electronic medical records using EpicCare.
- Compiled data, analyzed results and prepared reports for OCHIN leadership, board and clinic management.
- Interviewed executive team members on organizational changes. Identified key challenges and prepared report for executive leadership.

2002-2006 Kaiser Permanente Center for Health Research, Portland, OR. Research Clinician

- Conducted physical exams, managed study medications and performed study procedures for the Women's Health Initiative, Hemochromatosis Study and Asthma Study.
- Collaborated with clinical and genetic specialists to optimize study participant care.
- Conducted data collection and analyses for research studies.

1999-2001 Literacy and Adult Basic Education, Uganda. Office Administrator

- Managed day-to-day office administration.
- Developed office policies and procedures.
- Assisted with strategic planning sessions at the organization and board level.
- Reviewed and edited development grants from international funders.

1991-1999 Kaiser Permanente, Salem, OR. Physician Assistant

- Conducted patient histories and physical exams; ordered lab work and imaging studies; and determined appropriate treatment for persons over 14 years old in primary care department.
- Documented information using electronic medical record software, EpicCare.
- Conducted monthly menopause education workshops

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- Portland State University, Portland, OR. MPH, 2006
- McGill University, Montreal, Canada. Bachelors of English/Communications, 1977

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

- Physician Assistant, Oregon Board of Medical Examiners, 2018
- Basic Life Support, American Heart Association, 2017
- Physician Assistant Certification, St. Louis University, 1982

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

1. Jody Carson, Oregon EQR Director, HealthInsight Assure, Phone number: 503-382-3955, Fax number: 503-279-0190; E-mail address: jcarson@healthinsight.org

2. Joyce Caramella, QI Project Manager, HealthInsight Assure, Phone number: 503-382-3969; Fax number: 503-279-0190; E-mail address: jcaramella@healthinsight.org

3. Nicole O'Kane, Clinical Director, HealthInsight Oregon, Phone number: 503-382-3964; Fax number: 503-279-0190; E-mail address: NOKane@healthinsight.org

Section VIII – Other Informational Material

The below table provides a list of Attachments along with the section in which the attachment was referenced

Attachment	Section	Description	Section Page
VIII-1	2.1.1.1	Extract from 2016 GOBHI Report	2
VIII-2	2.1.1.2	2014 Performance Measure Analysis Report	19
VIII-3	2.1.1.2	2014 Performance Measure Analysis Report, Appendix B	113
VIII-4	2.1.1.2	2014 Performance Measure Analysis Report, Appendix C	200
VIII-5	2.1.2.2	HCBS Survey Report	202
VIII-6	2.1.2.2	HCBS Survey Report, Appendix A	333
VIII-7	2.1.2.2	HCBS Survey Report, Appendix B	380
VIII-8	2.1.2.2	HCBS Survey Report, Appendix C	436
VIII-9	2.1.2.2	2016 Adult Survey Report	444
VIII-10	2.1.2.2	2016 Youth Survey Report	544
VIII-11	2.1.2.4	PIP Presentation from April QHOC	648
VIII-12	2.1.3.1	Oregon Performance Measure Calculation – Summary Report of 2013 Measures	676
VIII-13	2.1.3.5	Extract from OMHAS Quality Strategy Review	702
VIII-14	2.1.3.5	Quality Strategy Review Report	722
VIII-15	2.1.3.5	Extract from 2013 WA EQR Annual Report	736
VIII-16	2.1.3.6	2016 OHA Annual EQR Report	742
VIII-17	2.1.3.6	2016 OHA Annual EQR Report, Appendix A	910
VIII-18	2.1.5.6	Opioid Metrics for PIP Primary	946
VIII-19	2.1.5.6	Opioid Metrics for PIP Secondary	950
VIII-20	2.2.2	HealthInsight 6-30-2016 Financial Statements	956
VIII-21	2.2.2	HealthInsight 6-30-2017 Financial Statements	978
VIII-22	2.2.2	HealthInsight Interim Statement 12-31-2017	1000
VIII-23	3.2.1.3 (3.1.9)	DataStat Capabilities	1003
VIII-24	3.1.2	5% Preference Letter	1007
VIII-25	3.1.9	HealthInsight Corporate Summary	1009

Note: ***As mentioned previously, HealthInsight Assure combines the EQR expertise and activities of HealthInsight Oregon (formerly known as Acumentra Health) and HealthInsight New Mexico. Any reports included as attachments from these organizations are representative of the current Assure team's work and processes.***

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

Under 42 CFR §438.240(d), a managed care organization that serves Medicaid enrollees must have an ongoing program of PIPs that focus on improving clinical care and nonclinical aspects of service delivery. The PIPs enable the organization to assess and improve the processes and, in turn, the outcomes of care.

PIPs are validated each year as part of the EQR to ensure that the projects are designed, conducted, and reported according to accepted methods, establishing confidence in the reported improvements. The PIPs must include:

- a relevant and prioritized study topic focused on local Medicaid population, related to outcomes, satisfaction, or quality of care
- measurement of performance using objective quality indicators
- implementation of system interventions to improve quality
- evaluation and initiation of the interventions
- planning and initiation of activities for increasing or sustaining improvement

Through repeated measurement of the selected quality indicators, a PIP is expected to demonstrate meaningful change in performance relative to the performance observed during baseline measurement.

This is the eleventh year in which Acumentra Health has evaluated the MHO's PIPs under the EQR contract.

OHA required the MHO to conduct two PIPs. The MHO could select the topic for both PIPs.

PIP Review Procedures

Data collection tools and procedures, adapted from the CMS protocol, involved document review and onsite interviews. Acumentra Health scored the MHO's PIPs according to criteria adapted from the CMS protocol and approved by OHA.

Acumentra Health reviews PIPs for the following elements:

- a clear, concise statement of the study topic and how it was determined, the specific questions the study is designed to address, and the quantifiable indicators that will answer those questions
- an analysis plan that defines indicators clearly, specifies the population being studied (if applicable, a sampling methodology), identifies data

sources and data collection procedure, data validation, and discusses the methods for analyzing the data and performing statistical tests

- a clear statement of the improvement strategies and the interventions, their impact on the study question, and how that impact will be assessed and measured
- a summary of results that covers all data collection and analysis, explaining limitations inherent in the data and methodologies and discussing whether the strategies resulted in improvements

The preamble at the beginning of each standard lists the criteria that Acumentra Health applied when scoring that standard, which will also serve as a guide for developing the highest quality PIPs.

Compliance Rating

To determine the level of compliance with federal standards, Acumentra Health assigns a score to each PIP. The scoring methodology involves rating the MHO's performance on 10 standards, listed in Table 5. Appendix B defines in detail the specific criteria used to evaluate performance.

Table 5. Standards for PIP Validation.

Demonstrable improvement	
1	Study Topic
2	Study Question
3	Study Population
4	Study Indicator
5	Data Collection and Data Analysis Plan
6	Study Results
7	Interpretation of Results
8	Improvement Strategies
Sustained improvement	
9	Repeated Measurement of the Study Indicator
10	Sustained Improvement

Each standard has a potential score of 100 points for full compliance. The total points earned for each standard are weighted and combined to determine an overall PIP score. The overall score is weighted 85 percent for the baseline and the first remeasurement (Standards 1–8), and 100 percent for second remeasurement and sustained improvement in later years (Standards 9–10). Thus, for a PIP that has completed one remeasurement, the maximum overall project score is 85 points. If the PIP has progressed to at least a second remeasurement, enabling reviewers to assess sustained improvement, the maximum overall project score is 100.

Table 6 shows the compliance ratings and associated scoring ranges for PIPs graded on the 85-point and 100-point scales. (Note: these compliance rating ranges for the overall PIP score are different from the ranges used in assessing compliance for individual PIP standards; see Appendix B, which also includes a sample worksheet.)

Table 6. Compliance Rating for PIPs by Overall Score.

Compliance rating	Description	100-point scale	85-point scale
Fully met	Meets or exceeds all requirements	80–100	68–85
Substantially met	Meets essential requirements, has minor deficiencies	60–79	51–67
Partially met	Meets essential requirements in most, but not all areas	40–59	34–50
Minimally met	Marginally meets requirements	20–39	17–33
Not met	Does not meet essential requirements	0–19	0–16

Review Results for PIP #1: Older Adult PIP

In response to Acumentra Health's 2015 recommendation to select a new PIP topic for 2016 that would affect a significant number of GOBHI's MHO enrollees, GOBHI conducted analyses of their MHO-only member population. During the site visit, Acumentra Health and GOBHI staff reviewed data and discussed potential study topics and metrics. Review of the data indicated underutilization of mental health services by older adults, and GOBHI has decided to focus this PIP on improving the penetration rate for this population.

At the time of this report, GOBHI had not developed the project beyond identification of the study topic (Standard 1). The overall score for this PIP reflects this early stage of development. By the time of the 2017 PIP review, GOBHI is expected to have completed Standards 2–5 (study design) and 8 (Improvement Strategies), and provided partial information for Standards 6 (Study Results) and 7 (Interpretation of Results).

The overall weighted score for this PIP is 14 on a scale of 85, resulting in a compliance rating of Not Met.

Standard 1: Study topic
Score: 85 (Substantially Met)

To meet Standard 1, the MHO needs to establish the importance of the study topic in general; present local data to demonstrate that the topic applies to a large or high-risk portion of the Medicaid population and will have a significant effect on enrollee health, functional status, or satisfaction; and demonstrate that a systematic selection and prioritization process, including opportunities for input by enrollees and providers, was used in choosing the topic.

In response to Acumentra Health's 2015 recommendation to select a new PIP topic for 2016 that would affect a significant number of GOBHI's MHO enrollees, GOBHI conducted analyses of its MHO-only member population. Analyses showed that although Malheur and Umatilla counties had the highest percentage of the GOBHI-enrolled members over the age of 60 (870 members), only 30 eligible members of the study population had received services from Lifeways, GOBHI's community mental health partner. GOBHI calculated the rate as "0.034%", but according to Acumentra Health's calculation the figure should be "3.4%." Also, it was not clear what measurement period was used in collecting the data.

As GOBHI observed, this low utilization rate is concerning in light of a 2014 OHA report estimate that 15–20% of older adults have depression, men aged 75 years and older have the highest suicide rate in the state, and up to 15% of older adults are at-risk drinkers. The cited statistics apply to all Oregonians, and GOBHI should discuss how the data should be interpreted given the make-up of the GOBHI population, which includes many people who are dually eligible for Medicare and Medicaid. In addressing the growing discrepancy between need and service delivery, GOBHI states that the first step is to identify the causes of low referrals and utilization.

This topic clearly relates to quality of care for enrollees since the target population does not appear to be receiving needed services. In addition to addressing an identified need for a high-risk population, this topic was prioritized because of the availability of data and the ability to share staff and material resources from an existing GOBHI project, the Older Adult Behavioral Health Initiative. The initiative focuses on improving behavioral health outcomes for older adults in GOBHI communities. It was not clear whether or not GOBHI presented this PIP selection to other stakeholders.

To fully meet this standard, GOBHI should identify the time frame used in collecting the local data, correct its utilization rate calculation, explain how the cited data applies to the GOBHI population, and discuss stakeholder input into the selection and prioritization process.

Standard 2: Study question

Score: 0 (Not met)

To meet Standard 2, the MHO needs to present a study question that provides a clear framework for data collection, analysis, and interpretation. The study question should refer to the proposed intervention, a study population (denominator), what is being measured (a numerator), a metric (e.g., average, percentage), and a direction of desired change.

This standard was not addressed in the report.

To fully meet this standard, GOBHI needs to develop an appropriate study question that states the study intervention(s), study population, what is being measured, metric, and the desired change in direction of the metric.

Standard 3: Study population

Score: 5 (Not met)

To meet Standard 3, the MHO needs to provide a brief description of the study population; list all inclusion and exclusion criteria for the study population, including enrollment criteria; and provide definitions and data sources, including, codes, and calculations. If a sample is selected, the MHO needs to describe the sampling methods.

This PIP does not include all eligible GOBHI MHO members over the age of 60. Instead, GOBHI will focus on Malheur and Umatilla counties since they have the highest percentage of the GOBHI-enrolled members over the age of 60 (870 members).

Other elements of this standard were not addressed in this report.

To fully meet this standard, GOBHI needs to describe the study population, list the appropriate inclusion and exclusion criteria (including enrollment criteria), and provide relevant definitions and calculations (e.g., age).

Standard 4: Study indicator

Score: 0 (Not met)

To meet Standard 4, the MHO needs to define the numerator (what is being measured) and the denominator; define key terms; describe the target goal; discuss the basis for adopting the indicator as a valid proxy for enrollee outcomes, satisfaction, or quality of care; list all inclusion and exclusion criteria for the numerator (what is being measured), including enrollment criteria; and provide definitions and data sources, including codes, and calculations.

This standard was not addressed in the report.

From the topic discussion, it appears that GOBHI will be measuring the penetration rate of older adults in its MHO-only population. Therefore, to fully meet this standard, GOBHI needs to define the measurement numerator and denominator and explain why this metric is a valid indicator for enrollee access and outcomes. In addition, GOBHI will need to list the numerator inclusion and exclusion criteria as well as provide any relevant definitions, codes and calculations.

Standard 5: Data collection and data analysis plan

Score: 0 (Not met)

To meet Standard 5, the MHO needs to describe data collection and data validation procedures, including a plan for addressing errors and missing data; and present a clear data analysis plan, including time frames for the measurement and intervention periods, and an appropriate statistical test to measure differences between the baseline and remeasurement periods.

This standard was not addressed in the report.

To fully meet this standard, GOBHI needs to describe its data collection plan, including procedures to ensure that the data are valid and reliable. The MHO should document a data analysis plan that includes time frames for the measurement and intervention periods, an appropriate statistical test to measure differences between the baseline and remeasurement periods, and a probability level.

Standard 6: Study results

Score: 0 (Not met)

To meet Standard 6, the MHO needs to present results according to the data analysis plan, including the study indicator; the original data used to compute the indicator; and a statistical test to measure differences between the baseline and remeasurement periods. The MHO needs to discuss any other data analyses for factors that may affect the study.

This standard was not addressed in the report.

To fully meet this standard, GOBHI would need to present baseline and first remeasurement results according to its data analysis plan. In its next (2017) report, GOBHI should be able to provide baseline results. Also, the MHO should discuss any other demographic or other data analyses that will assist in the interpretation of the study indicator results.

Standard 7: Interpretation of results

Score: 0 (Not met)

To meet Standard 7, the MHO needs to list any changes to the study design and discuss the effect of those changes on the comparability of data and interpretation of results; describe any factors that threaten the internal or external validity of the study; discuss if the intervention was implemented as planned; describe any improvement in enrollee health, functional status, or satisfaction and accomplishment of target goals; discuss how the intervention influenced the results; discuss lessons learned during the PIP process; draw a conclusion about the study results based on the above factors; and describe next steps for the study.

This standard was not addressed in the report.

To fully meet this standard, GOBHI will need to describe any changes in study design and describe how those changes might affect the interpretation of results. This description should also include a discussion on how using a sample might affect interpretation of results (i.e., can the sample be applied to the entire GOBHI population). Also, GOBHI should discuss any other factors that might threaten the internal or external validity of the study, the results of the intervention tracking and monitoring plan, lessons learned, the linkage between the intervention and the study results, and next steps for the study.

Standard 8: Improvement strategies

Score: 0 (Not met)

To meet Standard 8, the MHO needs to describe and document the implementation of the intervention(s) and discuss the following: the basis for adopting the intervention; how the intervention can be reasonably expected to result in measurable improvement; the cultural and linguistic appropriateness of the intervention; a tracking and monitoring plan (providing evidence of how the intervention was or will be implemented as planned); barriers encountered during implementation of the intervention and how they were addressed; and how the intervention will be adapted, adopted or abandoned.

This standard was not addressed in the report.

To fully meet this standard, GOBHI needs to describe the intervention, how the intervention can be expected to improve the study indicator, cultural and linguistic appropriateness of the intervention, and barriers encountered during the implementation of the intervention and how they were addressed. The MHO should also discuss how it plans to demonstrate that the intervention was implemented as planned and provide results of that plan. Finally, GOBHI will need to provide a rationale for adapting, adopting, or abandoning its intervention.

Standard 9: Repeated measurement of the study indicator

Score: n.a.

To meet Standard 9, the MHO needs to report complete study results for two measurement periods, including the study indicator, original data used to compute the indicator, and a statistical test of group differences; provide any other data analyses for factors that may affect the study; and discuss how the intervention, consistency of methodology and any confounders affected the study results in the second remeasurement period.

The PIP has not progressed to this standard. Standard 9 is not scored until a PIP reaches second remeasurement.

Standard 10: Sustained improvement

Score: n.a.

To meet Standard 10, the MHO needs to determine whether or not goals were met and sustained; improvement in the study indicator, as well as enrollee health, functional status or satisfaction was achieved; discuss lessons learned for the PIP and the system as a whole; and report next steps.

The PIP has not progressed to this standard. Standard 10 is not scored until a PIP reaches second remeasurement.

Review Results for PIP #2: Children 0–6 Years Old Primary Care PIP

In response to Acumentra Health's 2015 recommendation to select a new PIP topic for 2016 that would affect a significant number of GOBHI's MHO enrollees, GOBHI conducted analyses of their MHO-only member population. During the site visit, Acumentra Health and GOBHI staff reviewed data and discussed potential study topics and metrics. Review of the data indicated underutilization of services by older adults and young Hispanic children (0–6 years of age). This PIP will focus on improving the penetration rate for young Hispanic children in Umatilla and Malheur counties, GOBHI counties with the highest percentage of the target population. GOBHI provided documentation on the importance of the topic, the relevance to the local MHO population, and the topic prioritization process. The MHO identified a possible root cause for lower access by this population and briefly described its selected intervention.

At the time of this report, GOBHI had not developed the project much beyond identification of the study topic (Standard 1). The overall score for this PIP reflects this early stage of development. By the time of the 2017 PIP review, GOBHI is expected to have completed Standards 2–5 (study design) and 8 (Improvement Strategies), and provided partial information for Standards 6 (Study Results) and 7 (Interpretation of Results).

The overall weighted score for this PIP is 17 on a scale of 85, resulting in a compliance rating of Minimally Met.

Standard 1: Study topic

Score: 100 (Fully met)

To meet Standard 1, the MHO needs to establish the importance of the study topic in general; present local data to demonstrate that the topic applies to a large or high-risk portion of the Medicaid population and will have a significant effect on enrollee health, functional status, or satisfaction; and demonstrate that a systematic selection and prioritization process, including opportunities for input by enrollees and providers, was used in choosing the topic.

In response to Acumentra Health's 2015 recommendation to select a new PIP topic for 2016 that would affect a significant number of GOBHI's MHO enrollees, GOBHI collected data on and analyzed their MHO-only member population. Data analyses indicated significant gaps in utilization by two subpopulations: older adults and Hispanic children 0–6 years of age. This PIP is focusing on improving the penetration rate of Hispanic children 0–6 years of age.

In its report, GOBHI noted that both the state and federal governments have prioritized the topic of children's mental health, acknowledging the influence of good emotional health at an early age on healthy child and adult development. The literature identifies a number of significant risk factors for children's mental health, including poverty and associated lower levels of education. GOBHI presented data that in 11 out of 14 counties where it is operating, the poverty level is higher than the state average, and "given that eligibility for the Oregon Health Plan is closely associated with lower income levels, it is reasonable to conclude that these risk factors are accentuated within the GOBHI member population."

The under 5 years of age Hispanic population, a growing segment in Oregon, is at increased risk for mental health disorders due to poverty and other poverty-associated stressors. Despite an increased need for behavioral health services, Hispanic children continue to be underserved. Data analyses show that the penetration rate for GOBHI's MHO 0–6 years of age population is 4.81%, consistent with the national data that 2–5.3%. However, the penetration rate for Hispanic members in the same age range is 0%, indicating a significant unmet need.

This topic was selected over other potential topics because of the prioritization of the topic by state and federal governments, feasibility of implementation of the intervention, timing of other system transformation efforts and level of interest from GOBHI providers. GOBHI stated that the data analyses and topic proposal

were reviewed by the Quality Improvement Committee, which includes provider and consumer representatives.

This topic clearly addresses improving the quality of care for a small, but high-risk population that is not receiving services.

GOBHI fully meets this standard.

Standard 2: Study question

Score: 0 (Not met)

To meet Standard 2, the MHO needs to present a study question that provides a clear framework for data collection, analysis, and interpretation. The study question should refer to the proposed intervention, a study population (denominator), what is being measured (a numerator), a metric (e.g., average, percentage), and a direction of desired change.

This standard was not addressed in the report.

To fully meet this standard, GOBHI needs to develop an appropriate study question that states the study intervention(s), study population, what is being measured, metric, and the desired change in direction of the metric.

Standard 3: Study population

Score: 8 (Not met)

To meet Standard 3, the MHO needs to provide a brief description of the study population; list all inclusion and exclusion criteria for the study population, including enrollment criteria; and provide definitions and data sources, including, codes, and calculations. If a sample is selected, the MHO needs to describe the sampling methods.

This PIP does not include all eligible GOBHI MHO Hispanic members 0–6 years of age. Instead, GOBHI will focus on Malheur and Umatilla counties because they have the highest percentage of the GOBHI target population.

Other elements of this standard were not addressed in this report.

To fully meet this standard, GOBHI needs to describe the study population, list the appropriate inclusion and exclusion criteria (including enrollment criteria), and provide relevant definitions and calculations (e.g., age).

Standard 4: Study indicator

Score: 0 (Not met)

To meet Standard 4, the MHO needs to define the numerator (what is being measured) and the denominator; define key terms; describe the target goal; discuss the basis for adopting the indicator as a valid proxy for enrollee outcomes, satisfaction, or quality of care; list all inclusion and exclusion criteria for the numerator (what is being measured), including enrollment criteria; and provide definitions and data sources, including codes, and calculations.

This standard was not addressed in the report.

From the topic discussion, it appears that GOBHI will be measuring the penetration rate of Hispanic children 0–6 years of age in its MHO-only population. Therefore, to fully meet this standard, GOBHI needs to define the measurement numerator and denominator and explain why this metric is a valid indicator for enrollee access and outcomes. In addition, GOBHI will need to list the numerator inclusion and exclusion criteria as well as provide any relevant definitions, codes, and calculations.

Standard 5: Data collection and data analysis plan

Score: 0 (Not met)

T*o meet Standard 5, the MHO needs to describe data collection and data validation procedures, including a plan for addressing errors and missing data; and present a clear data analysis plan, including time frames for the measurement and intervention periods, and an appropriate statistical test to measure differences between the baseline and remeasurement periods.*

This standard was not addressed in the report.

To fully meet this standard, GOBHI needs to describe its data collection plan, including procedures to ensure the data is valid and reliable. The MHO should document a data analysis plan that includes time frames for the measurement and intervention periods, an appropriate statistical test to measure differences between the baseline and remeasurement periods, and a probability level.

Standard 6: Study results

Score: 0 (Not met)

To meet Standard 6, the MHO needs to present results according to the data analysis plan, including the study indicator; the original data used to compute the indicator; and a statistical test to measure differences between the baseline and remeasurement periods. The MHO needs to discuss any other data analyses for factors that may affect the study.

This standard was not addressed in the report.

To fully meet this standard, GOBHI would need to present baseline and first remeasurement results according to its data analysis plan. In its next (2017) report, GOBHI should be able to provide baseline results. Also, the MHO should discuss any other demographic or other data analyses that will assist in the interpretation of the study indicator results, such as referral and no-show rates.

Standard 7: Interpretation of results

Score: 0 (not met)

To meet Standard 7, the MHO needs to list any changes to the study design and discuss the effect of those changes on the comparability of data and interpretation of results; describe any factors that threaten the internal or external validity of the study; discuss if the intervention was implemented as planned; describe any improvement in enrollee health, functional status, or satisfaction and accomplishment of target goals; discuss how the intervention influenced the results; discuss lessons learned during the PIP process; draw a conclusion about the study results based on the above factors; and describe next steps for the study.

This standard was not addressed in the report.

To fully meet this standard, GOBHI will need to describe any changes in study design and describe how those changes might affect the interpretation of results. This description should also include a discussion on how using a sample might affect interpretation of results (i.e., can the sample be applied to the entire GOBHI population). Also, GOBHI should discuss any other factors that might threaten the internal or external validity of the study, the results of the intervention tracking and monitoring plan, lessons learned, the linkage between the intervention and the study results, and next steps for the study.

Standard 8: Improvement strategies

Score: 12 (Not met)

To meet Standard 8, the MHO needs to describe and document the implementation of the intervention(s) and discuss the following: the basis for adopting the intervention; how the intervention can be reasonably expected to result in measurable improvement; the cultural and linguistic appropriateness of the intervention; a tracking and monitoring plan (providing evidence of how the intervention was or will be implemented as planned); barriers encountered during implementation of the intervention and how they were addressed; and how the intervention will be adapted, adopted or abandoned.

GOBHI stated that national and state utilization data indicate that the Hispanic population is more likely to access mental health services through the physical health care system rather than specialty mental health clinics. On the basis of this preference, a Rand study recommended offering behavioral health services through primary care. GOBHI noted that the key to improvement is to develop informed strategies for appropriate and culturally informed care. GOBHI needs to provide more details about its root cause analysis process (e.g., other contributing factors/barriers, who was involved in the process).

The intervention strategy for this PIP is the embedding of a Spanish-speaking clinician in a primary care clinic in each of the two counties with the highest Hispanic population: Umatilla and Malheur. GOBHI stated that "we will not exclude an older population but will work with the primary care practice to identify patient populations who are at risk or may be at risk to develop social and emotional challenges." As the project develops, GOBHI should provide more details about the intervention strategy. In terms of cultural and linguistic appropriateness, GOBHI will want to describe other accommodations developed for this PIP (such as Spanish language materials) and how it plans to address other major cultural considerations, such as poverty and rural living.

To fully meet this standard, GOBHI should provide more details about the root cause analysis process and the intervention and the ways the intervention addresses cultural and linguistic appropriateness. As the project progresses, the MHO will need to describe barriers encountered and how they were addressed as well as presenting an intervention tracking and monitoring plan.

Standard 9: Repeated measurement of the study indicator

Score: n.a.

To meet Standard 9, the MHO needs to report complete study results for two measurement periods, including the study indicator, original data used to compute the indicator, and a statistical test of group differences; provide any other data analyses for factors that may affect the study; and discuss how the intervention, consistency of methodology and any confounders affected the study results in the second remeasurement period.

The PIP has not progressed to this standard. Standard 9 is not scored until a PIP reaches second remeasurement.

Standard 10: Sustained improvement

Score: n.a.

To meet Standard 10, the MHO needs to determine whether or not goals were met and sustained; improvement in the study indicator, as well as enrollee health, functional status or satisfaction was achieved; discuss lessons learned for the PIP and the system as a whole; and report next steps.

The PIP has not progressed to this standard. Standard 10 is not scored until a PIP reaches second remeasurement.

2014 Performance Measure Comparative Analysis Report

Washington Apple Health
Washington Medicaid Integration Partnership
Medical Care Services

December 2014

HCA Contract No. 0834-34555

Presented by

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Acumentra Health prepared this report under contract with the Washington Health Care Authority (Contract No. 0834-34555).

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Table of Contents

Executive Summary 1
Introduction 5
Methods 7
Immunization for Children and Adolescents 9
Comprehensive Diabetes Care 26
Well-Child Care Visits 37
Emergency Room Visits 42
New Measures for 2014 44
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents 45
- Appropriate Testing for Children with Pharyngitis 51
- Use of Appropriate Medications for People with Asthma 52
- Children's and Adolescents' Access to Primary Care Practitioners 53
- Mental Health Utilization 54
- Plan All-Cause Readmissions 55

Medical Care Services Measures 56
Washington Medicaid Integration Partnership (WMIP) 60
- Long-term performance trends 61
- Physical health care utilization 68
- Mental health care utilization 71
- Use of high-risk medications in the elderly 72
- Dependence treatment 73

Conclusions 75
Recommendations 76
References 77
Appendix A. Washington Medicaid MCO Summaries A-1
Appendix B. HEDIS Data Tables for All Measures ..... published separately

Index of Tables

Table 1. Washington Medicaid managed care plans and enrollees, December 2013 5

Table 2. Enrollees appropriately prescribed asthma medication by health plan, reporting year 2014 52

Table 3. Access to primary care practitioners by health plan, reporting year 2014 53

Table 4. Frequency of mental health outpatient and ED services by health plan, reporting year 2014 54

Table 5. Plan all-cause readmissions by health plan, reporting year 2014 55

Table 6. Race/ethnicity diversity of MCS enrollees, reporting year 2014 59

Index of Figures

Figure 1. Geographical coverage of Washington Medicaid enrollees by MCO, May 2013.....6
Figure 2. DTaP immunizations by health plan, reporting year 2014.....10
Figure 3. IPV immunizations by health plan, reporting year 2014.....11
Figure 4. MMR immunizations by health plan, reporting year 2014.....12
Figure 5. HiB immunizations by health plan, reporting year 2014.....13
Figure 6. Hep B immunizations by health plan, reporting year 2014.....14
Figure 7. VZV immunizations by health plan, reporting year 2014.....15
Figure 8. PCV immunizations by health plan, reporting year 2014.....16
Figure 9. Hep A immunizations by health plan, reporting year 2014.....17
Figure 10. Rotavirus immunizations by health plan, reporting year 2014.....18
Figure 11. Influenza immunizations by health plan, reporting year 2014.....19
Figure 12. Combo 2 immunizations by health plan, reporting year 2014.....20
Figure 13. Combo 3 immunizations by health plan, reporting year 2014.....21
Figure 14. Adolescent meningococcal immunizations by health plan, reporting year 2014.....22
Figure 15. Adolescent Tdap immunizations by health plan, reporting year 2014.....23
Figure 16. Adolescent Combo 1 immunizations by health plan, reporting year 2014.....24
Figure 17. Annual HbA1c tests by health plan, reporting year 2014.....27
Figure 18. Enrollees with poor control of HbA1c levels by health plan, reporting year 2014.....28
Figure 19. Enrollees with good control of HbA1c levels by health plan, reporting year 2014.....29
Figure 20. Dilated retinal exams by health plan, reporting year 2014.....30
Figure 21. Lipid profile (LDL-C screening) performed by health plan, reporting year 2014.....31
Figure 22. Lipids controlled (<100mg/dL) by health plan, reporting year 2014.....32
Figure 23. Nephropathy monitored annually by health plan, reporting year 2014.....33
Figure 24. Blood pressure controlled (<140/90 mm Hg) by health plan, reporting year 2014.....34
Figure 25. Blood pressure controlled (<140/80 mm Hg) by health plan, reporting year 2014.....35
Figure 26. Six or more well-child visits in the first 15 months of life by health plan, reporting year 2014.....38
Figure 27. Well-child visits in the 3rd, 4th, 5th, and 6th years of life by health plan, reporting year 2014.....39
Figure 28. Adolescents ages 12–21 with one or more well-care visits by health plan, reporting year 2014.....40

Figure 29. State and national averages for emergency room utilization, reporting years 2010–2014 42
Figure 30. Emergency room visits per 1000 member months by health plan, reporting years 2013–2014 43
Figure 31. BMI documentation for enrollees ages 3–11, by health plan, reporting year 2014 45
Figure 32. BMI documentation for enrollees ages 12–17, by health plan, reporting year 2014 46
Figure 33. Nutrition counseling for enrollees ages 3–11, by health plan, reporting year 2014 47
Figure 34. Nutrition counseling for enrollees ages 12–17, by health plan, reporting year 2014 48
Figure 35. Physical activity counseling for enrollees ages 3–11, by health plan, reporting year 2014 49
Figure 36. Physical activity counseling for enrollees ages 12–17, by health plan, reporting year 2014 50
Figure 37. Pharyngitis testing for enrollees age 2–18, by health plan, reporting year 2014 51
Figure 38. Ambulatory care visits for MCS enrollees, reporting years 2013–2014 57
Figure 39. Antidepressant medication management for MCS enrollees, reporting years 2013–2014 58
Figure 40. HbA1c testing and control for WMIP enrollees, reporting years 2006–2014 61
Figure 41. Diabetes screening measures for WMIP enrollees, reporting years 2006–2014 62
Figure 42. LDL-C screening, LDL-C control, and blood pressure control for WMIP enrollees, reporting years 2006–2014 63
Figure 43. Antidepressant medication management for WMIP enrollees, reporting years 2008–2014 64
Figure 44. Follow-up after mental health hospitalization for WMIP enrollees, reporting years 2008–2013 65
Figure 45. Outpatient visit rates for WMIP enrollees, reporting years 2007–2014 66
Figure 46. Emergency room visit rates for WMIP enrollees, reporting years 2007–2014 67
Figure 47. WMIP inpatient utilization discharges, reporting years 2010–2014 68
Figure 48. WMIP inpatient utilization days, reporting years 2010–2014 69
Figure 49. WMIP inpatient utilization average length of stay, reporting years 2010–2014 70
Figure 50. WMIP mental health utilization, reporting years 2012–2014 71
Figure 51. WMIP use of high-risk medications in the elderly, reporting years 2013–2014 72
Figure 52. WMIP identification of alcohol and other drug services, reporting years 2012–2014 73

Executive Summary

Apple Health, the Washington Medicaid program administered by the Health Care Authority (HCA), provides managed health care benefits for more than 1.1 million residents. Managed care enrollment has nearly doubled since July 2012 with implementation of the Affordable Care Act and the inclusion in managed care of Medicaid populations who previously received fee-for-service care.

HCA has used Healthcare Effectiveness Data and Information Set (HEDIS®)* measures since 1998 to assess the performance of the managed care organizations (MCOs) that serve Medicaid enrollees. Developed and maintained by the National Committee for Quality Assurance (NCQA), the HEDIS measures allow comparison of the Washington MCOs' performance with national benchmarks for the Medicaid population.

This report presents the 2014 results of HEDIS measures for the five MCOs that serve Apple Health enrollees:

- Amerigroup Washington Inc. (AMG)
- Community Health Plan of Washington (CHP)
- Coordinated Care Corp. (CCC)
- Molina Healthcare of Washington (MHW)
- UnitedHealthcare Community Plan (UHC)

Amerigroup, Coordinated Care, and UnitedHealthcare began contracting with HCA on July 1, 2012, and therefore had only 6 months of service data for enrollees in 2012. Since many HEDIS measures are based on services delivered to enrollees with 12 months of continuous enrollment, HCA required each MCO to report only inpatient and ambulatory care utilization measures in 2013—omitting performance data for childhood immunizations, well-child care, diabetes care, and other measures HCA had required historically. This year, the MCOs returned to reporting a full set of clinical care measures as required by HCA.

This 2014 report presents initial data in terms of analyzing the current MCOs' performance in serving the broad range of enrollees under Apple Health. Compared with the same measures in previous years, the 2014 measures apply to a greatly expanded Medicaid population, including many thousands of enrollees who formerly received fee-for-service care (e.g., disabled/blind SSI recipients and other adult clients). Despite differences in the 2012 and 2014 Medicaid populations, and in the roster of MCO contractors, this report presents formal statistical comparisons of the 2012 and 2014 state averages as an index of system change.

HCA required the MCOs to report certain HEDIS measures for the first time in 2014, as noted below. Also, MHW reported measures for the Washington Medicaid Integration Partnership (WMIP) pilot program in 2014, as in previous years. Because HCA ended the WMIP program on June 30, 2014, this report presents the final performance data for WMIP.

*HEDIS is a registered trademark of the National Committee for Quality Assurance.

2014 HEDIS results

The recent changes in Medicaid enrollment affect several aspects of performance measure reporting, and thus the interpretation of HEDIS results, as described below.

- **Continuous enrollment:** Several measures require that members be enrolled with their MCO at least 12 months to qualify for inclusion in the measure's denominator. These measures include immunizations, diabetes, asthma, and some utilization measures. Many members assigned to the new MCOs do not meet the enrollment criteria because the MCOs were newly contracted with HCA in July 2012. Therefore, even though MCO members may have received health care services through their MCOs in 2013, they may not be represented in the measures that require continuous enrollment.
- **Enrollment stability:** HCA required MCOs to meet network adequacy standards during 2012; however, most MCOs continued to add new providers to their networks throughout 2013. As a result, many enrollees may not have established a relationship with a care provider during 2013.
- **Access to data:** The "legacy" MCOs (CHP and MHW) have access to their members' historical administrative data for HEDIS reporting. While HCA supplied some historical data to the new MCOs, the administrative data may not be complete for those members.

2014 highlights

Given the caveats noted above, Acumentra Health's analysis of HEDIS results for 2014 revealed the following highlights.

- *Childhood immunization* measures showed different trends depending on how long HCA has required the measures to be reported.
  - For the seven antigens in Combo 3, which the Washington MCOs have reported for many years, the statewide average immunization rates in 2014 were uniformly lower than in 2012, and were significantly below the 2014 U.S. average rates. In Washington, average immunization rates for these antigens peaked most recently in 2010.
  - For the hepatitis A, rotavirus, and influenza vaccines, first reported in 2010, average immunization rates continued to rise from previous years. Although the statewide rates for hepatitis A and rotavirus remained significantly below the U.S. average rates, the statewide influenza immunization rate significantly exceeded the U.S. rate.
- Performance on *diabetes care indicators* showed mixed results.
  - Delivery of screening procedures generally increased from 2012 (except for a significant decline in dilated retinal exams), as did the overall percentage of enrollees with LDL-C levels under control.
  - The percentage of enrollees with acceptable HbA1c levels continued to fall, and the percentage of those with good control of their blood pressure declined markedly.
  - Relative to the U.S. Medicaid averages, the Washington MCOs significantly underperformed on six of the nine diabetes indicators. However, the statewide rate of HbA1c testing significantly exceeded the U.S. average rate.

- *Well-child care (WCC) visit rates* showed little change since the previous measurement in 2012. The Washington MCOs continue to lag behind the national Medicaid performance in providing WCC visits, particularly for older children and adolescents.
- The rate of *emergency room (ER) visits* by Washington MCO enrollees in 2014 rose significantly from 2013 to 2014, reversing a trend of declining ER utilization. However, the Washington Medicaid average remained significantly below the U.S. Medicaid average, as has been the case since 2006.
- *Access to primary care practitioners* for children and adolescents was a bright spot, as the Washington MCOs reported access rates significantly higher than the U.S. average rates for three of four age groups. In years before 2008 when the Washington MCOs were required to report this measure, access rates were similarly high.

Considering measures that HCA required the MCOs to report for the first time in 2014:

- The MCOs performed below the U.S. averages for adolescent meningococcal immunizations, weight assessment and counseling for nutrition and physical activity for children and adolescents, pharyngitis testing for children, and use of appropriate medications for people with asthma.

Performance by MCO: CHP remained the top performer for immunizations, followed by MHW and CCC. AMG and UHC reported the poorest results in 2014, often significantly below the state average. On diabetes care indicators, CHP and MHW generally outperformed the statewide average, as did CCC; however, UHC's generally poor performance on these indicators tended to weigh down the overall group performance.

On newer measures of services for children and adolescents, CHP outperformed other MCOs in delivering weight assessment and counseling for nutrition and physical activity, while MHW was the top performer in providing access to primary care practitioners.

WMIP final performance data: Acumentra Health analyzed long-term trends in HEDIS measures for the WMIP program, spanning 6 to 9 years, depending on data availability. This analysis revealed:

- Considering *diabetes care*, the delivery of screening measures showed little improvement over time, except for monitoring of diabetic nephropathy. The long-term trends in outcome measures (HBa1c levels and blood pressure and LDL-C control) also were discouraging.
- More encouragingly, the measures of *timely follow-up treatment after hospitalization for mental illness* improved significantly from 2008 to 2014. *Antidepressant medication management* for WMIP enrollees also trended in a positive direction over time.
- Trends in *ambulatory care utilization* showed a significant increase in outpatient visit rates coupled with a significant decrease in ER visit rates, suggesting that the program succeeded in treating enrollees at less intensive levels of care over time.

Appendix B presents detailed historical data on all HEDIS measures reported by the Washington MCOs since 2010.

Recommendations

Previous reports in this series have outlined recommendations for HCA and the MCOs, aimed at improving access to care and the quality and timeliness of care. Many of those recommendations remain valid, although their current feasibility may be limited by the resource constraints facing the Washington Medicaid program.

To sustain long-term improvement in the delivery of managed care for Medicaid enrollees, Acumentra Health recommends that HCA

- seek to align performance measures with other state and federal reporting requirements to reduce burden on providers and promote efficient use of health system resources
- consider requiring the MCOs to engage in formal activity to share best practices aimed at reducing the performance gaps among health plans for specific measures
- help MCOs overcome barriers to collecting complete member-level encounter data, including race/ethnicity data, so that the MCOs can use these data to assess resources for improving the quality of care and establish appropriate interventions to address health care disparities. In previous years, the EQRO found gaps in immunization and well-child datasets that limit the ability to perform comprehensive analysis.
- set performance expectations for HEDIS measures, such as requiring MCOs to perform a PIP or focused improvement study for measures that fail to meet specific benchmarks
- designate incentive measures for which MCOs can receive quality incentive payments for top performance
- continue to provide supplemental data on Early and Periodic Screening, Diagnosis, and Treatment to assist the MCOs in calculating HEDIS well-child measures
- consider adding a contract requirement for the MCOs to provide HEDIS-specific performance feedback to clinics and providers on a frequent and regular schedule

Acumentra Health recommends that the contracted MCOs

- participate in public health initiatives and partnerships such as the Washington State Collaborative to Improve Care and the DOH's Washington State Immunization Information System (formerly called Child Profile)
- provide dashboard reporting on a routine basis to providers to highlight regional rates, since public reporting may promote more local control and better coordination among providers and other entities providing services
- monitor member-level data to improve the completeness of race and ethnicity information, to aid in establishing appropriate interventions to address health care disparities
- conduct validation studies to improve the quality of encounter data to ensure that enrollees are receiving appropriate interventions
- monitor their HEDIS rates at least quarterly, using administrative data

Introduction

Traditionally, the Washington Medicaid program provided managed medical care primarily for children, mothers, and pregnant women, and for several thousand adult SSI or SSI-related clients through the WMIP program in Snohomish County. Since July 1, 2012, however, managed care enrollment has nearly doubled with the addition of disabled and blind SSI recipients and other new populations, such as those served by the former Medical Care Services program. The net effect has been a major shift toward adult enrollment.

As of January 1, 2014, all populations served by Washington Medicaid, including many thousands of newly eligible enrollees authorized by the federal Affordable Care Act, were rolled up under Apple Health.

Table 1 shows the name and acronym of each MCO and the number of enrollees by service population in December 2013.

Table 1. Washington Medicaid managed care plans and enrollees, December 2013.[a]

Health plan	Enrollment
Amerigroup Washington Inc. (AMG)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	34,241
SSI recipients (included in above)	*10,503*
Community Health Plan of Washington (CHP)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	236,404
SSI recipients (included in above)	*27,468*
Health Home	61
Medical Care Services (formerly GA-U)	7,180
CHP total	243,645
Coordinated Care Corp. (CCC)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	80,592
SSI recipients (included in above)	*15,759*
Molina Healthcare of Washington (MHW)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	375,231
SSI recipients (included in above)	*29,964*
WMIP	3,055
MHW total	378,286
UnitedHealthcare Community Plan (UHC)	
Healthy Options/Healthy Options Foster Care/CHIP/Basic Health Plus	60,754
SSI recipients (included in above)	*14,555*
Health Home	265
UHC total	61,019
Total	**797,783**

[a] Healthy Options includes SSI recipients in the Blind/Disabled population.

Source: Washington Health Care Authority.

Figure 1 shows the geographical distribution of MCO services as of May 1, 2013. AMG began serving enrollees in Benton and Franklin counties during 2013.

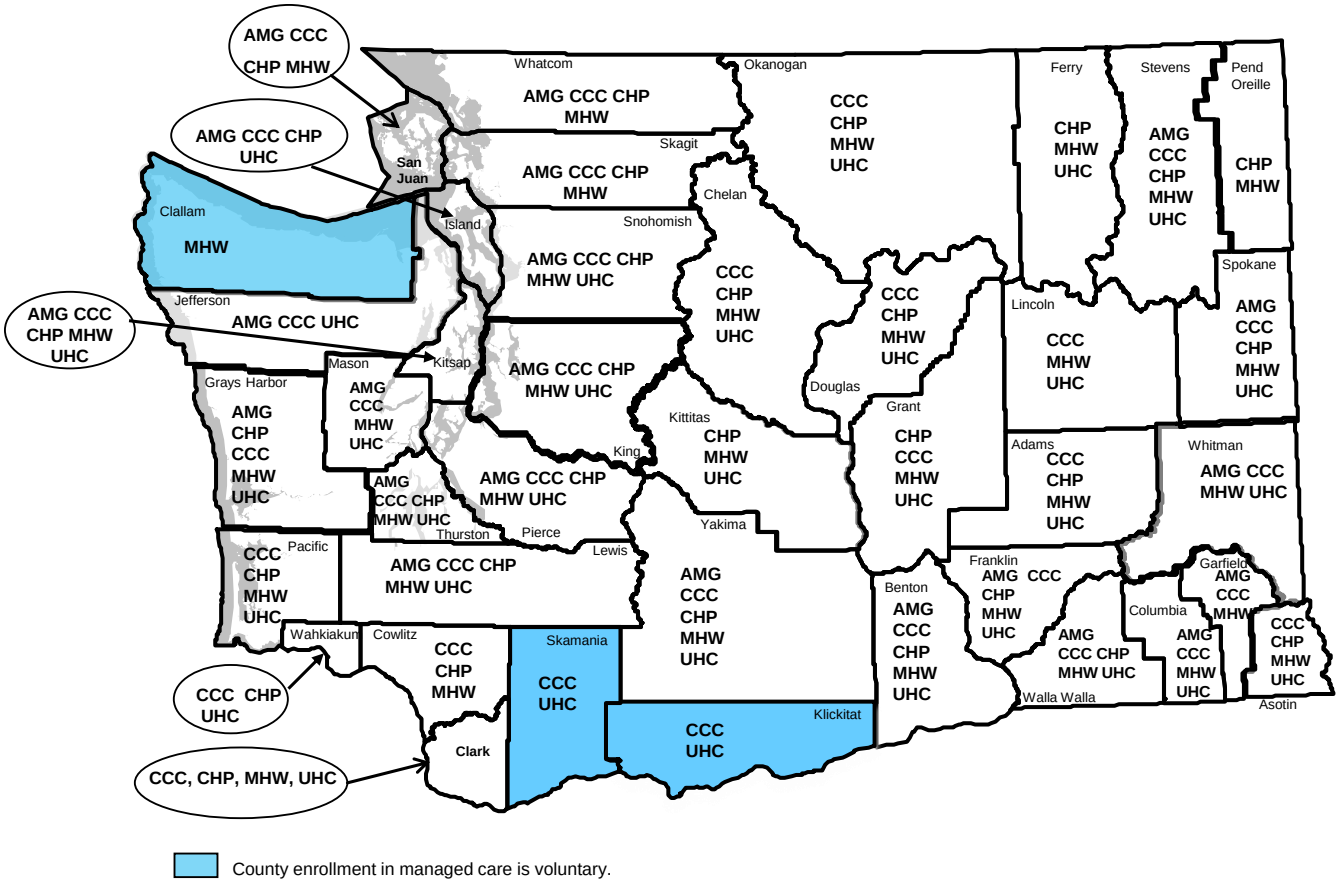

Figure 1. Geographical coverage of Washington Medicaid enrollees by MCO, May 2013.

HCA has stated that it will require all five currently contracted MCOs to hold NCQA accreditation by December 31, 2016. Those with current accreditation for the Medicaid product line include CCC, CHP, and MHW.

Methods

HEDIS results for a measurement year (the year in which care is given) are gathered, audited, and reported the following year, called the reporting year. Results are based on a statistically valid random sample of health plan enrollees. The HEDIS technical specifications set stringent criteria for identifying the eligible population for each measure.[1]

To ensure data integrity, NCQA verifies that a health plan collects data according to the technical specifications. Each plan's data collection process is audited by an NCQA-certified HEDIS auditor. The NCQA HEDIS Compliance Audit™ assures purchasers and health plans of fair and accurate comparisons of plan performance. HCA funds the HEDIS audit for the MCOs to fulfill the federal requirement for validation of state performance measures.

This report presents results for reporting year 2014 (measurement year 2013) for the HEDIS measures that HCA required the Washington MCOs to report. Results for the WMIP program appear in charts that display available data since 2006.

Acumentra Health compiled individual MCO data from the NCQA-audited Interactive Data Submission System (IDSS) results.[2] We derived the state average for each measure by adding individual MCO numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and converting the ratio to the appropriate reporting unit. Most HEDIS measures are reported as percentages; utilization measures are typically reported as counts per 1,000 member months. The 2014 national Medicaid averages came from NCQA's *Quality Compass*® report.[3]

Data graphs show the 95% confidence interval (CI) for each measurement, indicating the upper and lower limits within which each MCO percentage would be expected to fall 95 times if 100 identical studies were conducted. The smaller the CI, the higher the likelihood that the percentage found in the MCO sample reliably estimates the percentage that applies to MCO members overall. A small CI, therefore, indicates greater precision, usually due to adequate sample sizes.

For each measure, Appendix B reports the NCQA national Medicaid average rate and the 90th percentile rate. The latter is NCQA's highest benchmark rate, below which fall 90% of all rates reported nationally.

Note: HEDIS measures are not designed for case-mix adjustment or risk adjustment for existing co-morbidities, physical or mental disabilities, or severity of disease. Therefore, when reviewing and comparing plan performance, it may be difficult to determine whether differences among MCO rates were due to differences in the use of services or quality of care, or to differences in the health of the MCO's population.

Administrative vs. hybrid data collection

For certain measures, HEDIS technical specifications allow a health plan to collect data by the administrative or the hybrid method. In the administrative method, the health plan defines the eligible population and uses data from its information systems—such as claims and encounter data—to identify enrollees who received the service(s) for the measure. In the hybrid method, the health plan performs supplemental medical chart reviews to identify enrollees who received service(s) that might not be captured in the administrative data. Regardless of the data collection method, eligible enrollees who received services are counted as "numerator events."

A sample of hybrid numerator events is validated as part of the HEDIS audit process. This medical record review validation (MRRV) ensures that chart reviews performed by the health plan, or by its contracted vendor, meet audit standards for sound processes and that abstracted medical data are accurate.

Beginning in 2013, NCQA implemented new audit requirements intended to make the MRRV process "more rigorous." Health plans must meet a deadline of May 15 each year to finish abstracting medical records for all measures and to send the associated data to the HEDIS auditor. No charts are accepted past that date, when auditors began to review records.

The new audit procedure also uses a different, more sensitive statistical test to determine bias in medical record review. This test is intended to reduce the number of errors allowed in the sample of data collected using the hybrid method.

For the past several years, Acumentra Health has analyzed and reported on the difference between HEDIS rates calculated through the administrative vs. the hybrid method. For 2014, MCOs reported five hybrid measures: childhood immunizations, adolescent immunizations, weight assessment and counseling, comprehensive diabetes care, and the well-child measure set. Analysts reviewed data collected for the hybrid measures and found that the amount of data from medical record review varies by measure and by health plan. For some clinical measures, virtually all of the data is collected by medical record review. Since this was the initial year for reporting for three of the five plans, it was difficult to compare data collection methods for the newly contracted plans.

Supplemental data

For years, many MCOs have used supplemental data to calculate their HEDIS measures. Supplemental data are defined as any health care delivery information that is available outside of the MCO's claims/encounter data system. In 2013, NCQA created a formal structure and processes for supplemental data, and the 2014 HEDIS technical specifications provide guidelines for collection, validation, and use of these data. All supplemental data used by the MCO must meet NCQA specifications as determined by the auditor.

Three distinct categories of supplemental data apply to HEDIS reporting: Standard, Nonstandard, and Member-reported. The auditor must determine which category each supplemental data source belongs to and must communicate that determination to the MCO.

In 2014, all Washington MCOs used auditor-approved supplemental data in calculating their HEDIS measures. Examples of approved supplemental data include lab data, historical medical record data, and fee-for-service data on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provided by HCA. The EPSDT supplemental data file was produced for HEDIS for the first time in 2014. The auditor examined HCA's processes and source data as a component of the MCO audit. All MCOs reported that the state-supplied data had a positive impact on their well-child measures.

Member-level data analysis

In the past, HCA has required the MCOs to submit de-identified member-level data (including elements for gender, primary language, race/ethnicity, and county) on childhood immunizations. HCA did not require submission of member-level data in 2014.

Immunization for Children and Adolescents

For 2014, HCA required the MCOs to report 19 indicators of Childhood Immunization Status (10 individual antigens plus 9 combinations of antigens). For the first time, HCA required the MCOs to report Immunization for Adolescents. See measure definitions below.

Measure definition

Childhood Immunization Status assesses the percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthday, and who received the following vaccinations:

- four diphtheria, tetanus, and acellular pertussis (DTaP)
- three polio (IPV)
- one measles, mumps, and rubella (MMR)
- three *Haemophilus influenzae* type b (HiB)
- three hepatitis B (Hep B)
- one varicella-zoster virus (VZV)
- four pneumococcal conjugate (PCV)
- one hepatitis A (Hep A)
- two or three rotavirus (RV)
- two influenza (flu)
- Combination #2 (Combo 2) includes all antigens listed above except for PCV, Hep A, RV, flu
- Combination #3 (Combo 3) includes all antigens listed above except for Hep A, RV, flu
- Combination #4 (Combo 4) includes all antigens listed above except for RV, flu
- Combination #5 (Combo 5) includes all antigens listed above except for Hep A, flu
- Combination #6 (Combo 6) includes all antigens listed above except for Hep A, RV
- Combination #7 (Combo 7) includes all antigens listed above except for flu
- Combination #8 (Combo 4) includes all antigens listed above except for RV
- Combination #9 (Combo 9) includes all antigens listed above except for Hep A
- Combination #10 (Combo 10) includes all antigens listed above

Immunization for Adolescents assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine or one tetanus, diphtheria toxoids (Td) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Data collection method: Administrative or hybrid

Childhood immunization rates

Diphtheria, Tetanus, and Pertussis (DTaP)

Figure 2 displays the 2014 results for DTaP immunizations by MCO. The statewide average immunization rate (72.25%) was significantly lower than the U.S. average rate and significantly lower than the 2012 statewide rate. CHP's rate (79.81%) was significantly higher than the state average, while the rates for AMG and UHC were significantly below average.

The epidemic of pertussis in Washington during 2012–2013 underscores the importance of delivering the full series of four DTaP vaccinations for infants, as well as Tdap boosters for adolescents and adults. Through mid-October 2014, the Washington Department of Health (DOH) reported 373 pertussis cases, down from 627 in the same period of 2013.[4] The highest incidence rate was among infants under one year of age (57.6 cases per 100,000).

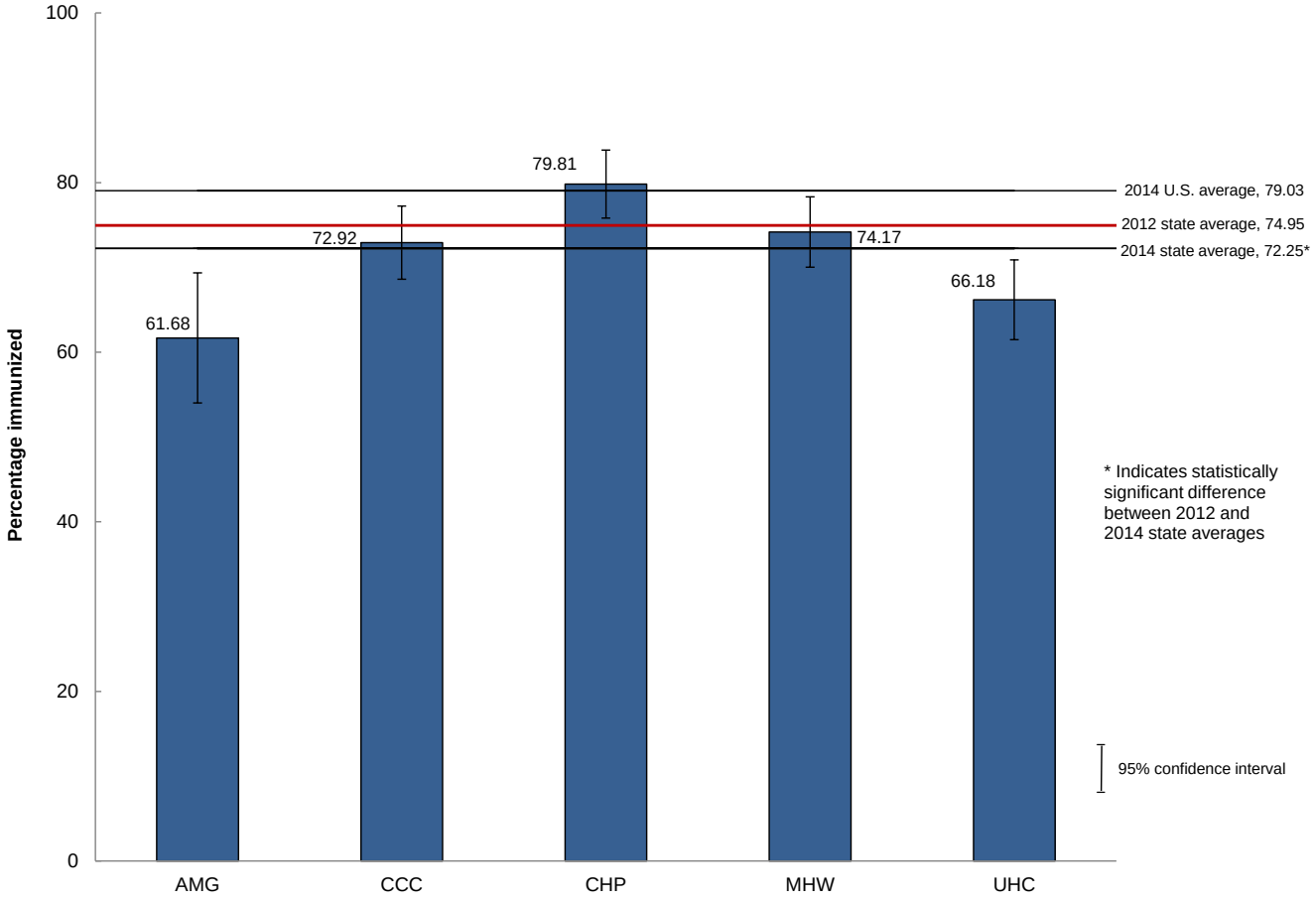

Figure 2. DTaP immunizations by health plan, reporting year 2014.

Inactivated Polio Vaccine (IPV)

Statewide IPV immunization rates in 2014 averaged 85.27%, significantly lower than the U.S. average and significantly lower than the 2012 statewide rate (see Figure 3). The rates for CHP (91.24%) and MHW (89.18%) were significantly higher than the state average, while the rates for AMG and UHC were significantly below average.

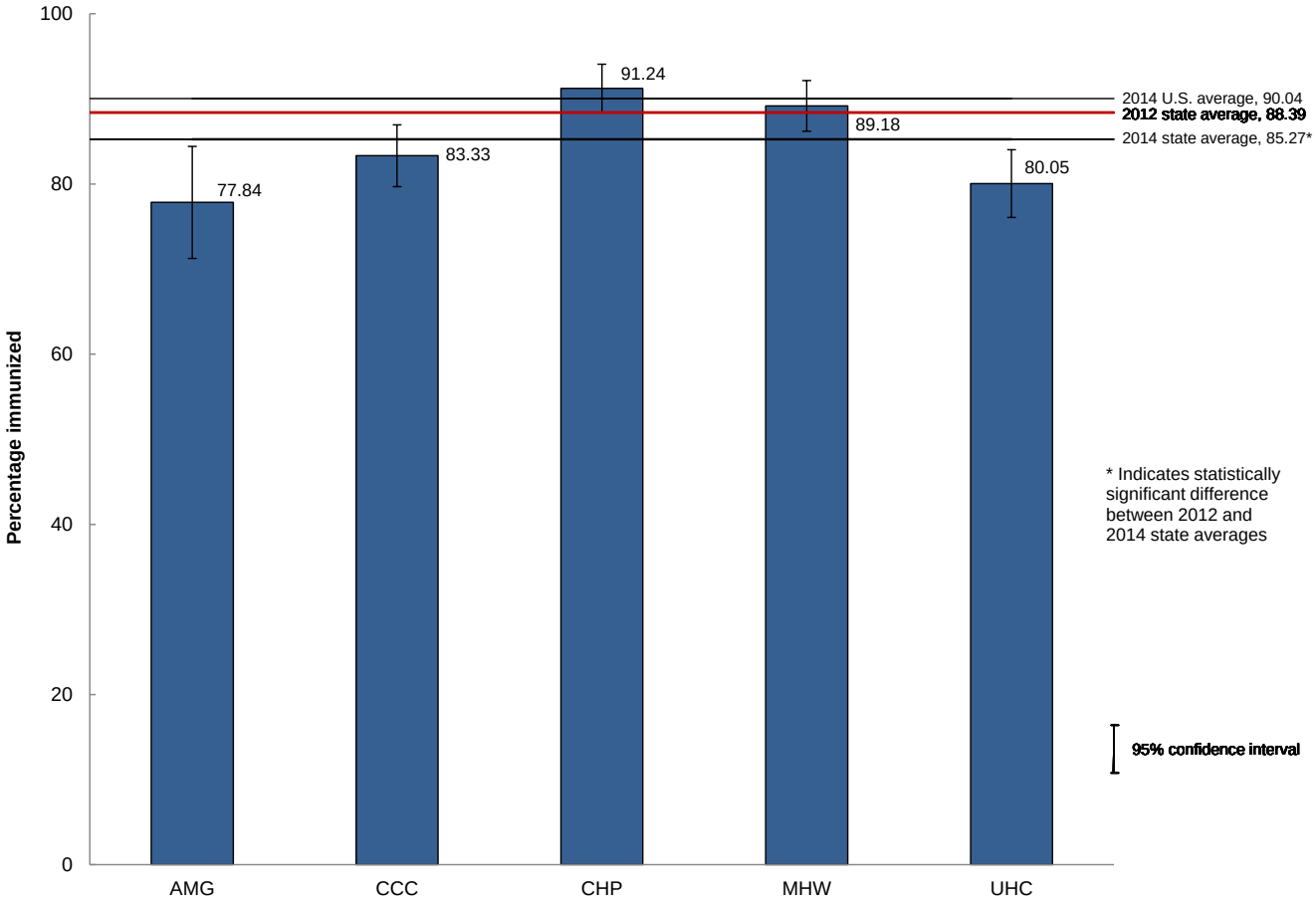

Figure 3. IPV immunizations by health plan, reporting year 2014.

Measles, Mumps, and Rubella (MMR)

Statewide MMR immunization rates in 2014 averaged 86.29%, significantly lower than the U.S. average and significantly lower than the 2012 statewide rate (see Figure 4). CHP significantly outperformed the state average with a rate of 90.51%, while the rates for AMG and UHC were significantly below average.

In mid-July 2014, measles cases in Washington were reported at an 18-year high of 27 cases, compared with only 5 cases in 2013.[5] The recent outbreak comes after a five-year decline in the percentage of Medicaid managed care recipients receiving MMR vaccinations.

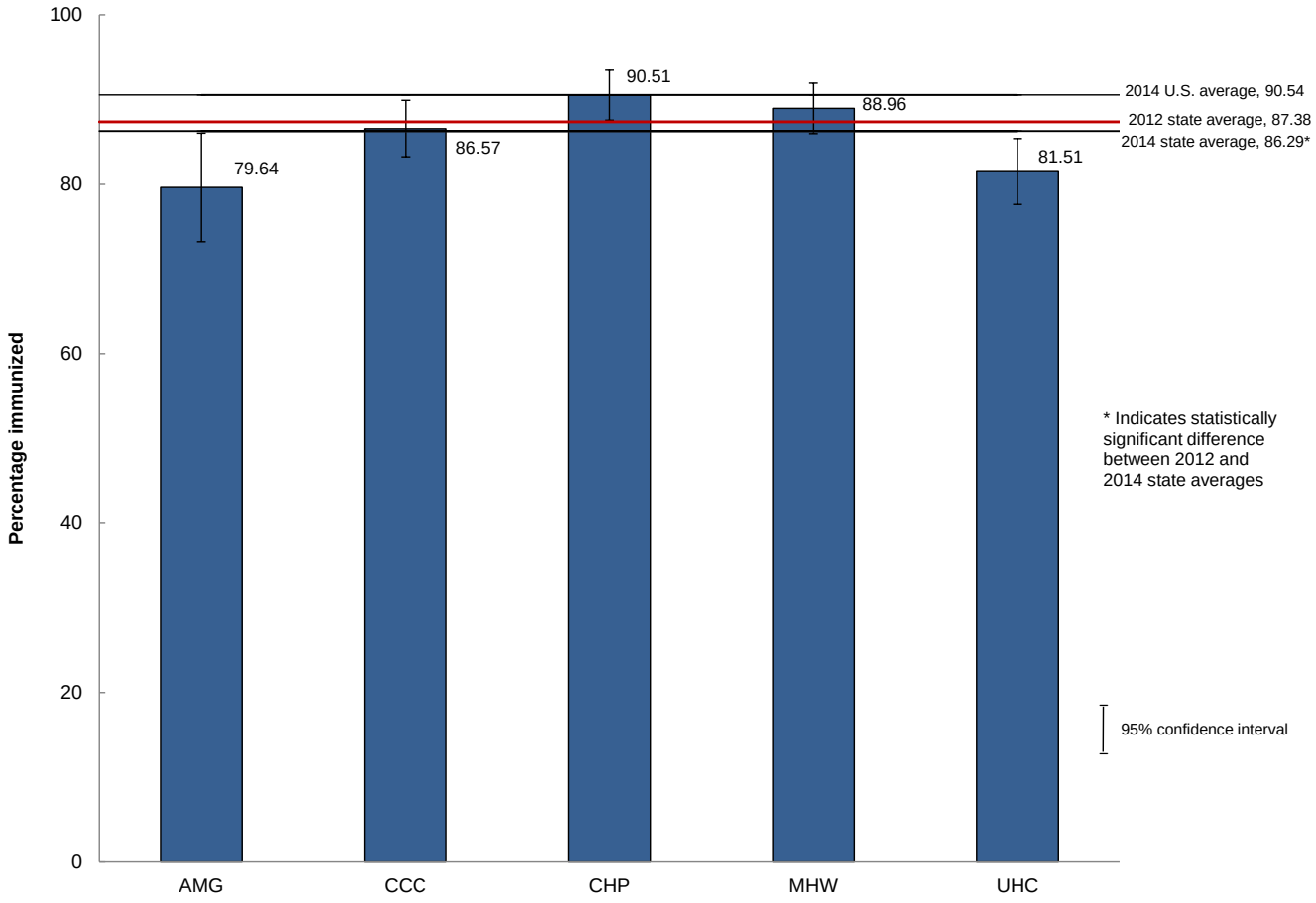

Figure 4. MMR immunizations by health plan, reporting year 2014.

Haemophilus Influenzae Type B (HiB)

Figure 5 displays the 2014 results for HiB immunizations by MCO. The statewide average immunization rate (86.39%) was significantly lower than the U.S. average and significantly lower than the 2012 statewide rate. CHP's rate (91.73%) was significantly higher than the state average, while UHC's rate (80.29%) was significantly below average.

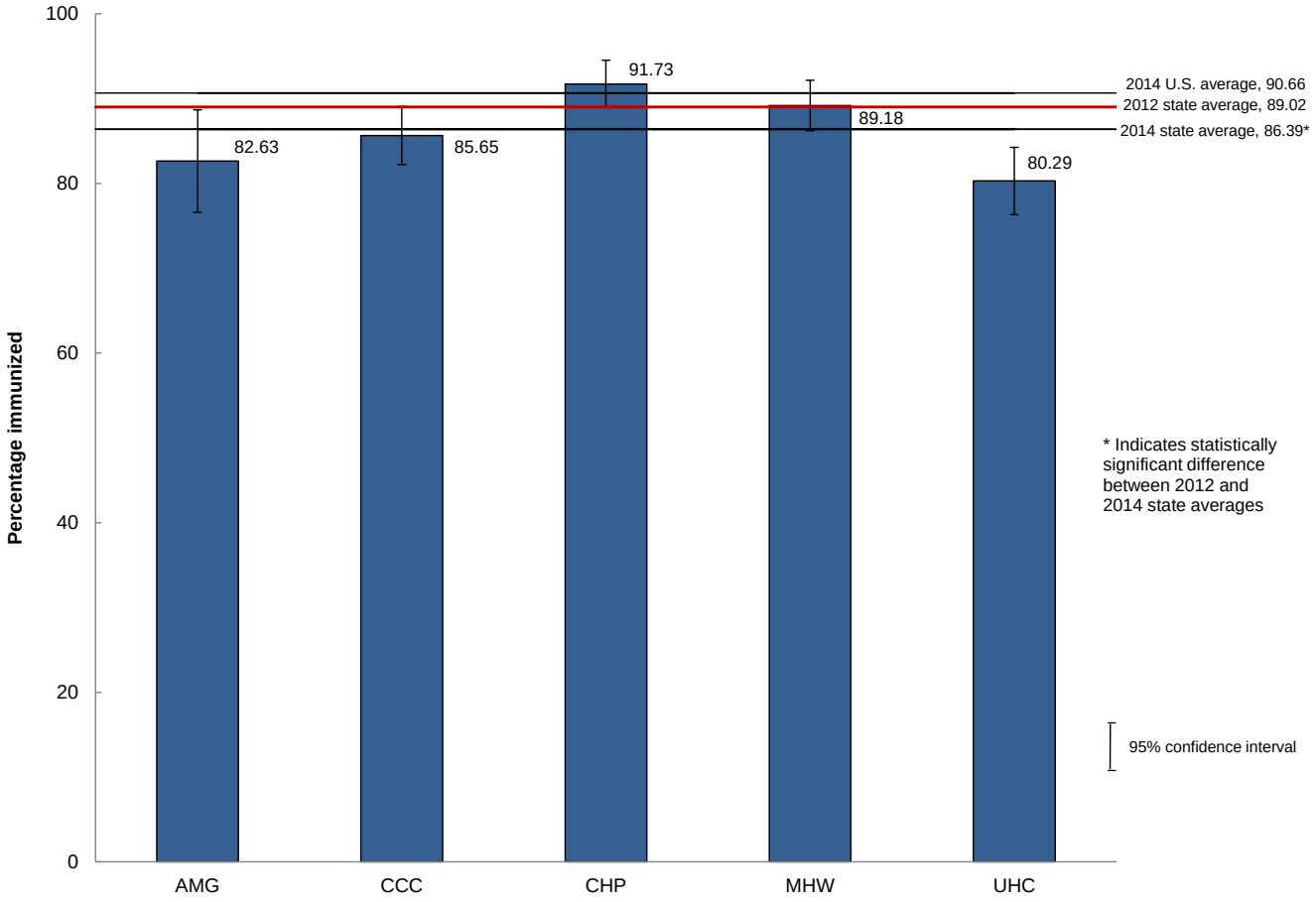

Figure 5. HiB immunizations by health plan, reporting year 2014.

Hepatitis B (Hep B)

Statewide Hep B immunization rates in 2014 averaged 83.88%, significantly lower than the U.S. average and significantly lower than the 2012 statewide rate (see Figure 6). CHP's rate (90.75%) was significantly higher than the state average, while UHC's rate (76.40%) was significantly below average.

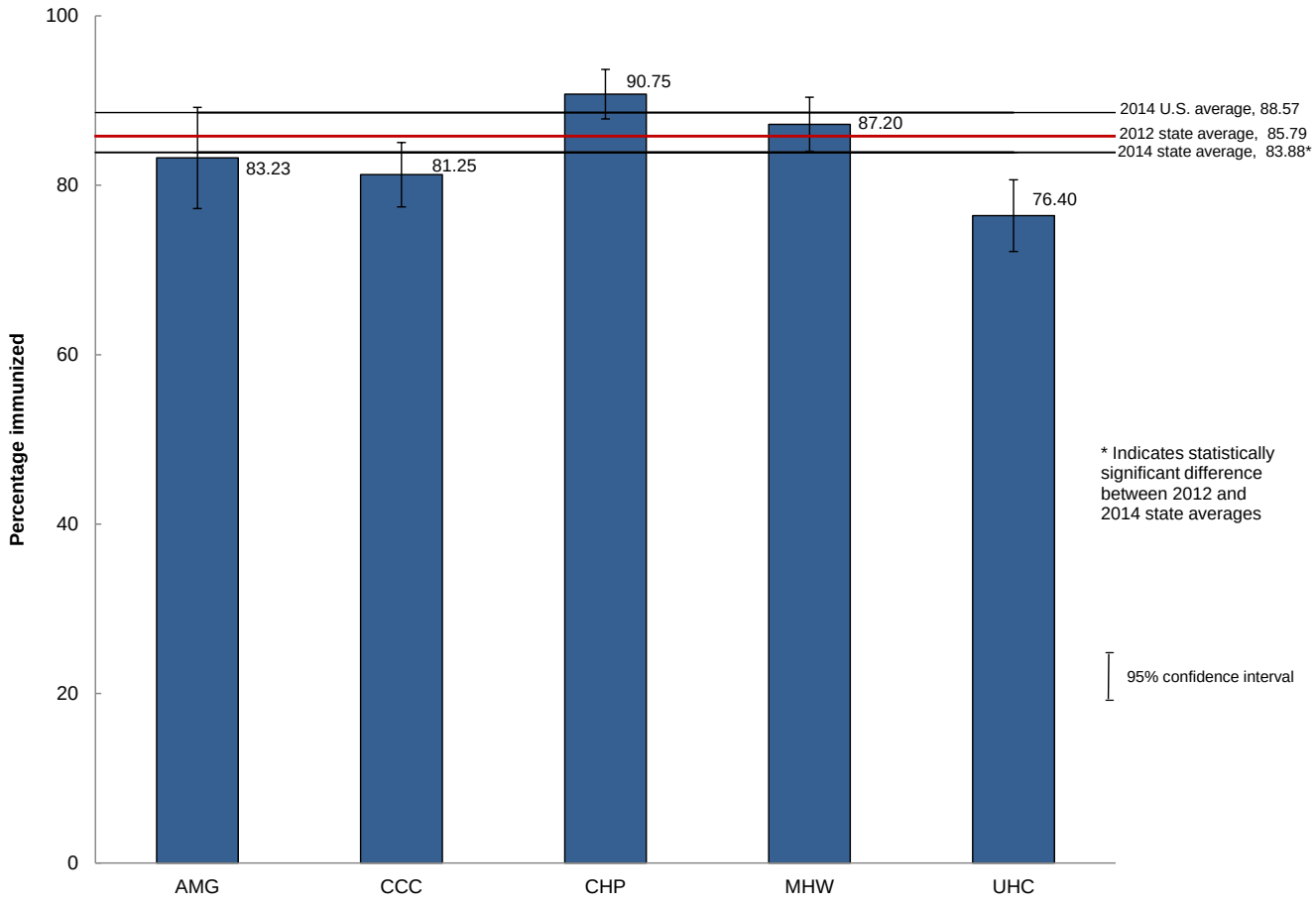

Figure 6. Hep B immunizations by health plan, reporting year 2014.

Varicella-Zoster Virus (VZV)

Statewide VZV immunization rates in 2014 averaged 85.59%, significantly lower than the U.S. average and significantly lower than the 2012 statewide rate (see Figure 7). AMG's immunization rate (77.84%) was significantly lower than the state average.

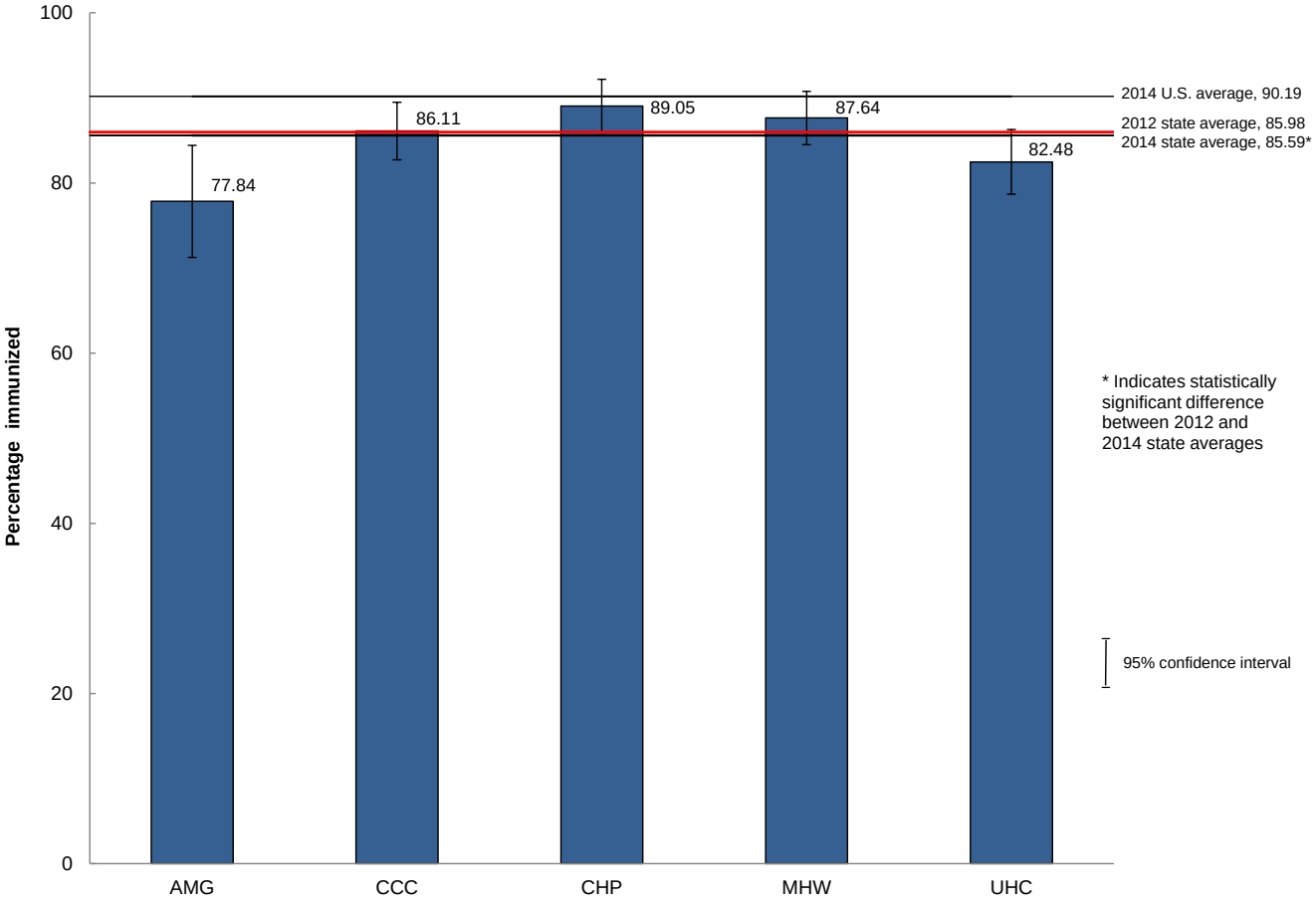

Figure 7. VZV immunizations by health plan, reporting year 2014.

Pneumococcal Conjugate (PCV)

Figure 8 displays the 2014 results for PCV immunizations by MCO. The statewide average immunization rate (73.64%) was significantly lower than the U.S. average and significantly lower than the 2012 statewide rate. CHP's rate (79.32%) was significantly higher than the state average, while AMG's rate (62.87%) was significantly below average.

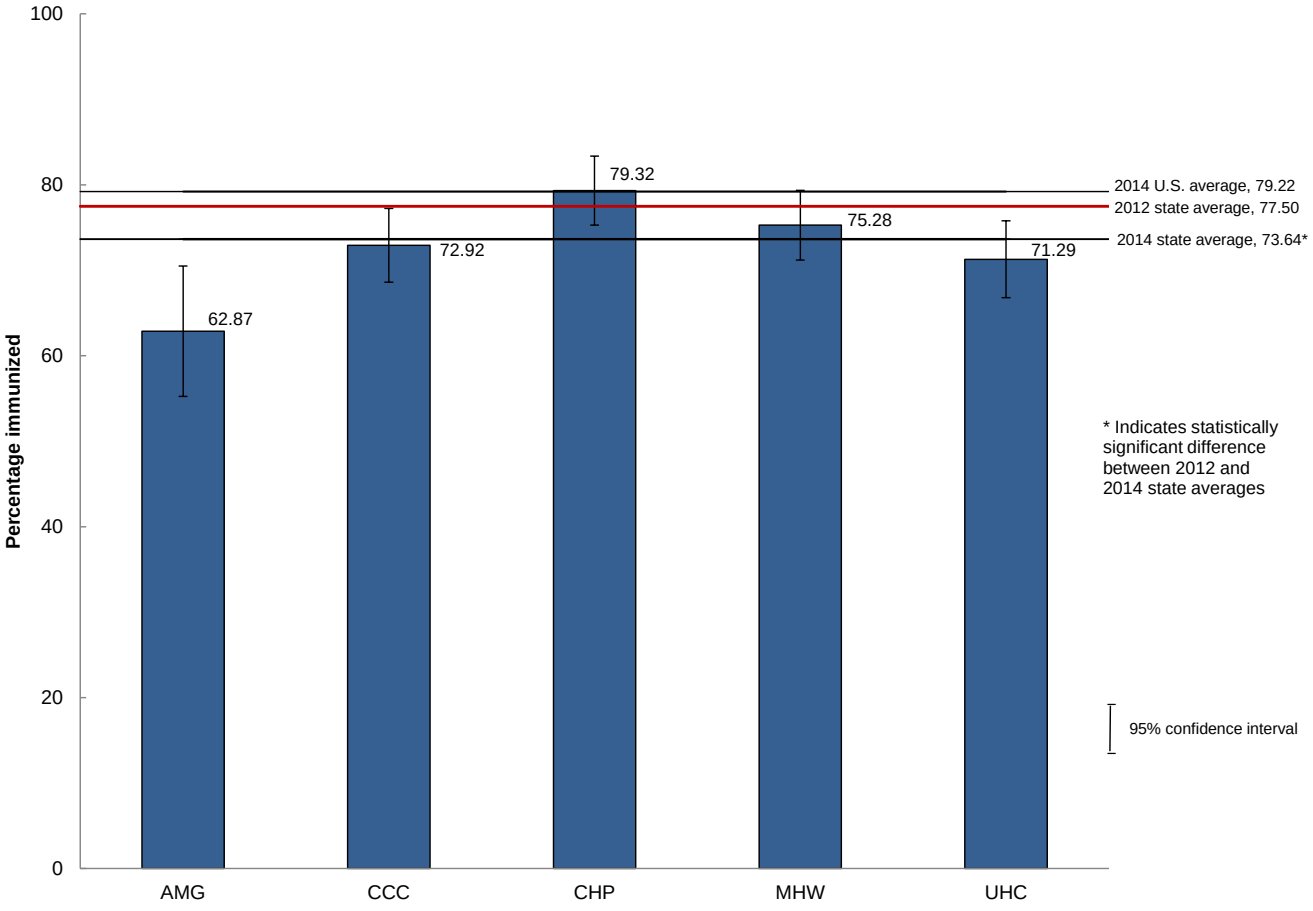

Figure 8. PCV immunizations by health plan, reporting year 2014.

Hepatitis A (Hep A)

The statewide average Hep A immunization rate climbed to 77.21% in 2014, a significant improvement over the 2012 statewide rate, yet still significantly below the U.S. average (see Figure 9). CCC and CHP significantly outperformed the state average, while the rates for AMG and UHC were significantly below average. Note: In 2014, this measure required only one dose of the vaccine for compliance; in 2012, two doses were required.

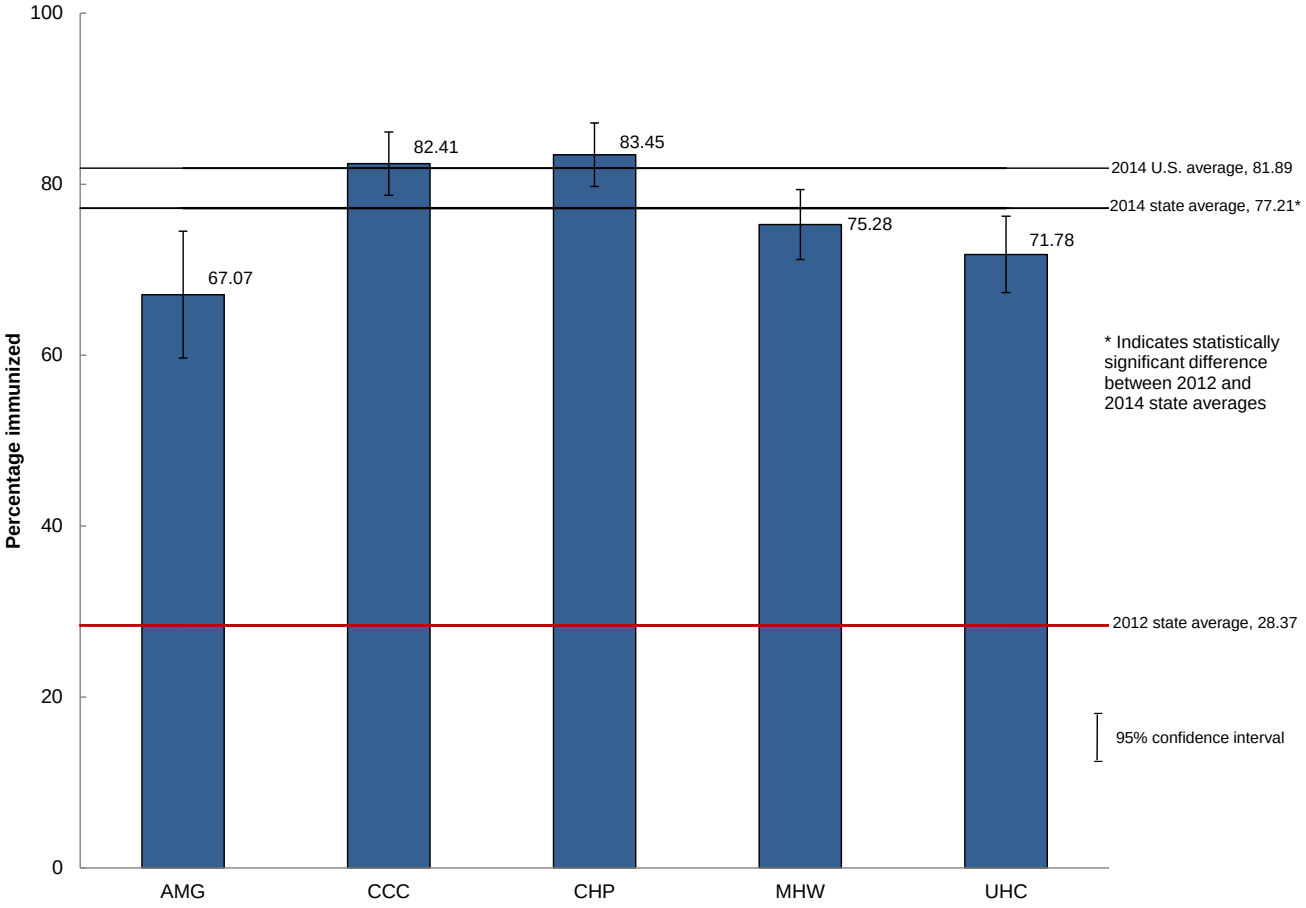

Figure 9. Hep A immunizations by health plan, reporting year 2014.

Rotavirus

Similar to the trend for Hep A, the 2014 statewide average rotavirus immunization rate (65.37%) was significantly higher than the 2012 statewide rate, yet significantly below the U.S. average (see Figure 10). CHP's rate (70.80%) was significantly higher than the state average, while AMG's rate (53.89%) was significantly below average.

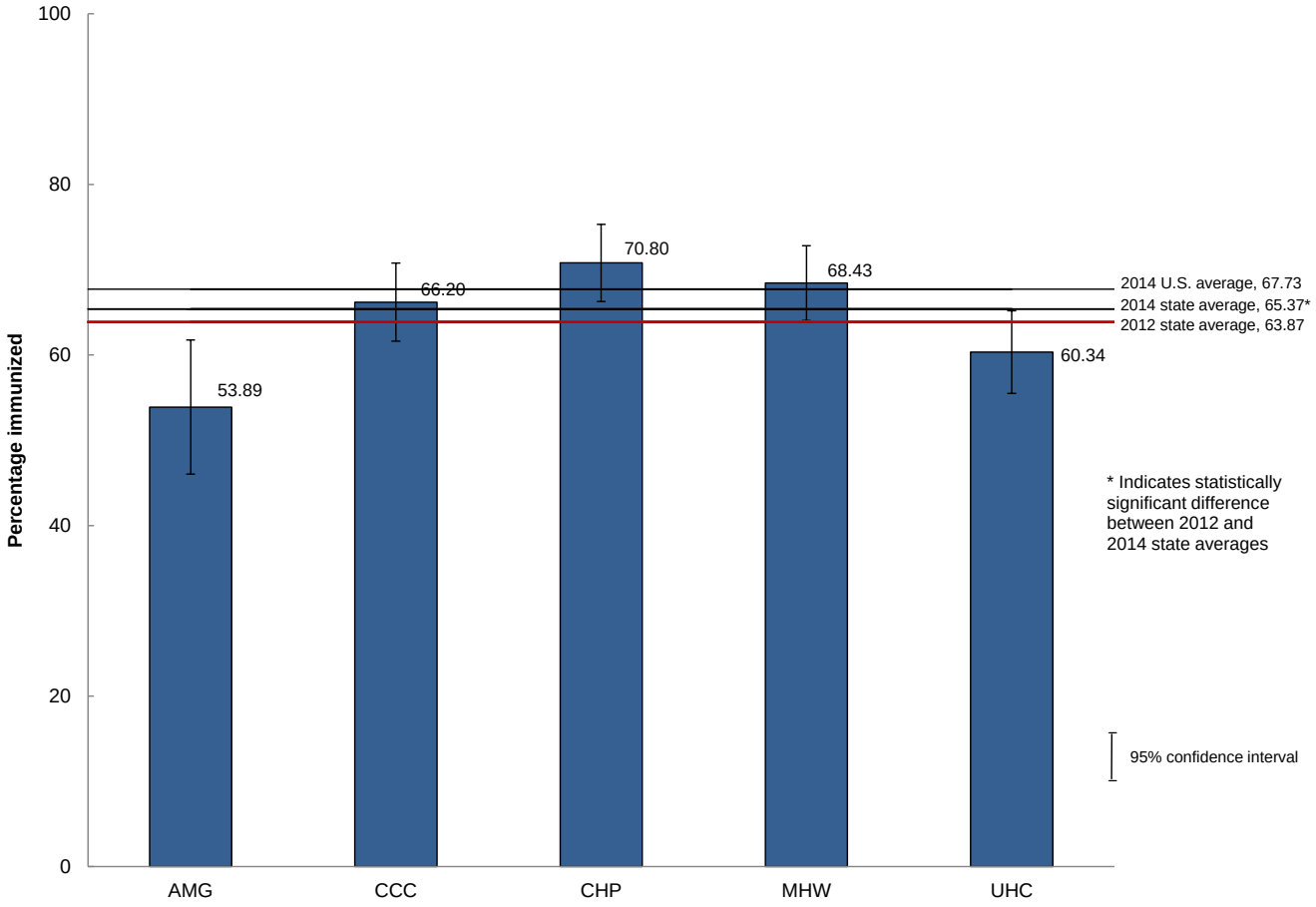

Figure 10. Rotavirus immunizations by health plan, reporting year 2014.

Influenza

The 2014 statewide average influenza immunization rate rose significantly from 2012 to 2014, reaching 53.84% (see Figure 11) and significantly outperforming the U.S. average of 50.00%. AMG's rate (38.92%) was significantly lower than the state average.

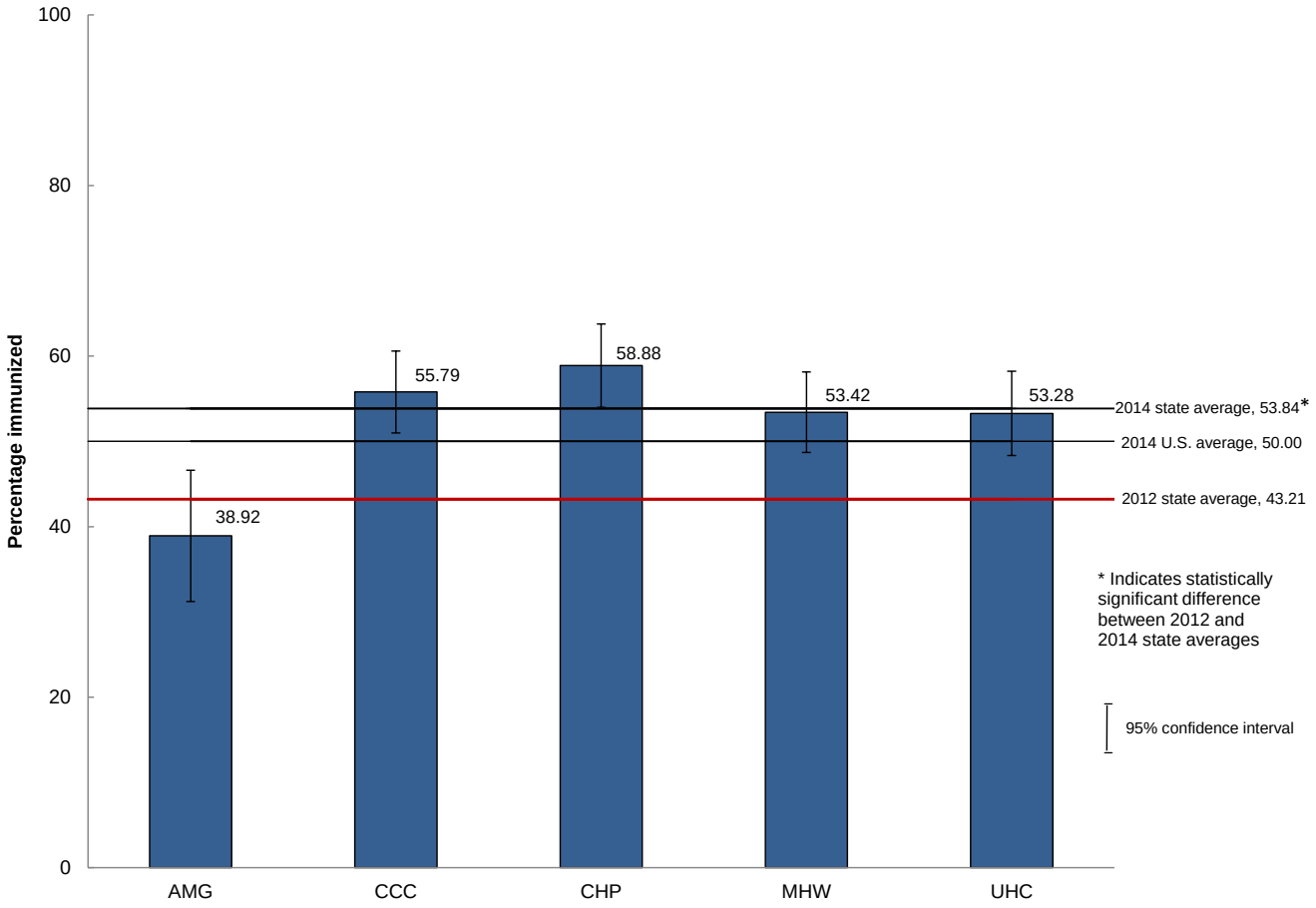

Figure 11. Influenza immunizations by health plan, reporting year 2014.

Childhood Combination #2 (Combo 2)

The Combo 2 indicator measures the percentage of children who received the following numbers of specific vaccinations on schedule:

- four DTaP
- three IPV
- one MMR
- three HiB
- three Hep B
- one VZV

As shown in Figure 12, Combo 2 rates among the Washington MCOs averaged 65.96% in 2014, significantly lower than the 2012 state average and significantly lower than the U.S. average. CHP significantly outperformed the state average with a rate of 76.89%, while the rates for AMG and UHC were significantly below average.

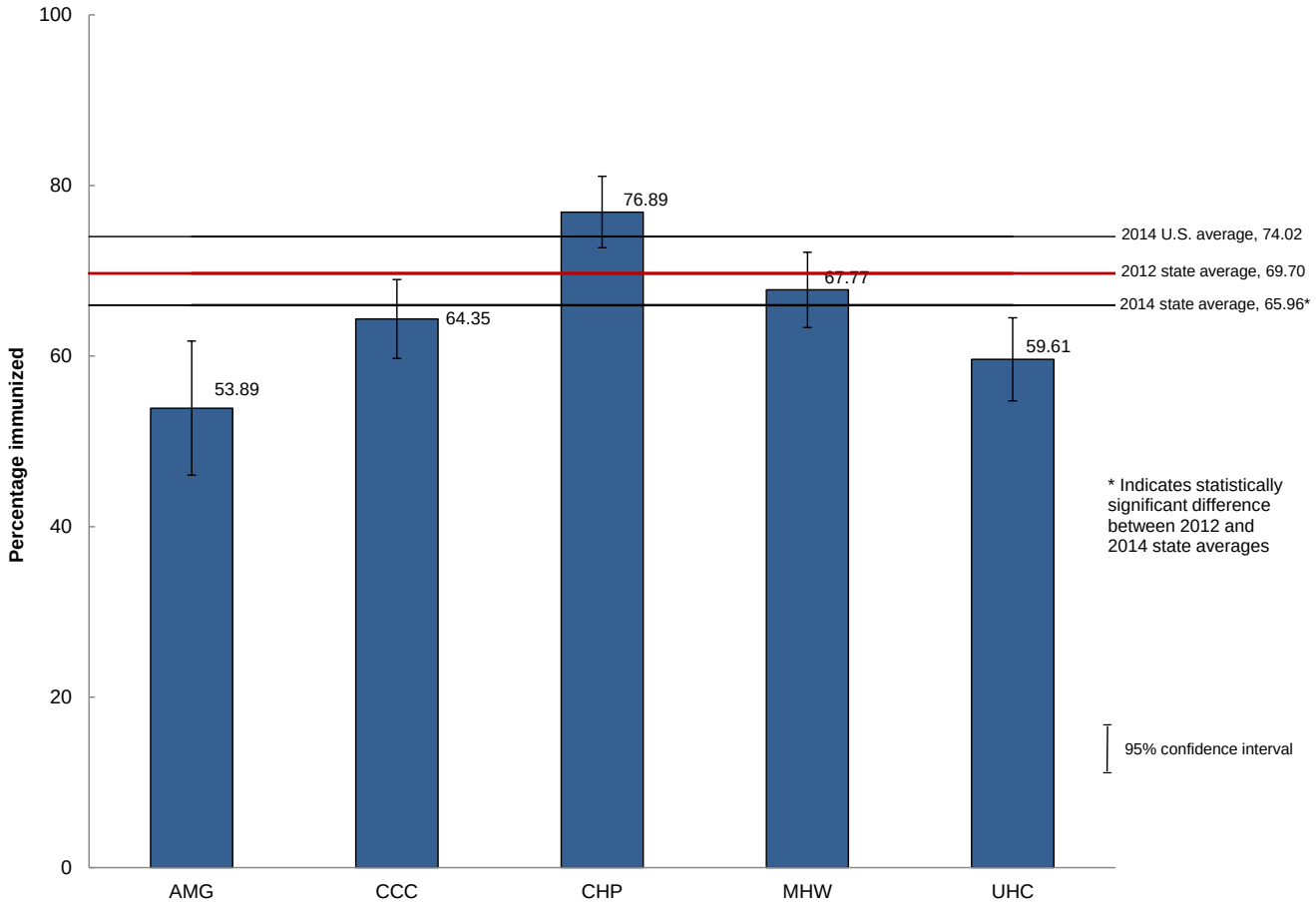

Figure 12. Combo 2 immunizations by health plan, reporting year 2014.

Childhood Combination #3 (Combo 3)

Figure 13 displays 2014 results for the Combo 3 indicator, which measures the percentage of children who received the following numbers of specific vaccinations on schedule:

- four DTaP
- three IPV
- one MMR
- three HiB
- three Hep B
- one VZV
- four PCV

The 2014 state average (62.59%) was down significantly from 2012, and significantly lower than the 2014 U.S. average. CHP significantly outperformed the state average, while AMG's rate was significantly below average.

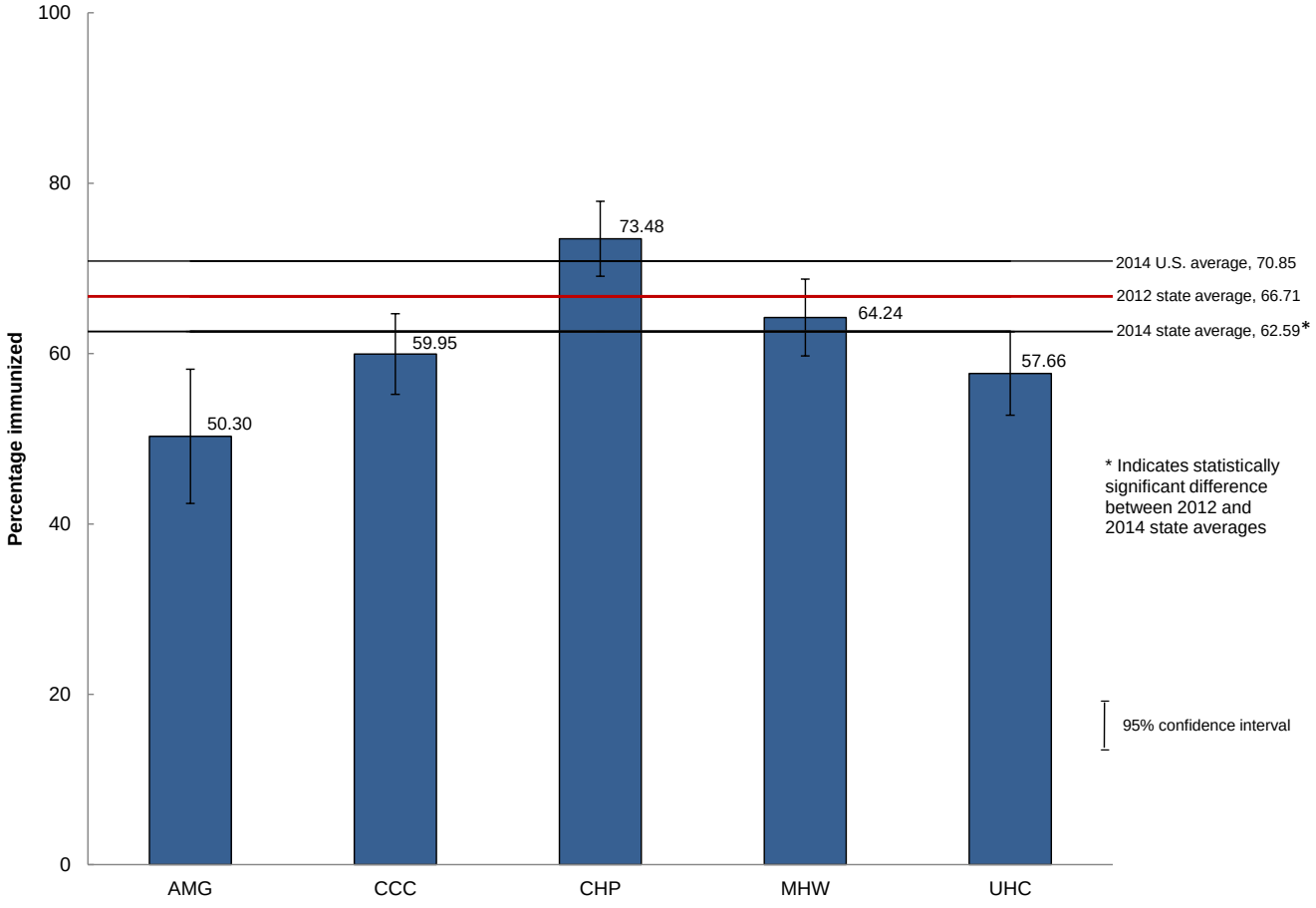

Figure 13. Combo 3 immunizations by health plan, reporting year 2014.

Adolescent immunization rates

HCA required the Washington MCOs to report three measures of immunization for adolescents for the first time in 2014. Results are displayed on this page and the following two pages.

Meningococcal Conjugate Vaccine

This vaccine protects against some of the bacteria that cause meningococcal disease, which can cause brain damage, hearing loss, learning disabilities, and even death. The Centers for Disease Control and Prevention (CDC) recommends vaccination for all preteens at age 11 or 12 and a booster shot for teens at age 16. Teens who received the vaccine for the first time at age 13–15 need a one-time booster dose at 16–18 years of age.[6]

As shown in Figure 14, the 2014 immunization rates among Washington MCOs averaged 67.41%, significantly below the national average. CCC and CHP significantly outperformed the statewide average with rates above 72%, while AMG's rate of 55.38% was significantly below average.

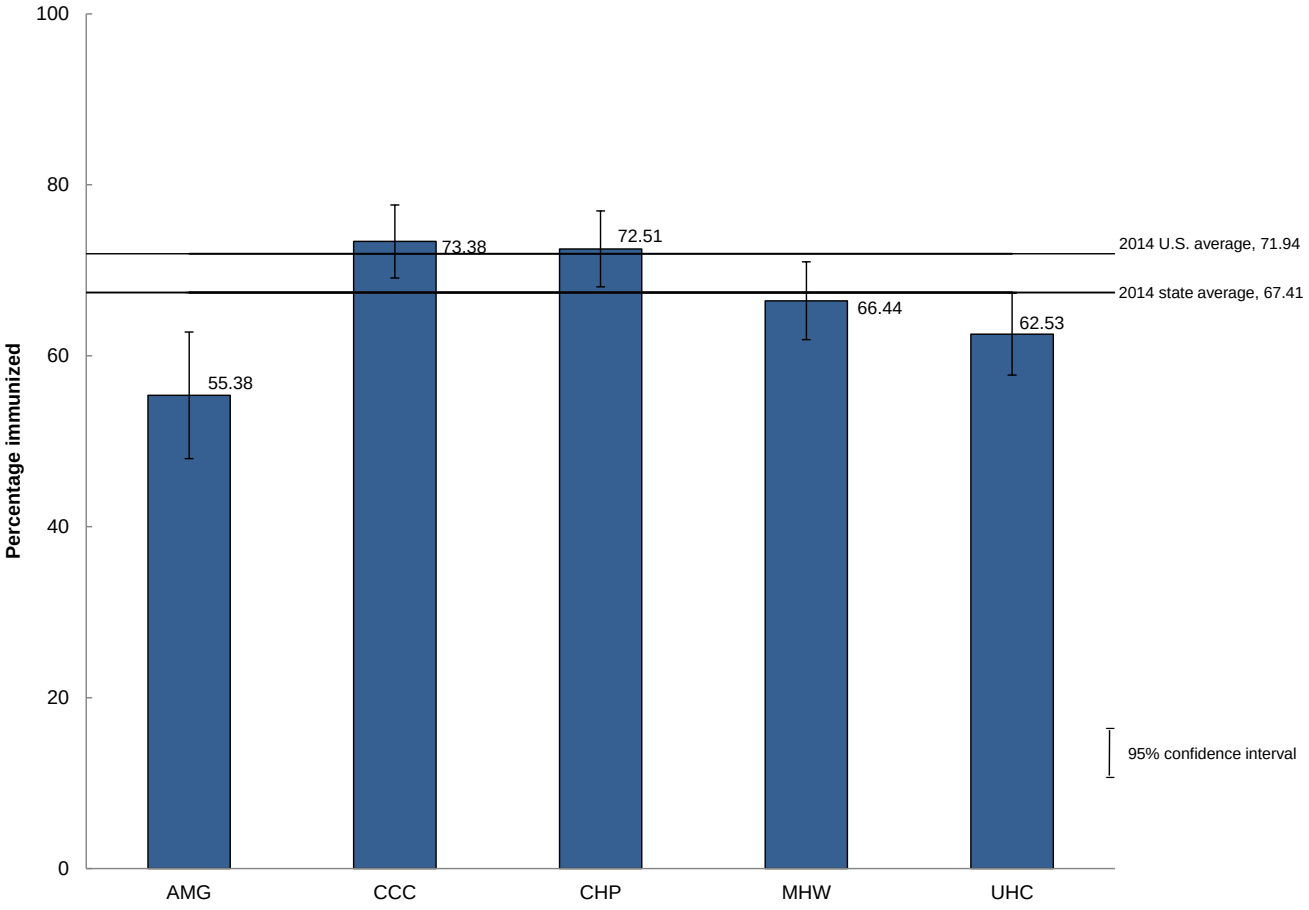

Figure 14. Adolescent meningococcal immunizations by health plan, reporting year 2014.

Tetanus, Diphtheria, and Pertussis (Tdap)

The Tdap booster shot helps protect preteens and teens from the same diseases that DTaP shots protect younger children from. The CDC recommends that all preteens receive one Tdap shot when they are 11 or 12 years old.[7]

Figure 15 shows the 2014 immunization rates by MCO, averaging 83.97%, nearly identical to the U.S. average. CCC and CHP significantly outperformed the statewide average with rates between 88% and 89%, while UHC's rate of 74.21% was significantly below average.

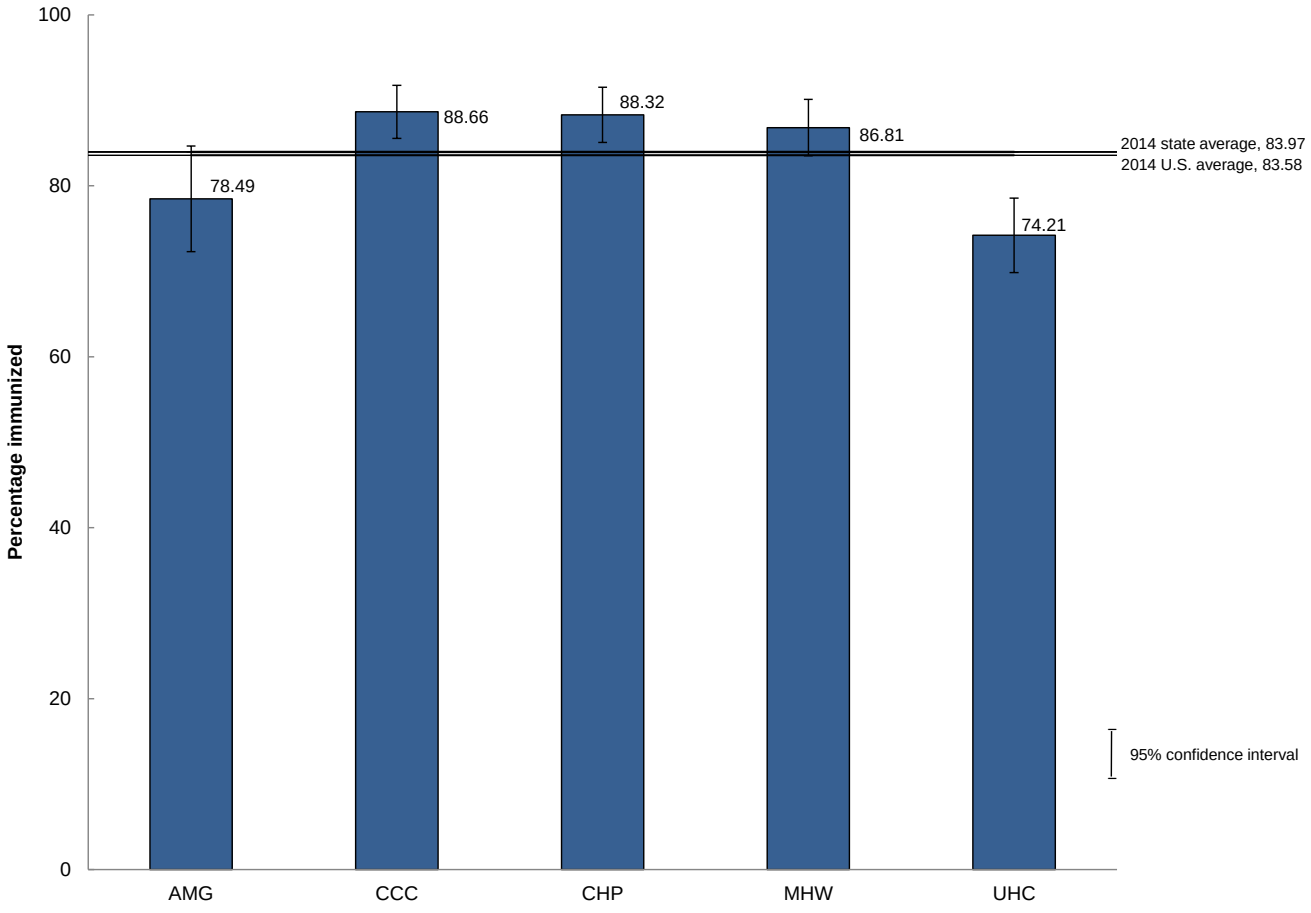

Figure 15. Adolescent Tdap immunizations by health plan, reporting year 2014.

Adolescent Combination #1 (Combo 1)

The Combo 1 measure represents the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine *and* one Tdap vaccine or one tetanus, diphtheria toxoids (Td) vaccine by their 13th birthday.

Figure 16 shows the 2014 immunization rates by MCO, averaging 65.44%, significantly lower than the U.S. average. CHP's rate (71.29%) was significantly higher than the statewide average, while AMG's rate (54.84%) was significantly below average.

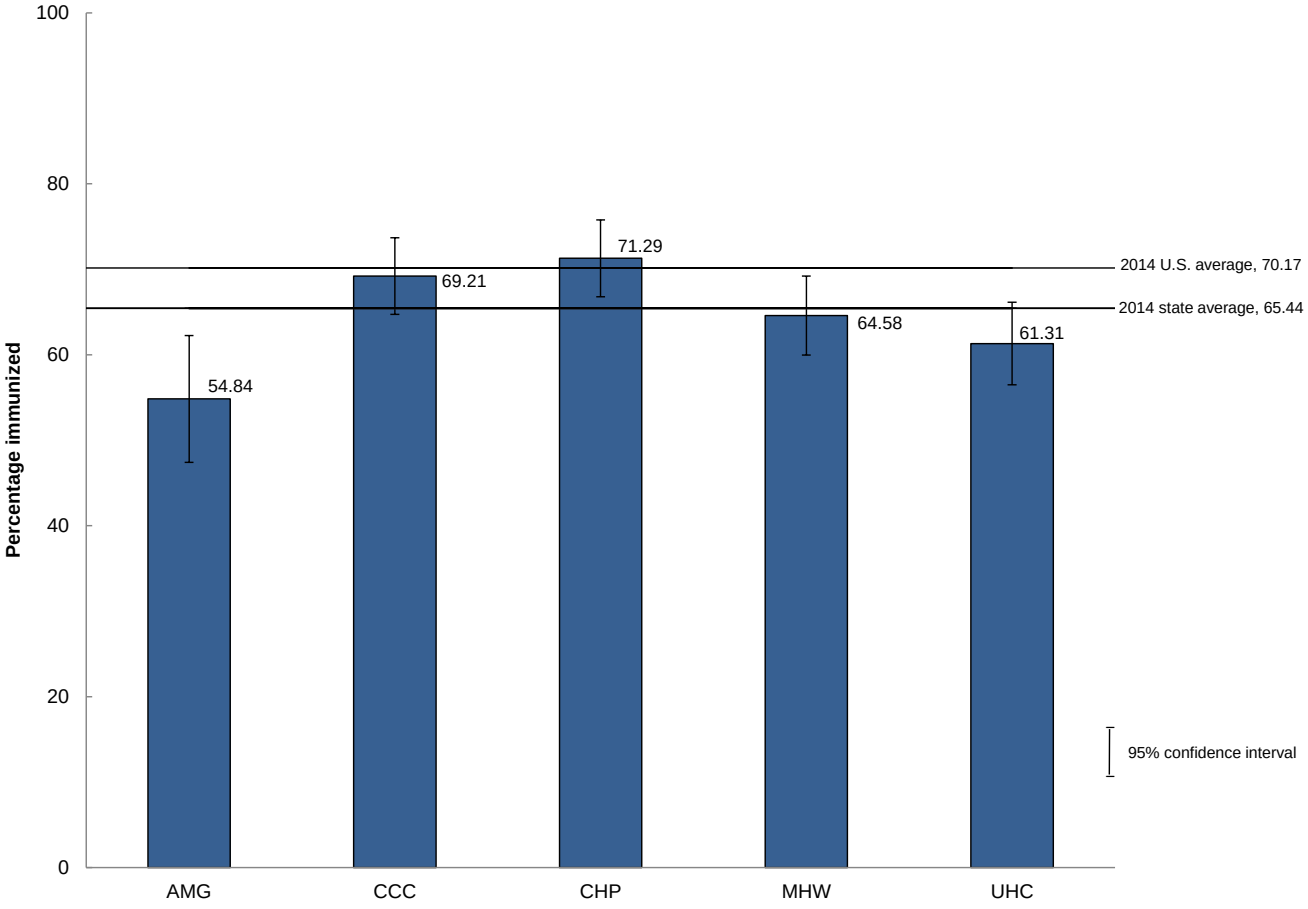

Figure 16. Adolescent Combo 1 immunizations by health plan, reporting year 2014.

Discussion

Childhood immunization measures show different trends depending on how long HCA has required the measures to be reported.

- For the seven antigens in Combo 3, which the MCOs have reported for many years, the statewide average immunization rates in 2014 are uniformly lower than in 2012, and significantly below the U.S. average rates. Statewide average immunization rates for these antigens peaked most recently in 2010.
- For the Hep A, rotavirus, and influenza vaccines, first reported in 2010, statewide average immunization rates continue to rise. (The marked increase for Hep A, from an average 28% in 2012 to an average 77% in 2014, appears to be due in large part to a change in the dosing requirements, from two doses to one.) Although the statewide rates for Hep A and rotavirus are still significantly below the U.S. average rates, the statewide influenza immunization rate significantly exceeded the U.S. rate.
- The Washington MCOs reported three measures of adolescent immunizations for the first time in 2014. The statewide average immunization rates for the meningococcal conjugate vaccine and for Combo 1 were significantly lower than the U.S. average rates. However, the average Tdap immunization rate for the Washington MCOs was nearly identical to the U.S. average rate.

Among MCOs, CHP remains the top performer for immunizations, followed by MHW and CCC. AMG and UHC reported the poorest results in 2014, often significantly below the state average.

"Herd immunity" exists when a group resists attack by a disease because a large percentage of individuals are immune, though outbreaks of disease can and do occur even when a high level of herd immunity is reached.[8] Given that the statewide average immunization rates for Medicaid managed care enrollees are below 90% for all vaccines—and below 80% for many—the MCOs need to continue to seek ways to improve their immunization rates.

The CDC has ranked Washington among states with the highest percentage of exemptions from school vaccination requirements.[9] State law (ESB 5005, enacted in 2011) now requires a parent or guardian who seeks an exemption to obtain a note from a health care practitioner, stating that the parent or guardian has been informed of the benefits and risks of immunization. DOH has worked closely with schools, preschools, and child care staff to inform parents about the change to the exemption law and to provide support for parents to make informed decisions about immunizations. Exemption rates for kindergarteners dropped after the law went into effect, from 6.0% in the 2010–2011 school year to 4.5% in the 2011–2012 school year. The rate remained steady at 4.6% in school year 2013–2014.

DOH's Washington State Immunization Information System (formerly called Child Profile) remains a highly positive force for improving immunization rates. About 99% of all vaccination providers in the state participate in the registry, which now contains 8.1 million active patient records and 86 million immunizations.

Comprehensive Diabetes Care

HCA requires the MCOs to report nine indicators of comprehensive diabetes care, as defined below. NCQA introduced a new indicator of blood pressure control <140/80 mm Hg in 2011, and the MCOs reported this new indicator to HCA for the second year in 2012.

Measure definition

This measure assesses the percentage of enrollees with diabetes (type 1 or type 2), ages 18–75, who were continuously enrolled during the measurement year and who had:

- Hemoglobin A1c (HbA1c) level tested
- poor control of HbA1c levels (HbA1c > 9.0%)
- good control of HbA1c levels (HbA1c < 8.0%)
- lipid profile (LDL-C screening) performed during the measurement year
- LDL-C levels controlled (<100 mg/dL)
- dilated retinal exam during, or prior to, the measurement year*
- monitoring for nephropathy (kidney disease) through screening for microalbuminuria, medical attention for nephropathy, a visit to a nephrologist, a positive macroalbuminuria test, or evidence of ACE inhibitor/ARB therapy
- blood pressure control (<140/90 mm Hg) for the most recent blood pressure reading
- blood pressure control (<140/80 mm Hg) for the most recent blood pressure reading

Data collection method: Administrative or hybrid

*Dilated retinal exams performed prior to the measurement year must meet the following criteria for inclusion:
- the dilated retinal exam had a negative outcome (no evidence of retinopathy)
- the enrollee was not prescribed or dispensed insulin during the measurement year

Annual HbA1c test

Blood sugar testing showed significant improvement in 2014, as 86.27% of eligible MCO enrollees across the state received HbA1c tests (see Figure 17). The statewide testing rate in 2014 was significantly higher than the U.S. average rate. CHP's rate (91.79%) significantly exceeded the statewide average and was within the NCQA 90th percentile, while AMG's rate (81.64%) was significantly below average.

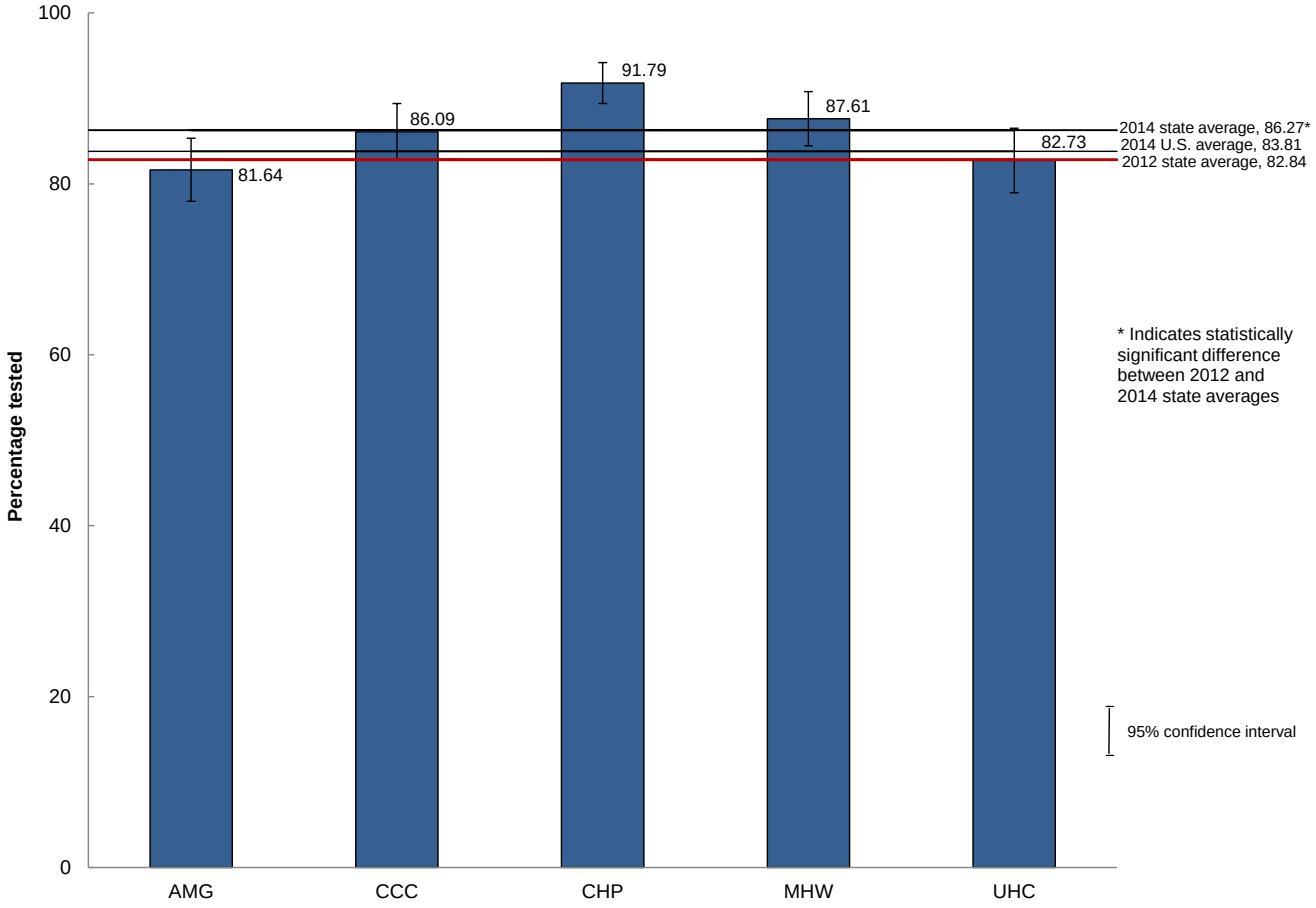

Figure 17. Annual HbA1c tests by health plan, reporting year 2014.

Poor HbA1c control (> 9.0%)
Good HbA1c control (< 8.0%)

HbA1c control levels (Figures 18 and 19) varied widely among MCOs in 2014, as in previous years. The statewide trends are discouraging, as the percentage of enrollees with poor control continues to increase while the percentage of those with good control declines. In 2014, the statewide average of enrollees with poor control (53.25%) was significantly higher than in 2012, and significantly higher than the U.S. average.

Among MCOs, almost 88% of UHC enrollees had poor control of HbA1c levels—significantly higher (i.e., worse) than the statewide average. In contrast, CHP and MHW enrollees fared significantly better than average on this indicator.

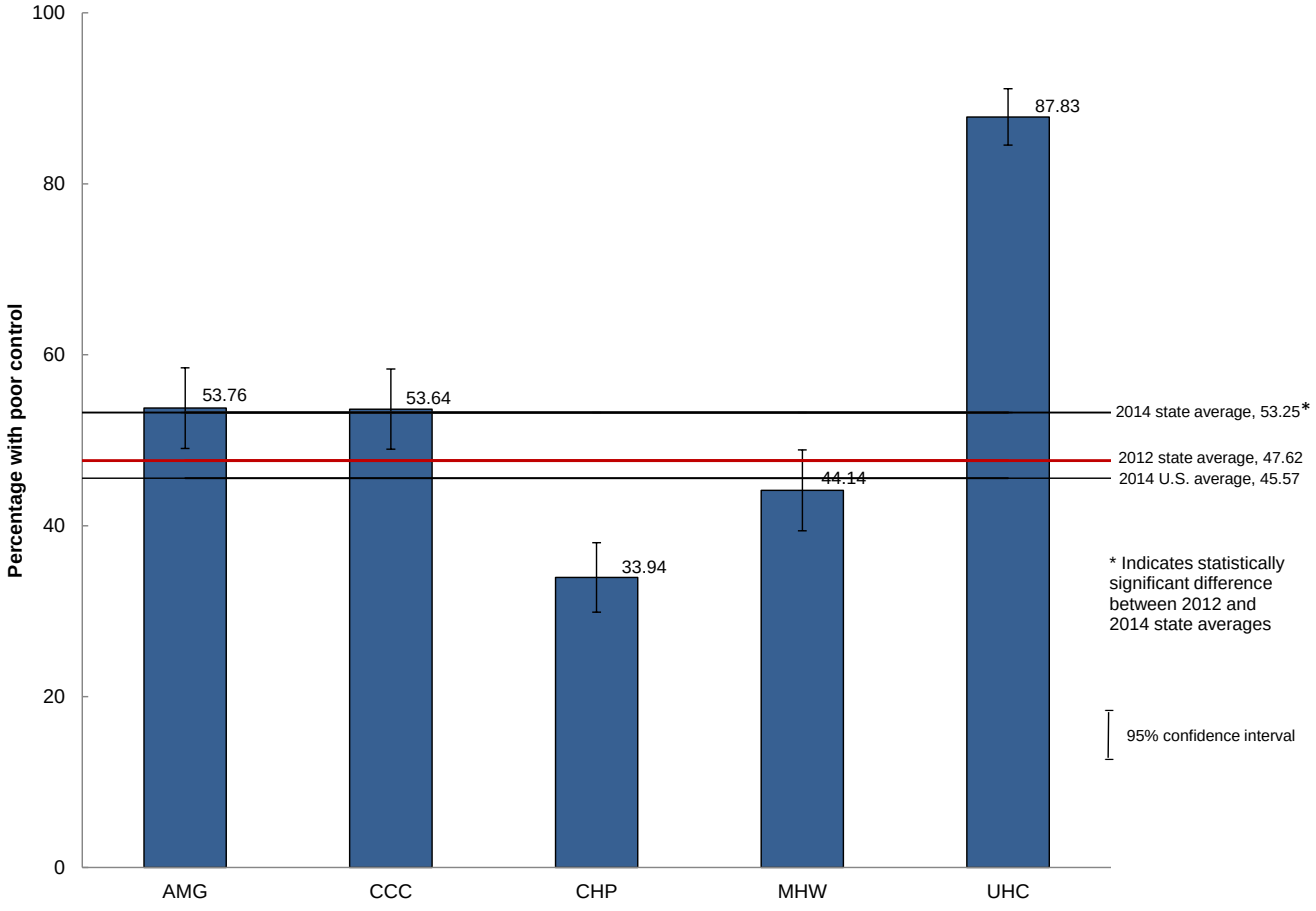

Figure 18. Enrollees with poor control of HbA1c levels by health plan, reporting year 2014.

Only about 11% of UHC enrollees had good control of their HbA1c levels, significantly below the statewide average, while CHP and MHW enrollees were significantly above average. The 2014 statewide average of enrollees with good control (39.64%) was significantly lower than the U.S. average.

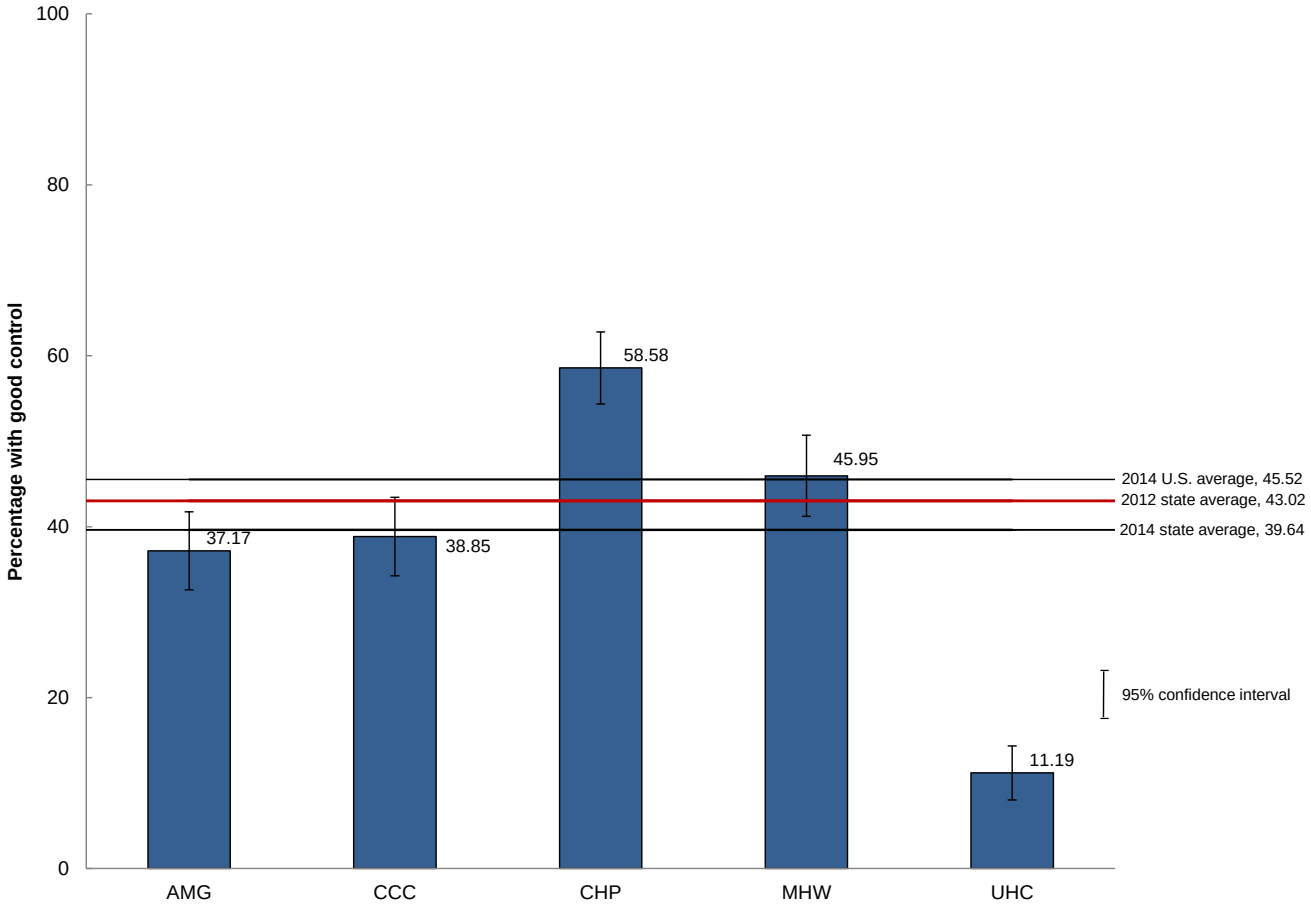

Figure 19. Enrollees with good control of HbA1c levels by health plan, reporting year 2014.

Eye exam

Delivery of dilated retinal exams (Figure 20) followed a trend of significant decline in 2014. Only 46.06% of MCO enrollees across the state received these exams, although CHP and MHW reported significantly better results. The statewide rate was significantly lower than the U.S. average rate. Exam rates for AMG and UHC were significantly below the state average.

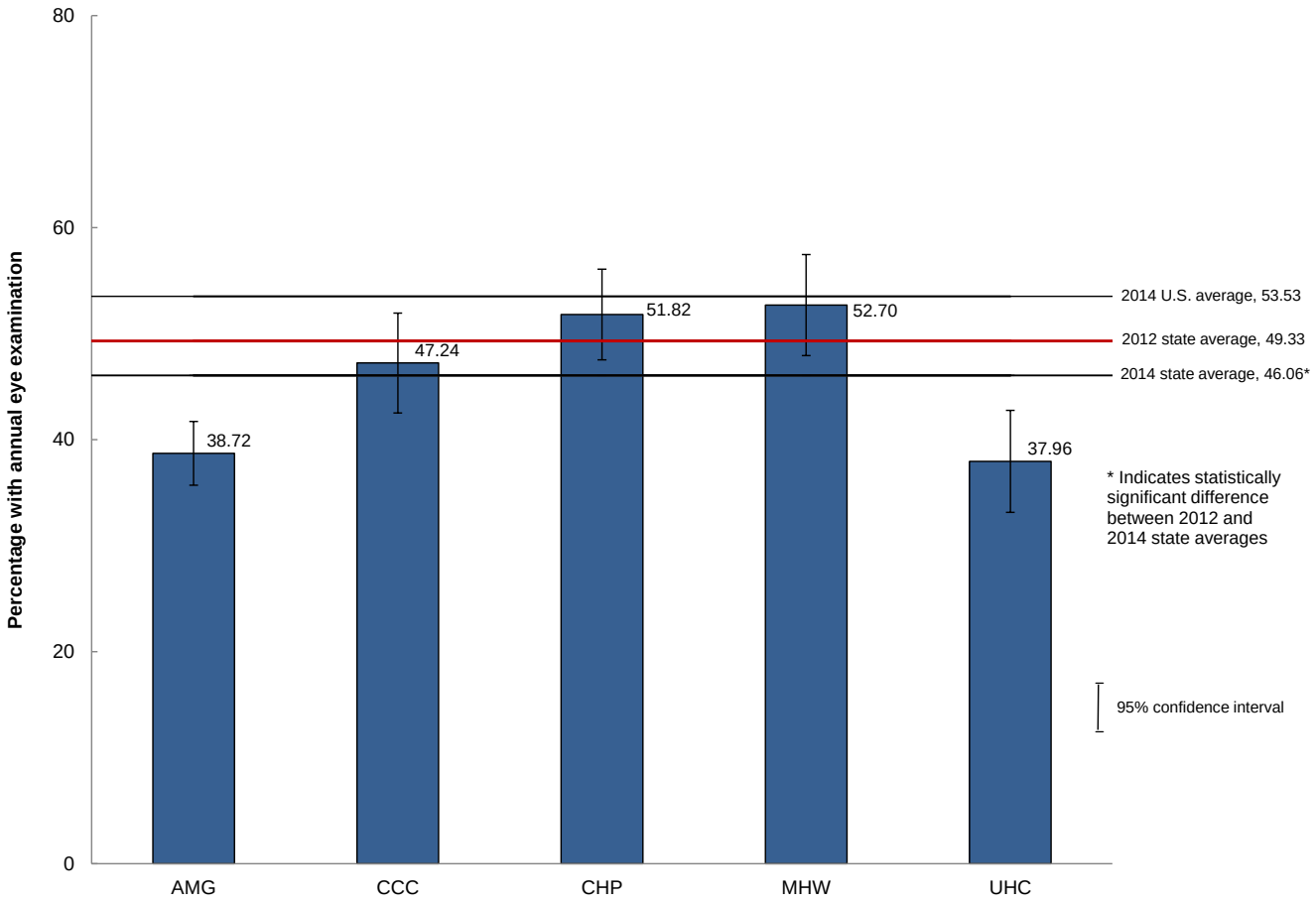

Figure 20. Dilated retinal exams by health plan, reporting year 2014.

LDL-C screening

LDL-C screening (Figure 21) occurred for 71.97% of MCO enrollees in the measurement year, with relatively little variation among health plans. The statewide average showed significant improvement from 2012, yet remained significantly below the U.S. average rate.

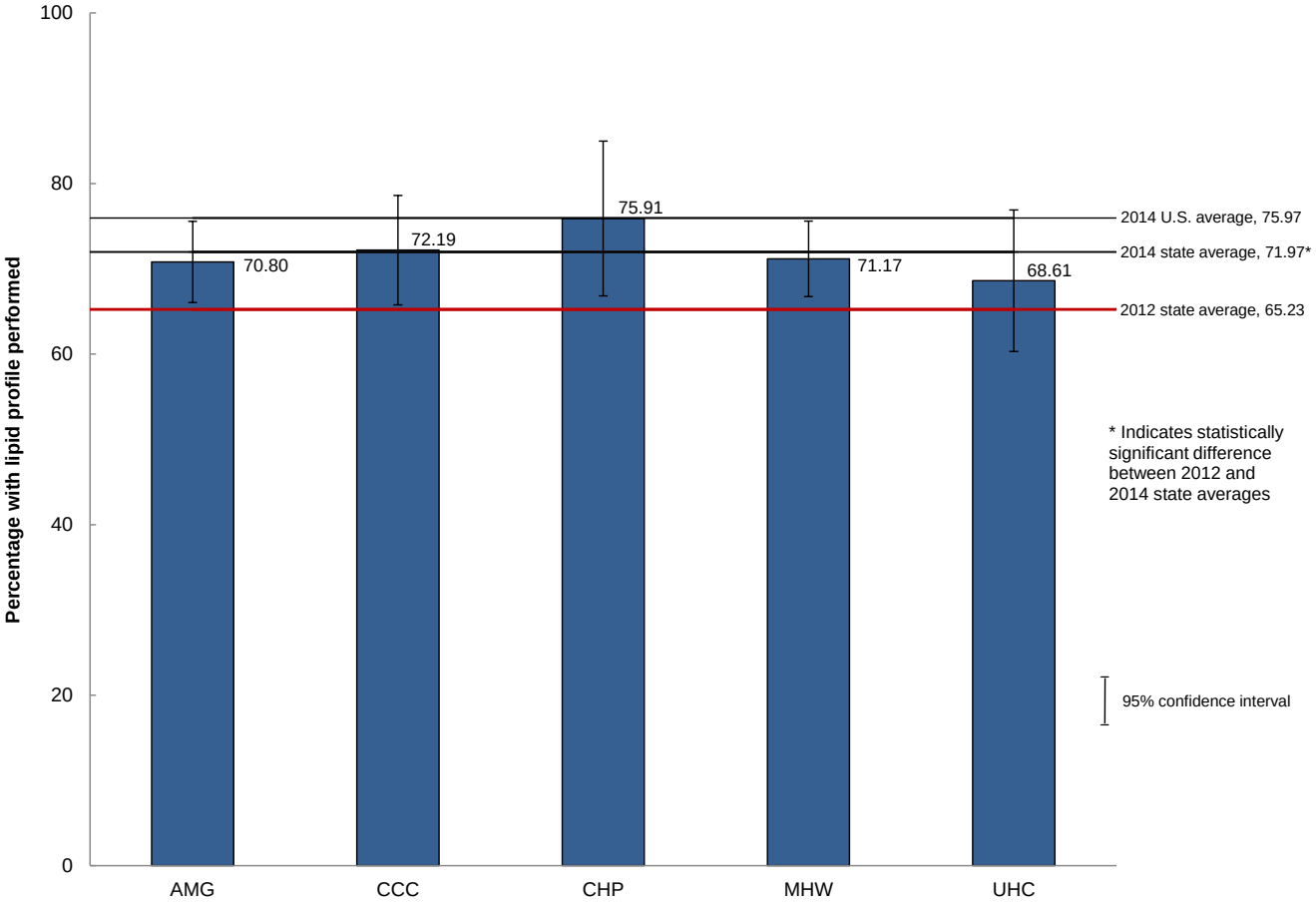

Figure 21. Lipid profile (LDL-C screening) performed by health plan, reporting year 2014.

LDL-C level <100 mg/dL

As shown in Figure 22, about 26% of eligible enrollees had their lipids under control in 2014, a significant improvement over 2012, yet still well below the U.S. average. The rate for CHP enrollees (34.31%) significantly exceeded the statewide average. In contrast, only about 10% of UHC enrollees met the standard.

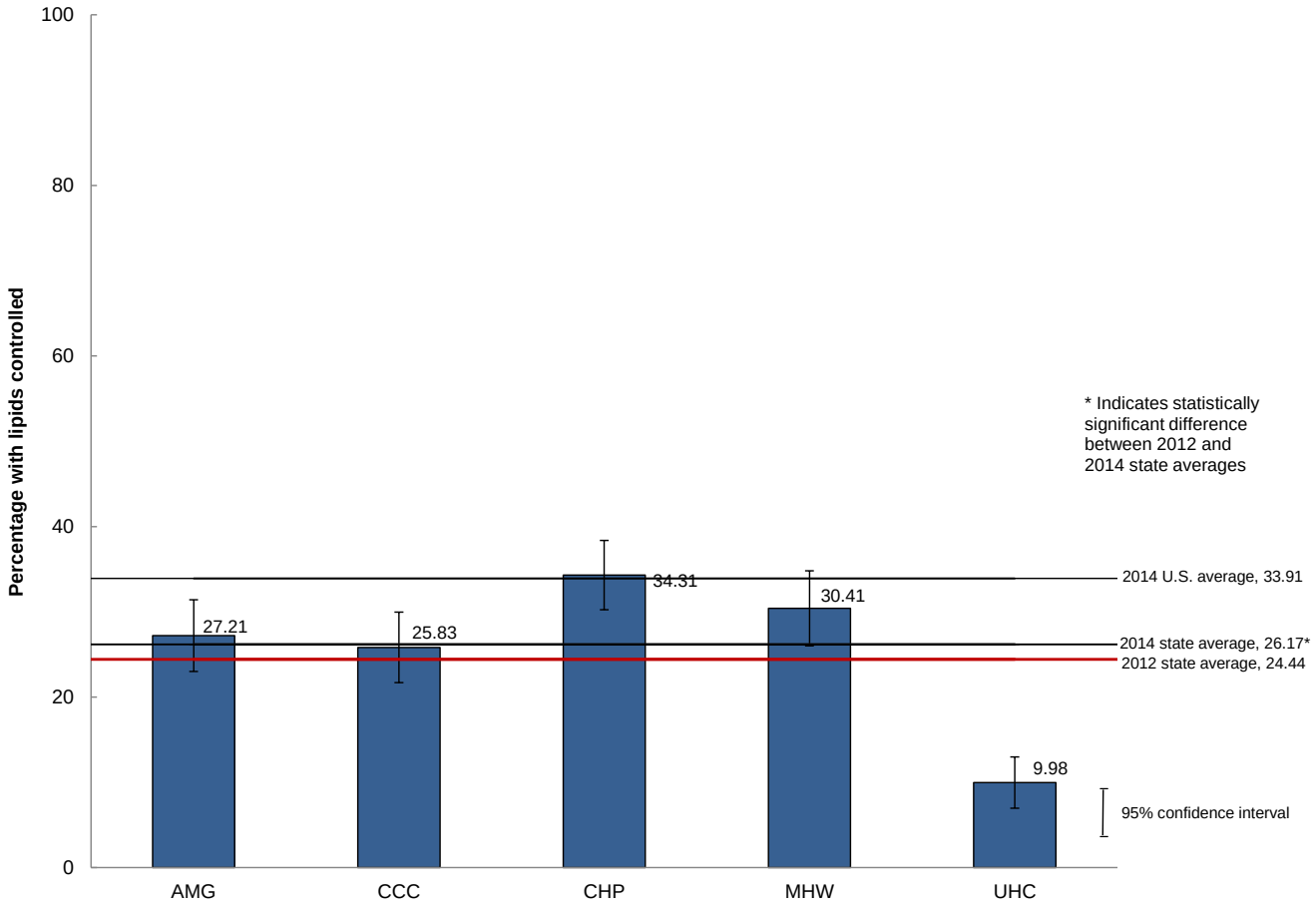

Figure 22. Lipids controlled (<100mg/dL) by health plan, reporting year 2014.

Monitoring for diabetic nephropathy

Nephropathy monitoring (Figure 23) occurred for almost 80% of MCO enrollees in the measurement year, with little variation among health plans. The 2014 statewide average showed significant improvement from 2012, and was nearly identical to the U.S. average.

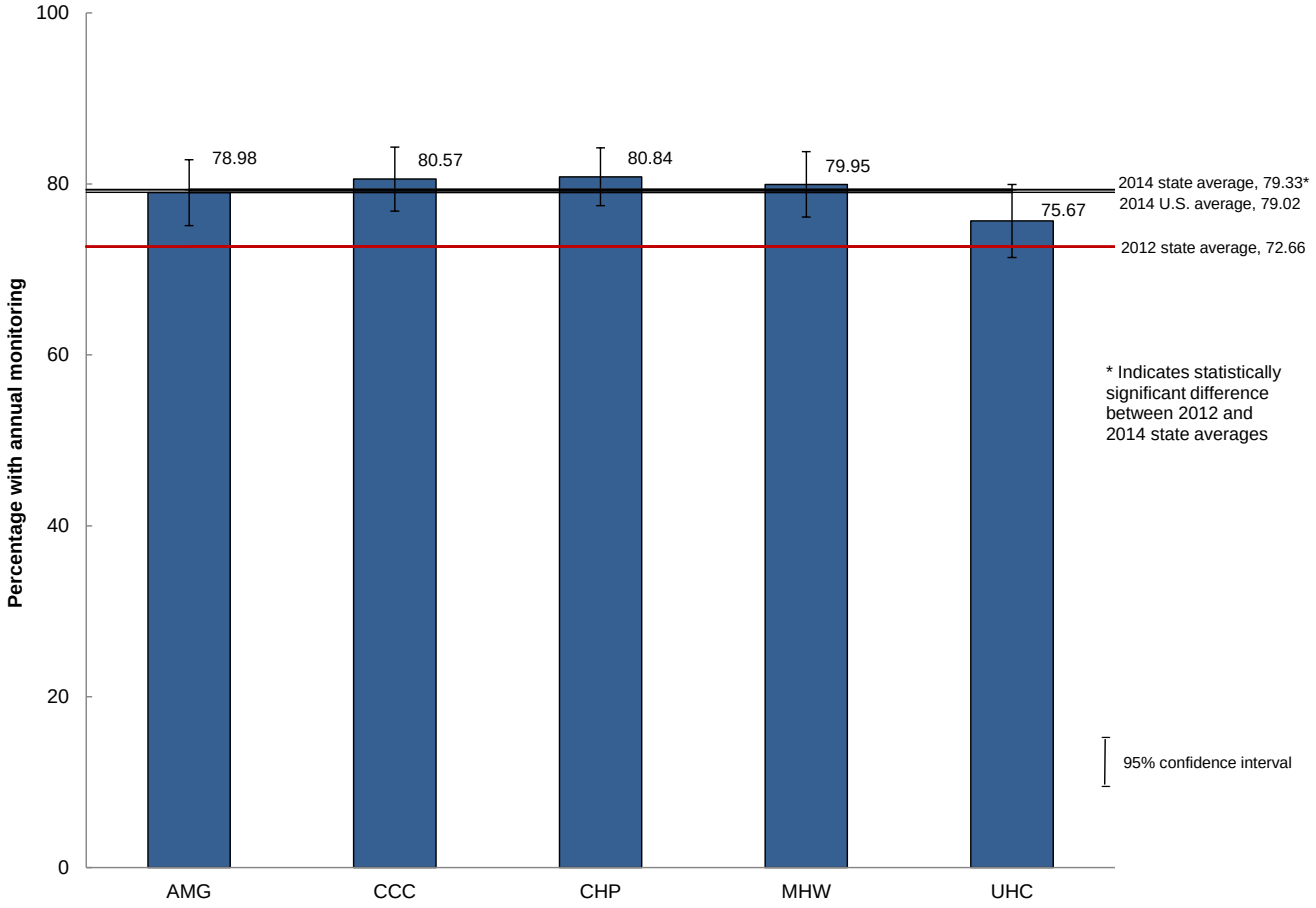

Figure 23. Nephropathy monitored annually by health plan, reporting year 2014.

Blood pressure control (<140/90 mm Hg)

The percentage of MCO enrollees with blood pressure controlled at this level fell significantly in 2014, to 53.25%, significantly below the U.S. average (Figure 24). In 2012 and previous years, the Washington MCOs outperformed the U.S. Medicaid average for this indicator. Individual MCO results varied substantially in 2014, with CHP, MHW, and CCC significantly exceeding the state average while only 11% of UHC enrollees met the standard.

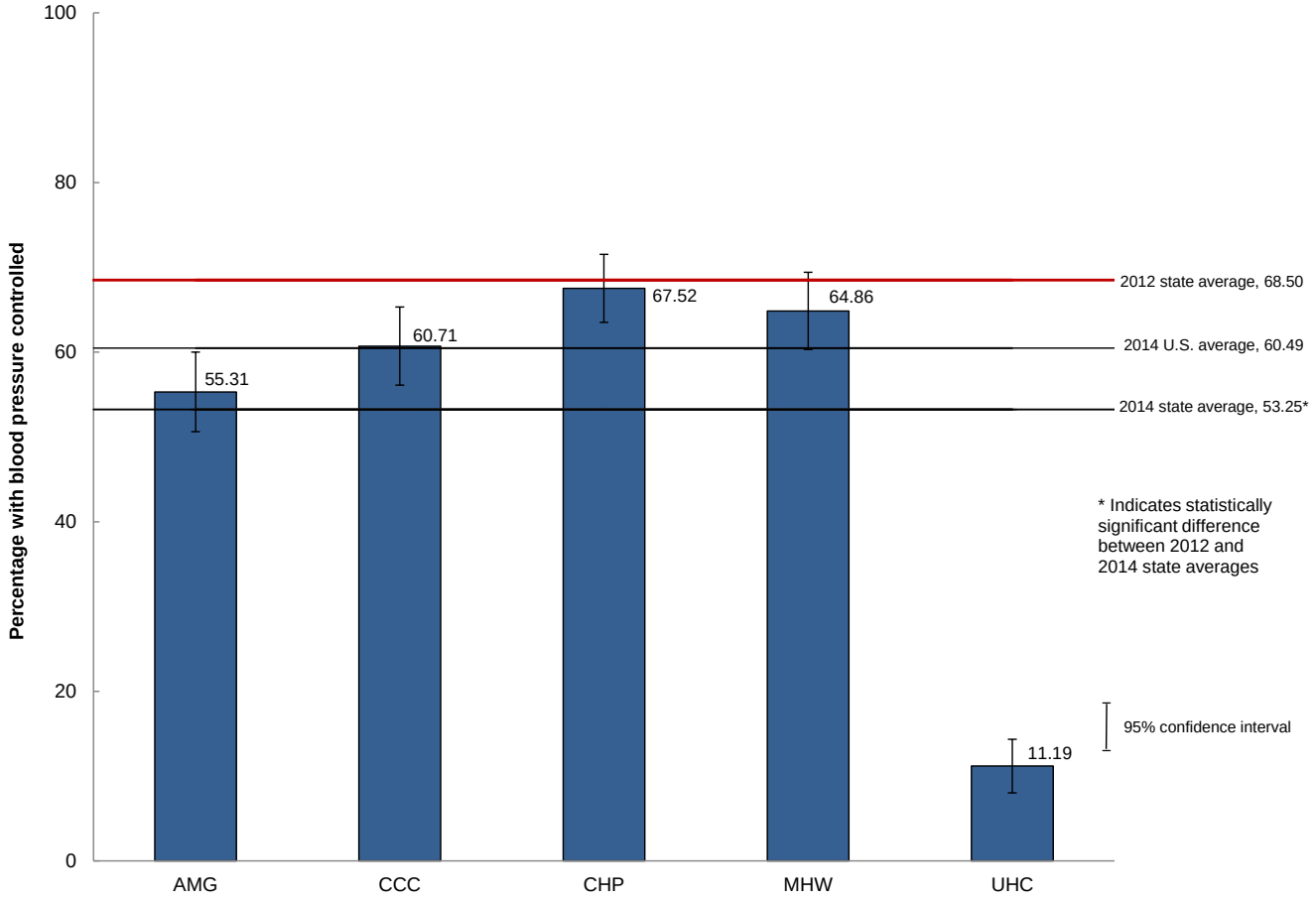

Figure 24. Blood pressure controlled (<140/90 mm Hg) by health plan, reporting year 2014.

Blood pressure control (<140/80 mm Hg)

On average, only 35.49% of Washington MCO enrollees had their blood pressure controlled at this level, a significant decline from 2012 and significantly below the U.S. average (Figure 25). The magnitude of the overall decline was due mainly to UHC's reported rate of 6.57%, as CHP and MHW significantly exceeded the statewide average.

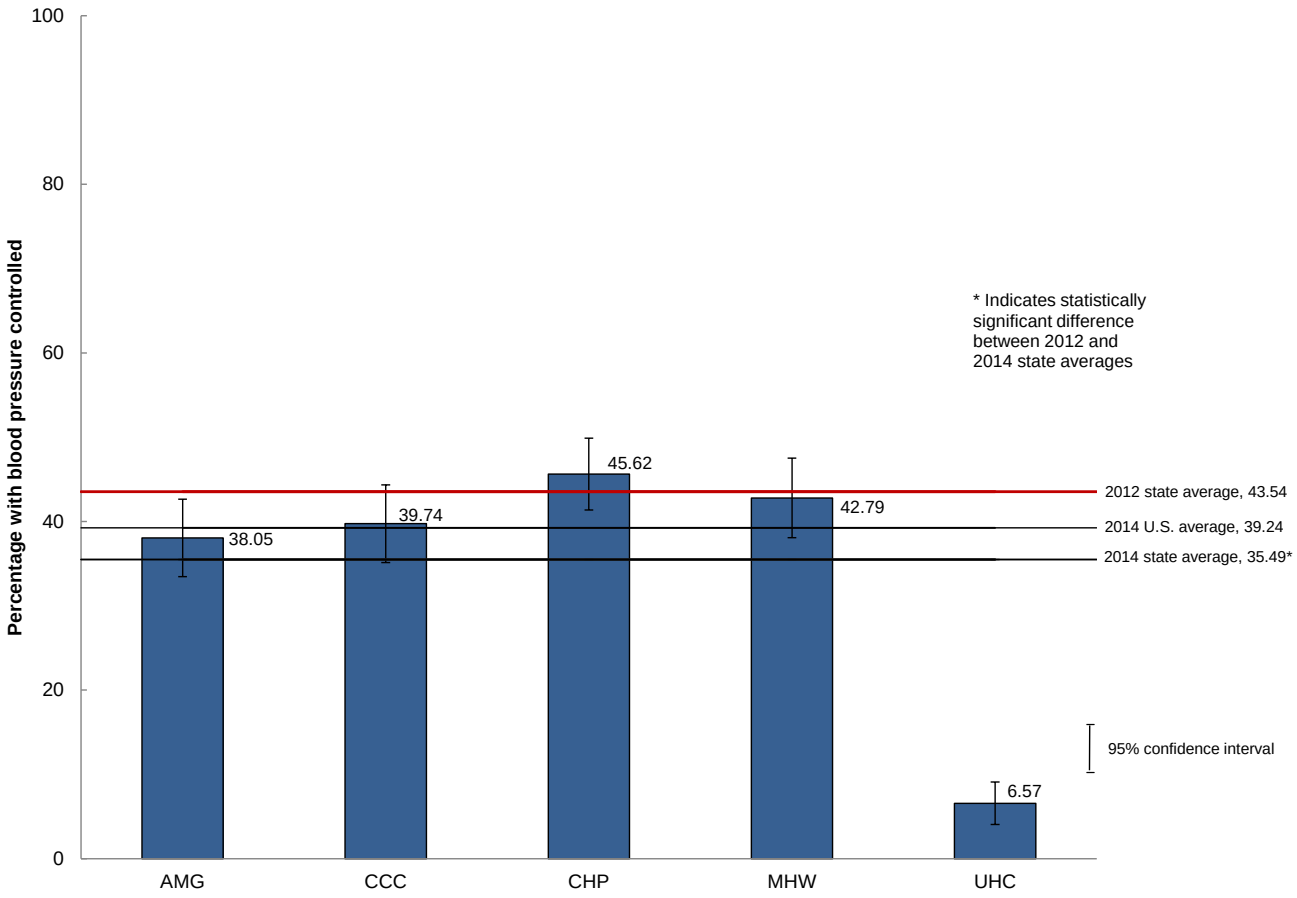

Figure 25. Blood pressure controlled (<140/80 mm Hg) by health plan, reporting year 2014.

Discussion

Performance on the diabetes care indicators showed mixed results in 2014, the first year of reporting by three new MCO contractors. Delivery of preventive screening generally increased from 2012 (except for a significant decline in delivery of dilated retinal exams), as did the overall percentage of enrollees with LDL-C levels under control. At the same time, the percentage of enrollees with acceptable HbA1c levels continued to fall, and the percentage of those with good control of their blood pressure declined markedly.

The current roster of MCOs significantly underperformed relative to the national Medicaid averages on six of the nine indicators. Notably, fewer than 40% of Washington's managed care enrollees with diabetes have good control of their blood-sugar levels. More positively, the statewide rate of HbA1c testing was significantly higher than the U.S. average rate, and the statewide rate of monitoring for diabetic nephropathy improved significantly from 2012.

CHP and MHW, the more established MCOs, generally outperformed the statewide average, as did CCC. However, UHC's generally poor performance on these indicators tended to weigh down the overall group performance.

Some of the variability in MCO performance may reflect disparate levels of data completeness for various indicators, limiting the ability to make valid comparisons among health plans. Individual MCOs need to conduct drill-down analyses of patient-level data, and review their systems for recording and collecting data used to report performance measures, to determine whether their reported rates reflect actual performance or data completeness.

Well-Child Care Visits

HCA requires the MCOs to report WCC visit rates for young Medicaid enrollees in three age brackets, as defined below. For the infant category, Acumentra Health breaks out rates according to the number of visits in the first 15 months, from 0 to 6+.

Measure definitions

HEDIS measures evaluate the success of health plans in providing well-child services by assessing the percentage of Medicaid children with the recommended number of

- well-child visits in the first 15 months of life: the percentage of enrolled children who turned 15 months old during the measurement year, were continuously enrolled in the plan from 31 days and received between zero and six or more well-child visits with a PCP in their first 15 months of life
- well-child visits in the 3rd, 4th, 5th, and 6th years of life: the percentage of enrolled children who were between three and six years old during the measurement year, were continuously enrolled for 12 months, and received one or more well-child visits with a PCP during the measurement year
- adolescent well-care visits: the percentage of enrolled adolescents ages 12–21 years during the measurement year who were continuously enrolled for 12 months and had at least one comprehensive well-care visit with a PCP or an obstetrics/gynecology practitioner during the measurement year

Data collection method: Administrative or hybrid

Well-child care in the first 15 months of life

In 2014, 56.25% of infants enrolled with the Washington MCOs received six or more WCC visits, down slightly from 58.09% in 2012, and significantly lower than the U.S. average rate (see Figure 26). MHW outperformed all other MCOs at 67.77%, significantly above the state average, while the rates for AMG and CCC enrollees were significantly below average.

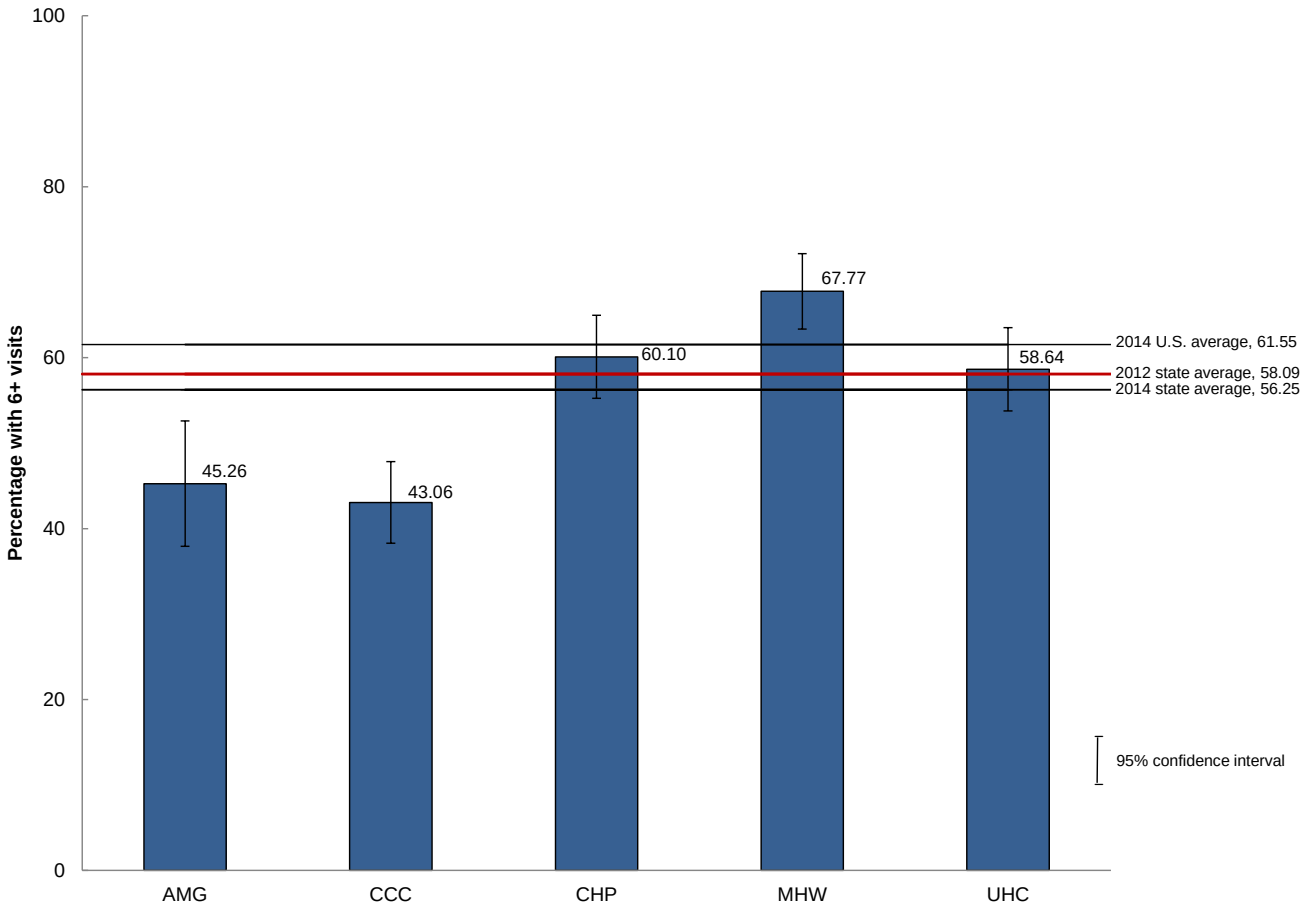

Figure 26. Six or more well-child visits in the first 15 months of life by health plan, reporting year 2014.

Well-child care for children in the 3rd, 4th, 5th, and 6th years of life

The 2014 statewide average visit rate for this age group, 63.84%, was marginally higher than the 2012 average, yet still significantly below the U.S. average (Figure 27). MCOs' performance rates fell within a relatively narrow range, except that AMG's rate of 58.33% was significantly lower than the state average.

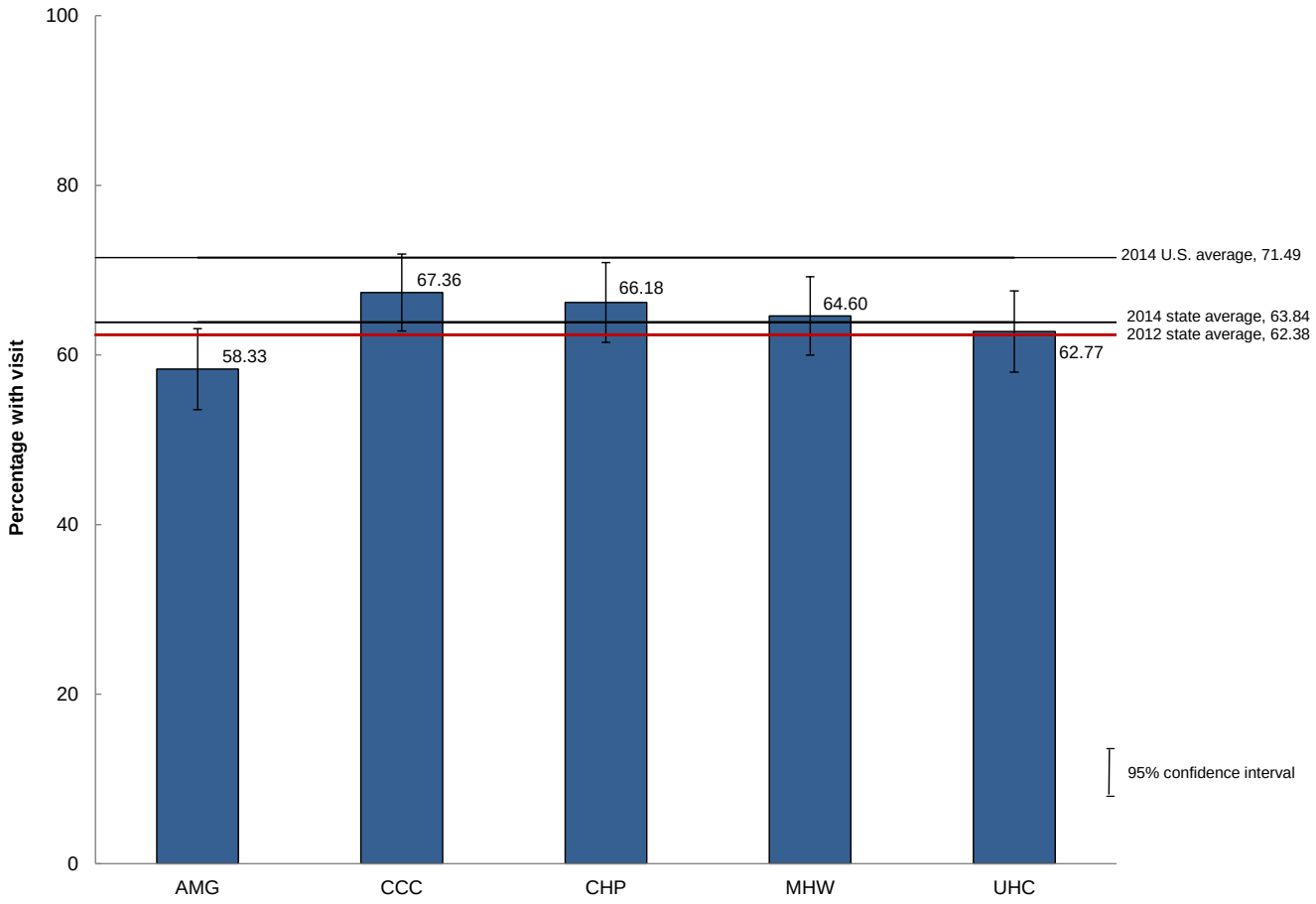

Figure 27. Well-child visits in the 3rd, 4th, 5th, and 6th years of life by health plan, reporting year 2014.

Adolescent well-child care

The statewide average visit rate for adolescents in 2014 (39.13%) was almost identical to the 2012 average, and remained significantly below the U.S. average (Figure 28). MHW significantly outperformed the state average with a rate of 44.37%.

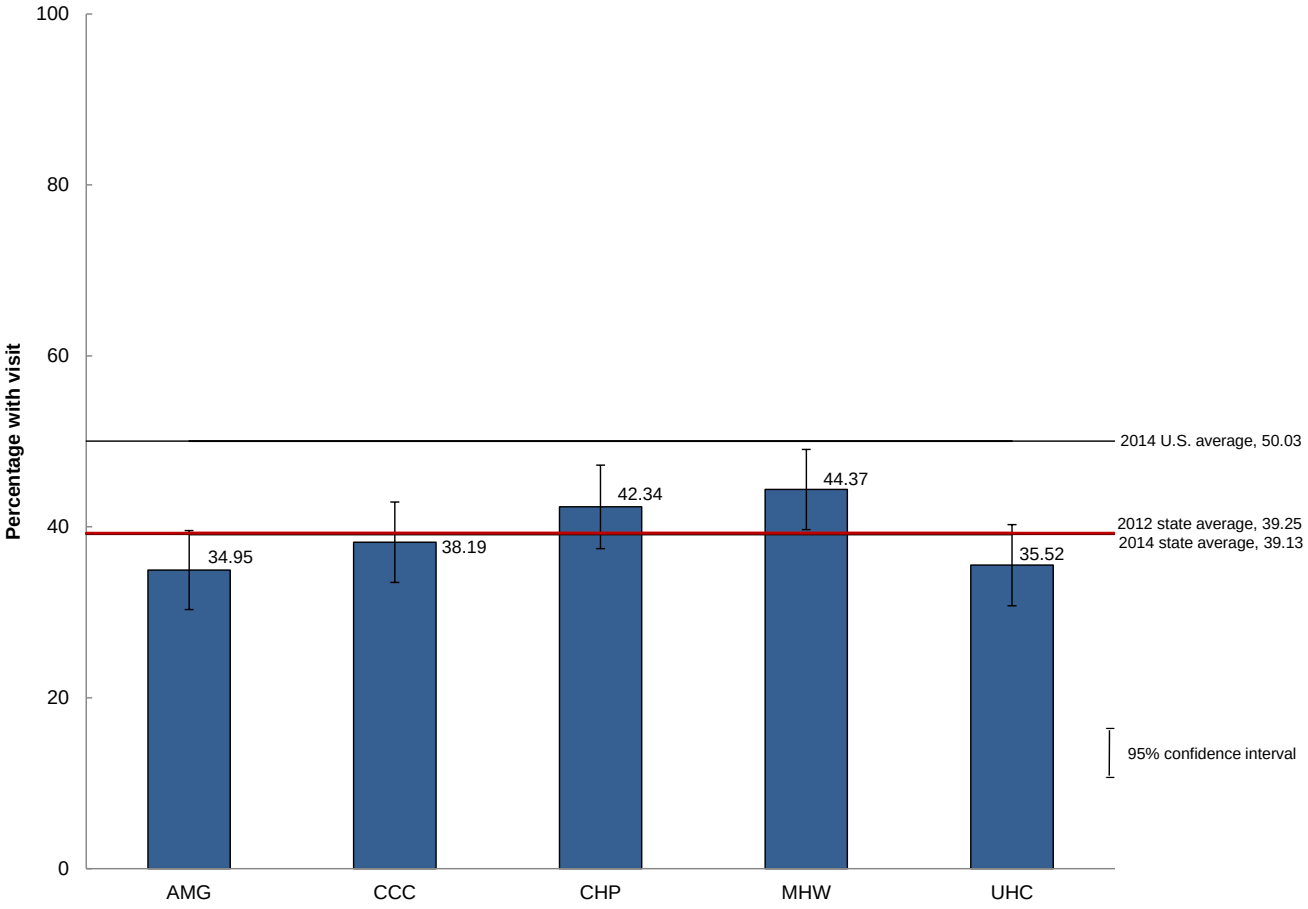

Figure 28. Adolescents ages 12–21 with one or more well-care visits by health plan, reporting year 2014.

Discussion

WCC visit rates reported in 2014 showed little change since the previous measurement in 2012. The Washington MCOs continue to lag behind the national Medicaid performance in providing WCC visits, particularly for older children and adolescents.

If an MCO's WCC visit rates fall below certain NCQA national benchmarks, HCA requires the MCO to conduct a clinical performance improvement project (PIP) designed to increase rates. The benchmarks are:

- WCC visits in the first 15 months, five or more visits: NCQA 75th percentile
- WCC visits in the 3rd, 4th, 5th, and 6th years of life: NCQA 75th percentile
- adolescent well-care visits: NCQA 50th percentile

All MCOs reported that the EPSDT supplemental data file supplied by HCA in 2014 had a positive impact on their well-child measures. Acumentra Health recommends that HCA continue to provide EPSDT supplemental data to aid the MCOs in calculating these measures.

Emergency Room Visits

Measure definition

This measure summarizes emergency room utilization by MCOs during the measurement year, expressed in ER visits per 1000 member months. The numerator includes all ER visits by enrollees that do not result in inpatient encounters, regardless of the intensity or duration of the visit.

In 2014, Medicaid managed care enrollees in Washington averaged 51.64 ER visits per 1000 member months (see Figure 29). This visit rate was significantly higher than in 2013, reversing a trend of declining ER utilization. However, the Washington MCO average remained significantly below the U.S. Medicaid average, as has been the case since 2006.

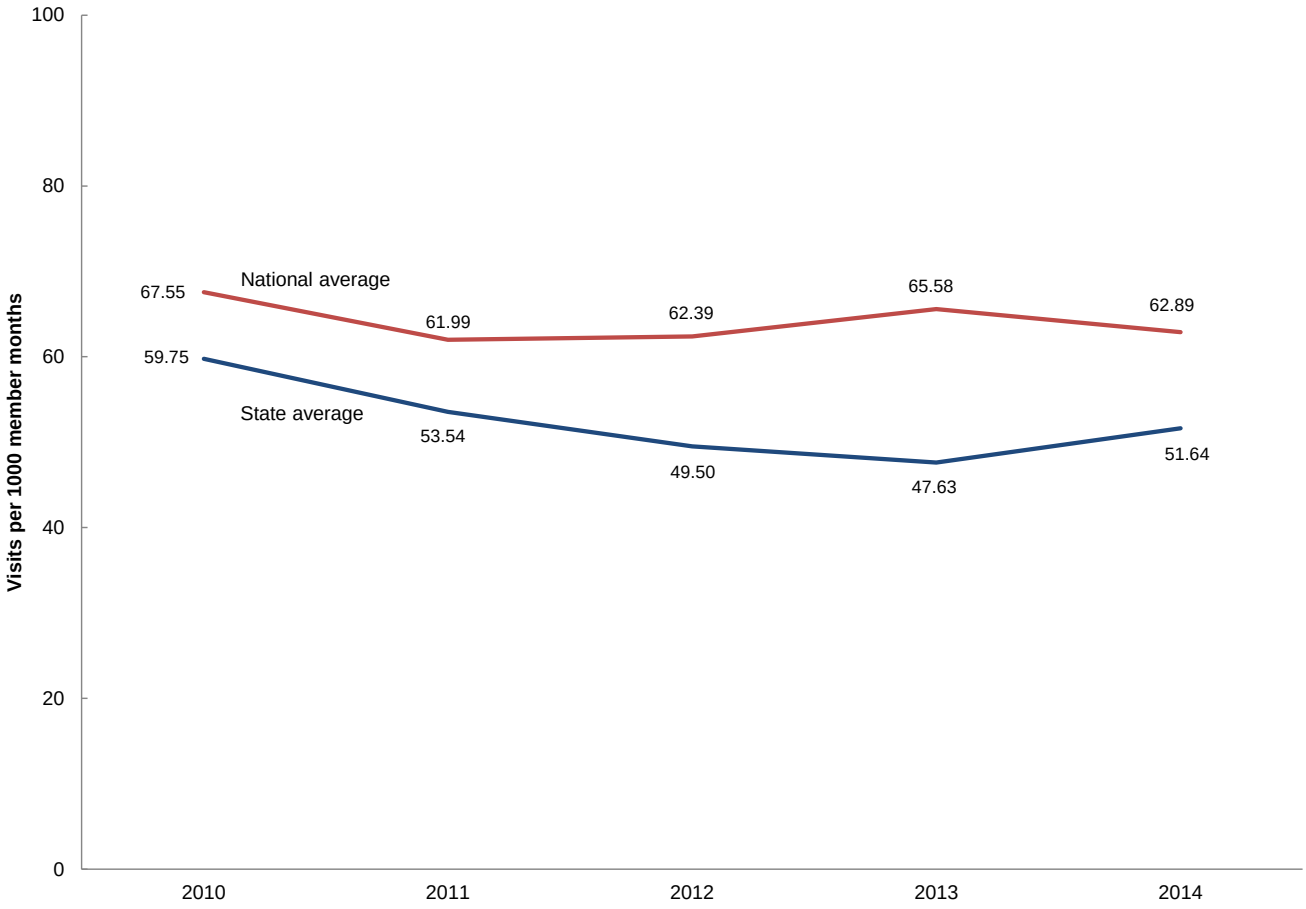

Figure 29. State and national averages for emergency room utilization, reporting years 2010–2014.

As shown in Figure 30 on the next page, ER visit rates varied considerably among the Washington MCOs in 2014. CHP and MHW reported visit rates significantly below the statewide average, while visit rates for AMG, CCC, and UHC were significantly above average. All MCOs' visit rates, however, were significantly higher than in 2013—perhaps because many new enrollees sought care from the ER before they had established relationships with primary care providers in the MCOs' expanding networks.

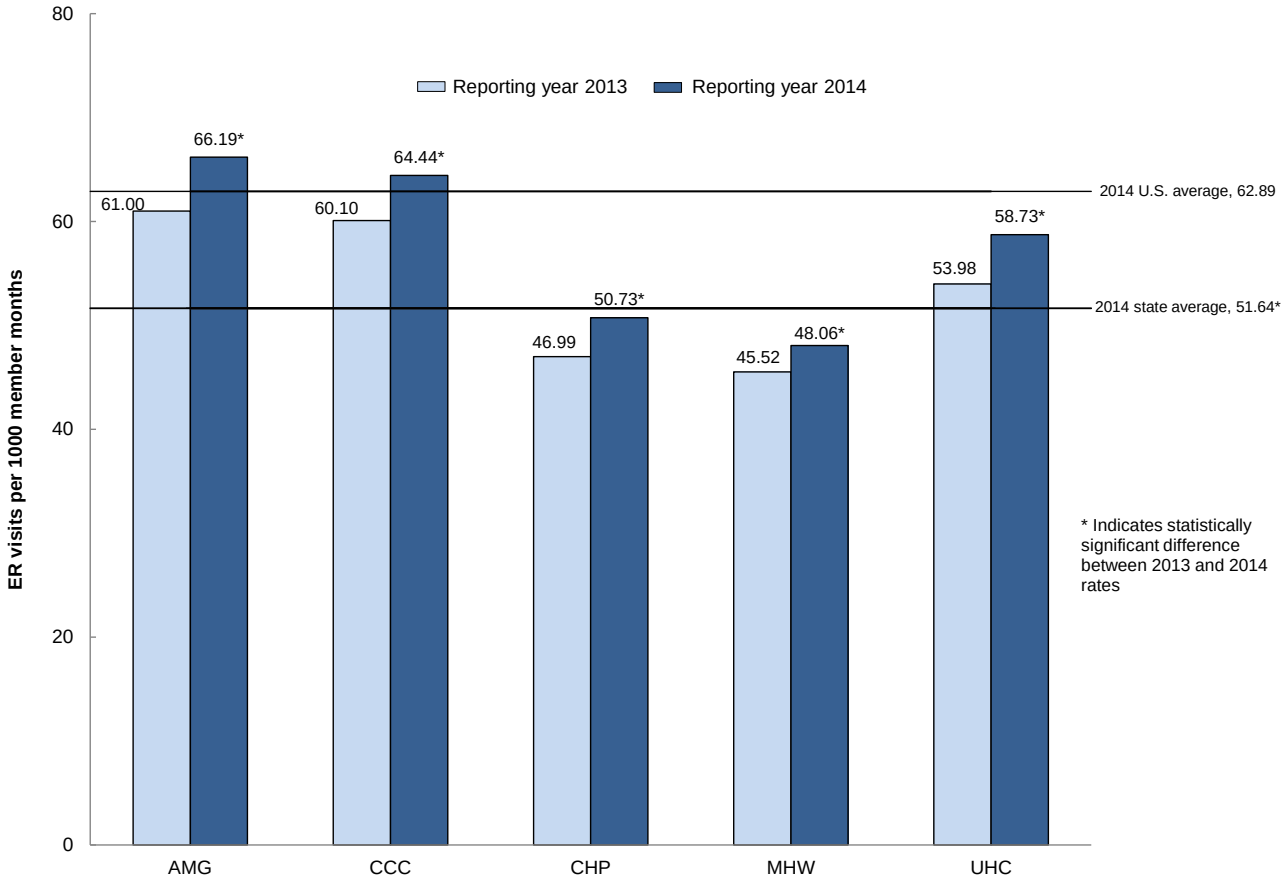

Figure 30. Emergency room visits per 1000 member months by health plan, reporting years 2013–2014.

Discussion

HCA has noted that a relatively small number of clients are responsible for the majority of ER visits, many for conditions that would be treated more appropriately in primary care. In 2012, the state legislature directed HCA to work with stakeholders to develop best practices aimed at reducing non-emergency use of the ER and overutilization of emergency services. The initiative established procedures and systems to refer non-emergency patients to PCPs and to educate all enrollees about appropriate use of the ER.[10] HCA continues to collaborate with the Washington State Hospital Association, the Washington Chapter of the American College of Emergency Room Physicians, and the Washington State Medical Association to expand and enhance the seven best practices for emergency departments. These best practices include patient education, appropriate opioid prescribing, and monthly hospital feedback reports.

As part of a 2010 legislative mandate to design a system of hospital quality incentive payments, HCA developed improvement measures to reduce preventable ER visits by Medicaid enrollees. Qualifying hospitals received incentive payments from July 1, 2012, until June 2013. Twenty-three hospitals currently qualify for incentive payments, which began again on July 1, 2014, with additional measures aimed at preventing excessive ER use by high-utilizing patients.

New Measures for 2014

HCA required the MCOs to report additional measures in 2014 that were not reported in previous years, with one exception.

Prevention and Screening:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Respiratory Conditions:

- Appropriate Testing for Children with Pharyngitis
- Use of Appropriate Medications for People with Asthma

Access/Availability of Care:

- Children's and Adolescents' Access to Primary Care Practitioners (last reported in 2007)

Utilization:

- Mental Health Utilization
- Plan All-Cause Readmissions (Medicare HEDIS measure)

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

This measure expresses the percentage of enrollees 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- body mass index (BMI) percentile documentation
- counseling for nutrition
- counseling for physical activity

Figure 31 shows the 2014 rates of BMI documentation for enrollees ages 3–11 by MCO. Figure 32 on the next page shows the equivalent rates for enrollees ages 12–17. For both indicators, the average rate reported by the MCOs was significantly below the U.S. average. CHP's BMI documentation rates significantly outperformed the state averages, while the rates for CCC and UHC were significantly below average.

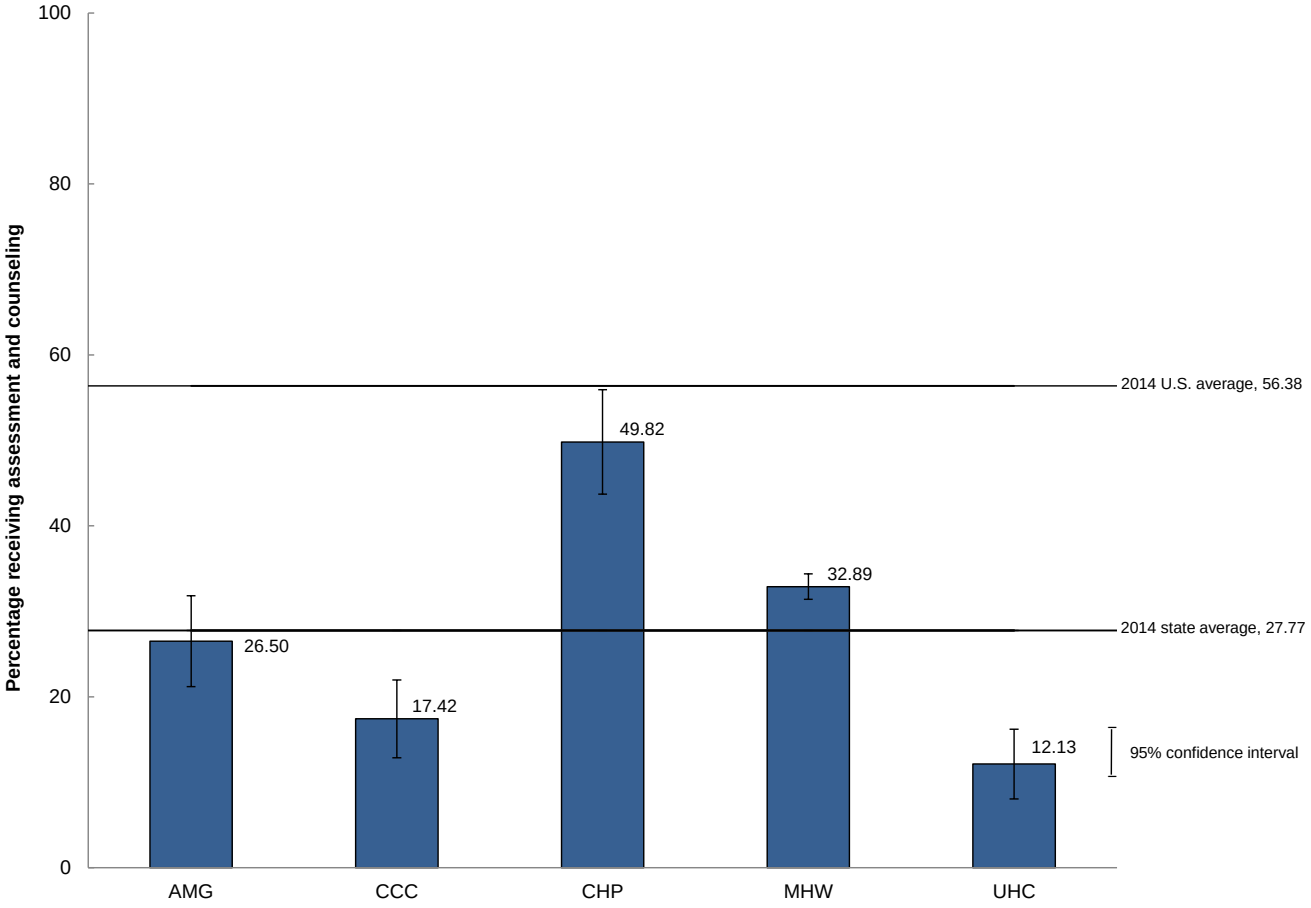

Figure 31. BMI documentation for enrollees ages 3–11 by health plan, reporting year 2014.

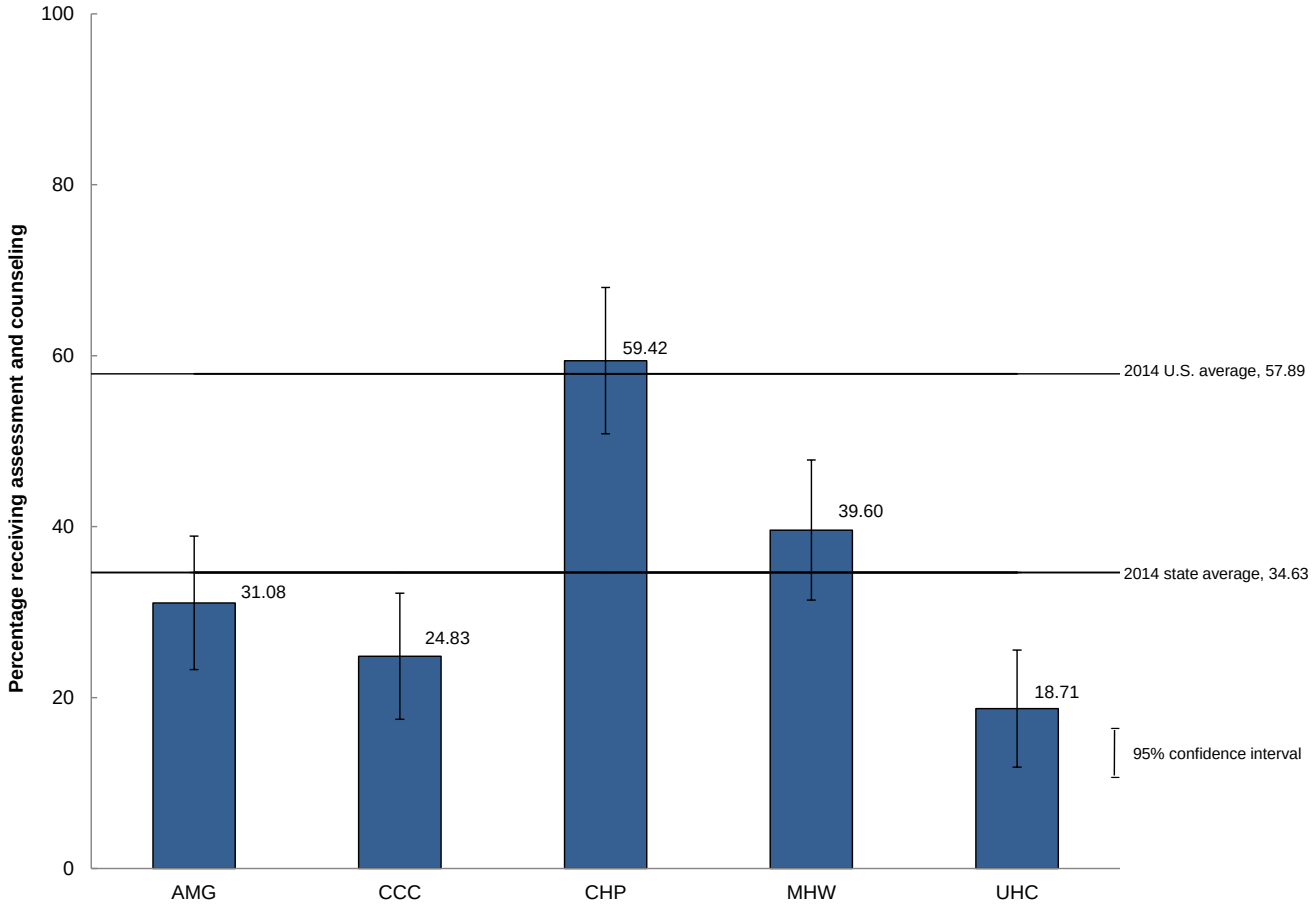

Figure 32. BMI documentation for enrollees ages 12–17 by health plan, reporting year 2014.

Figure 33 shows the 2014 rate of nutrition counseling for enrollees ages 3–11 by MCO. Figure 34 on the next page shows the equivalent rates for enrollees ages 12–17. For both indicators, the average rate reported by the MCOs was significantly lower than the U.S. average.

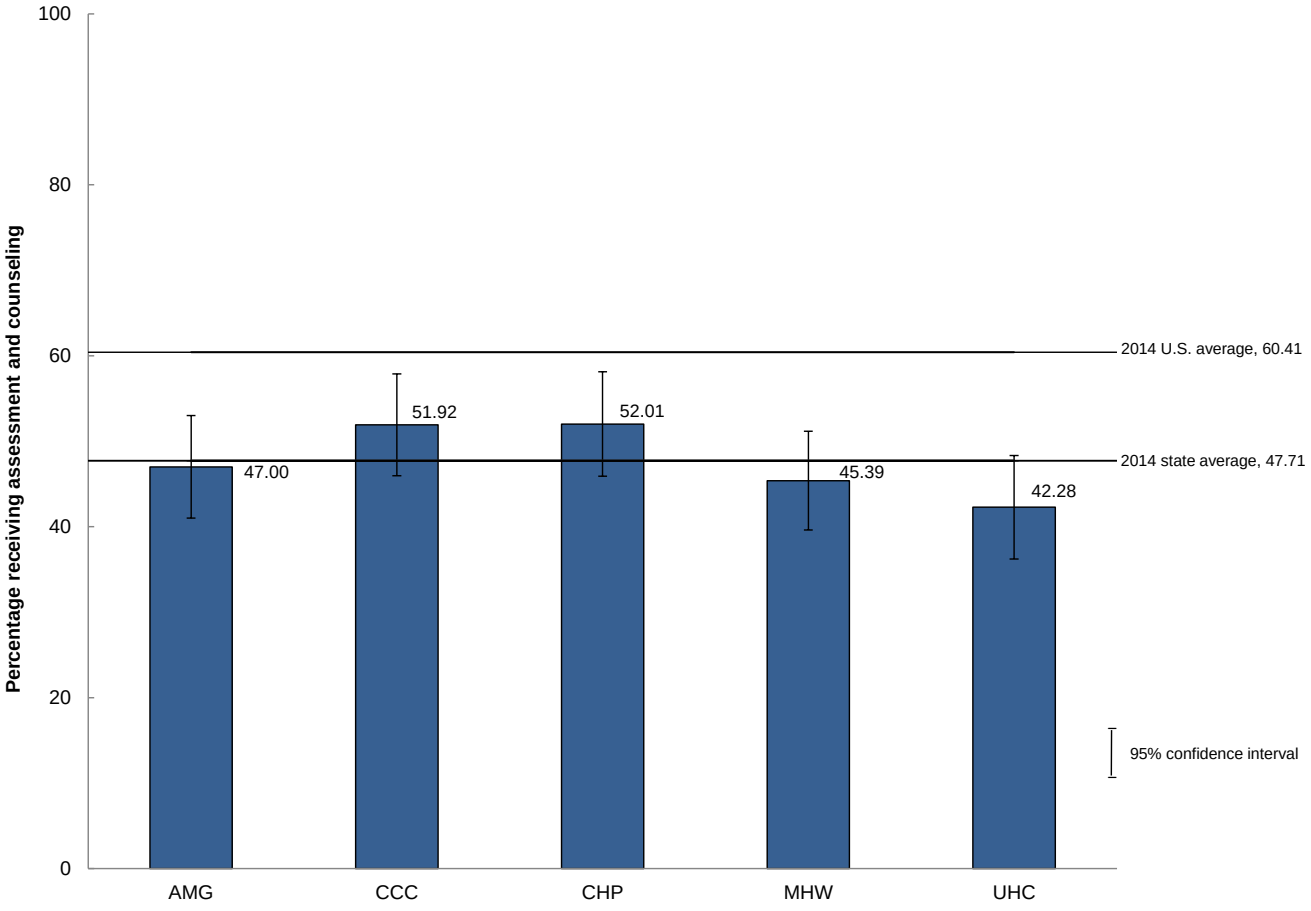

Figure 33. Nutrition counseling for enrollees ages 3–11 by health plan, reporting year 2014.

CHP delivered nutrition counseling for 54.35% of enrollees ages 12–17, significantly exceeding the state average for this indicator.

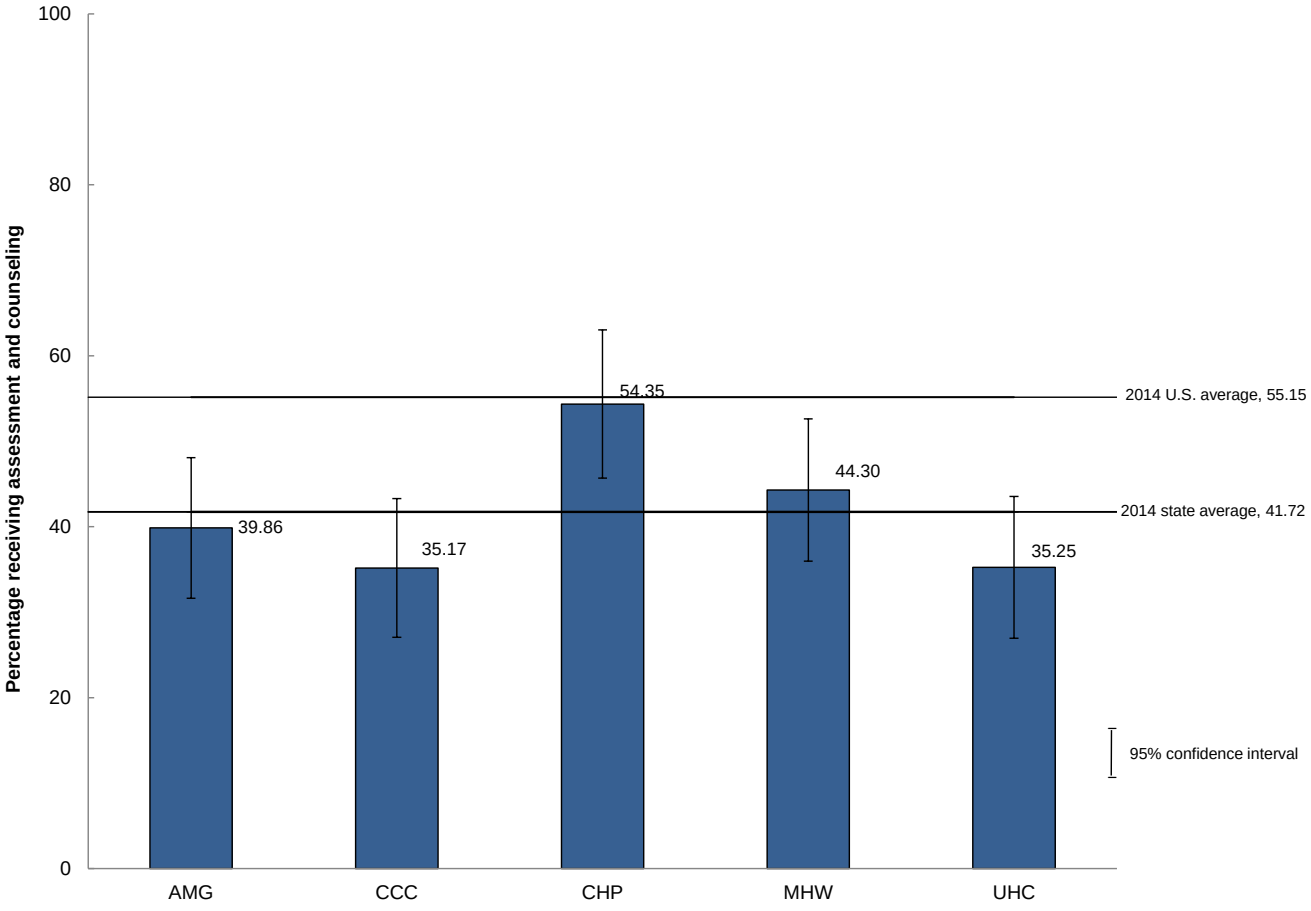

Figure 34. Nutrition counseling for enrollees ages 12–17 by health plan, reporting year 2014.

Figure 35 shows the 2014 rate of physical activity counseling for enrollees ages 3–11 by MCO. Figure 36 on the next page shows the equivalent rates for enrollees ages 12–17. For both indicators, the average rate reported by the MCOs was significantly lower than the U.S. average. CHP significantly outperformed the state average for both indicators.

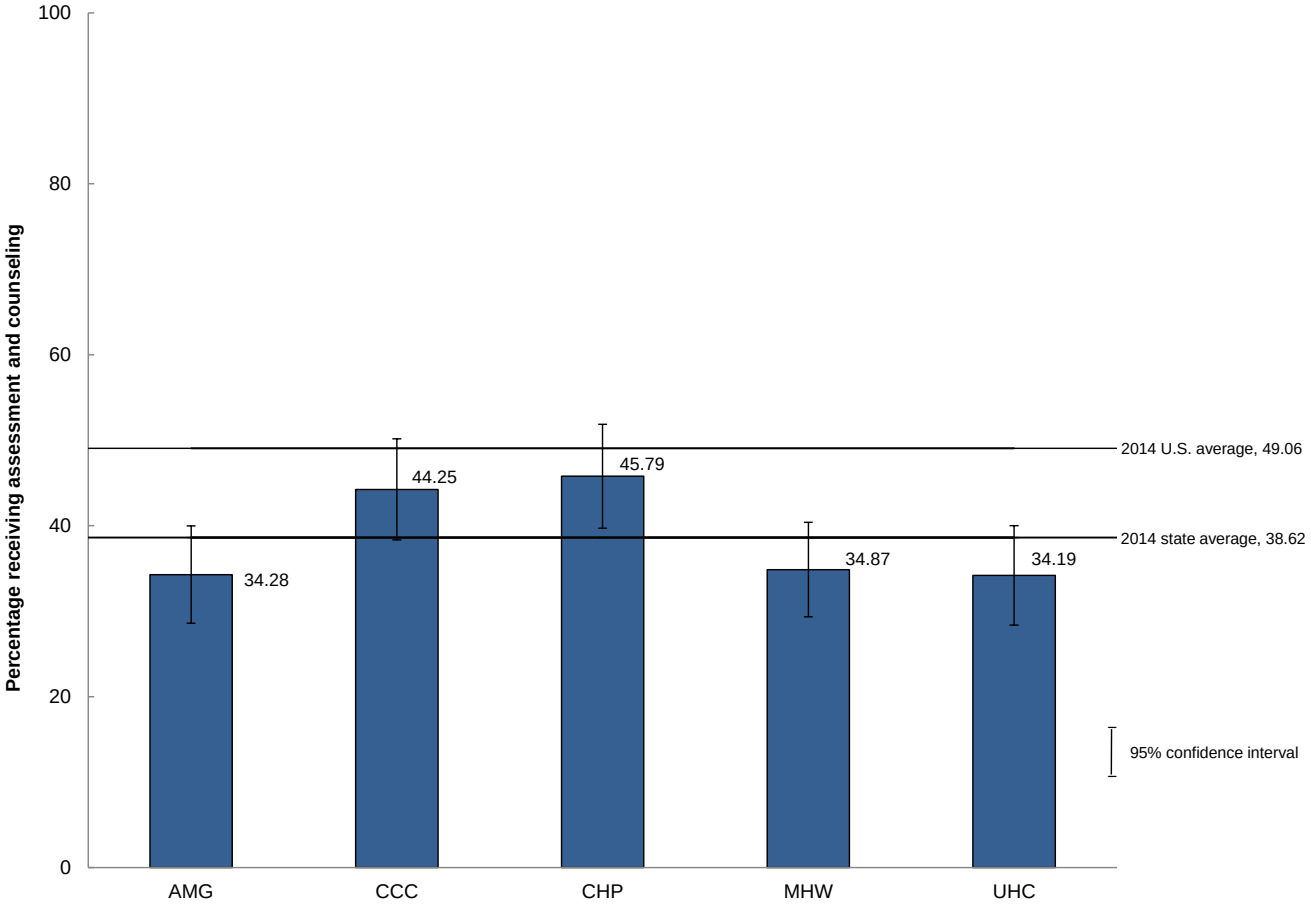

Figure 35. Physical activity counseling for enrollees ages 3–11 by health plan, reporting year 2014.

UHC's delivery of physical activity counseling for enrollees ages 12–17 was significantly lower than the state average.

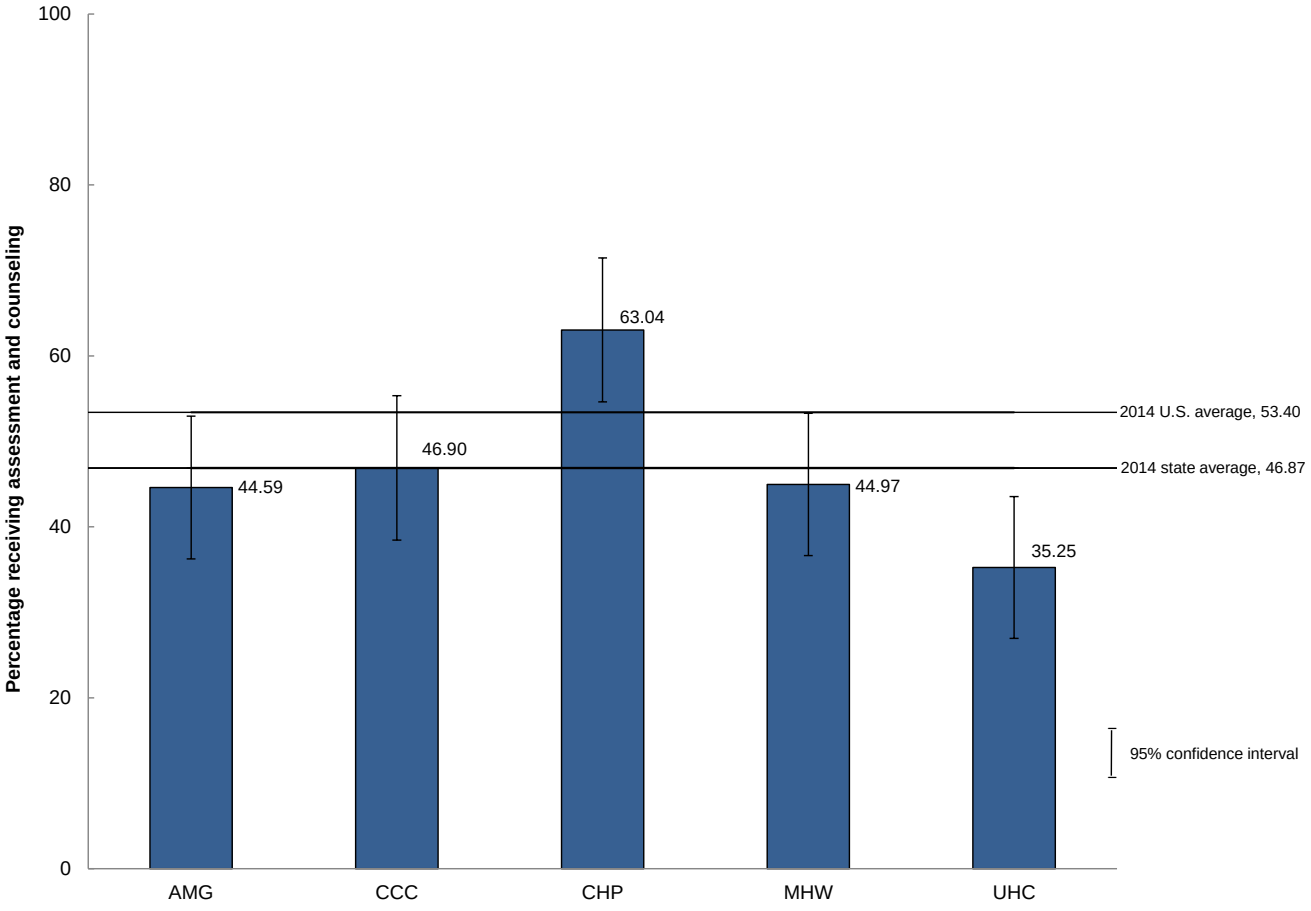

Figure 36. Physical activity counseling for enrollees ages 12–17 by health plan, reporting year 2014.

Appropriate Testing for Children with Pharyngitis

This measure expresses the percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Figure 37 shows the 2014 rate of pharyngitis testing by MCO. Statewide, 63.74% of enrollees in this age group received testing, significantly below the nationwide rate. MHW significantly outperformed the state average with a rate of 67.38%, while the rates for CCC and CHP were significantly below average.

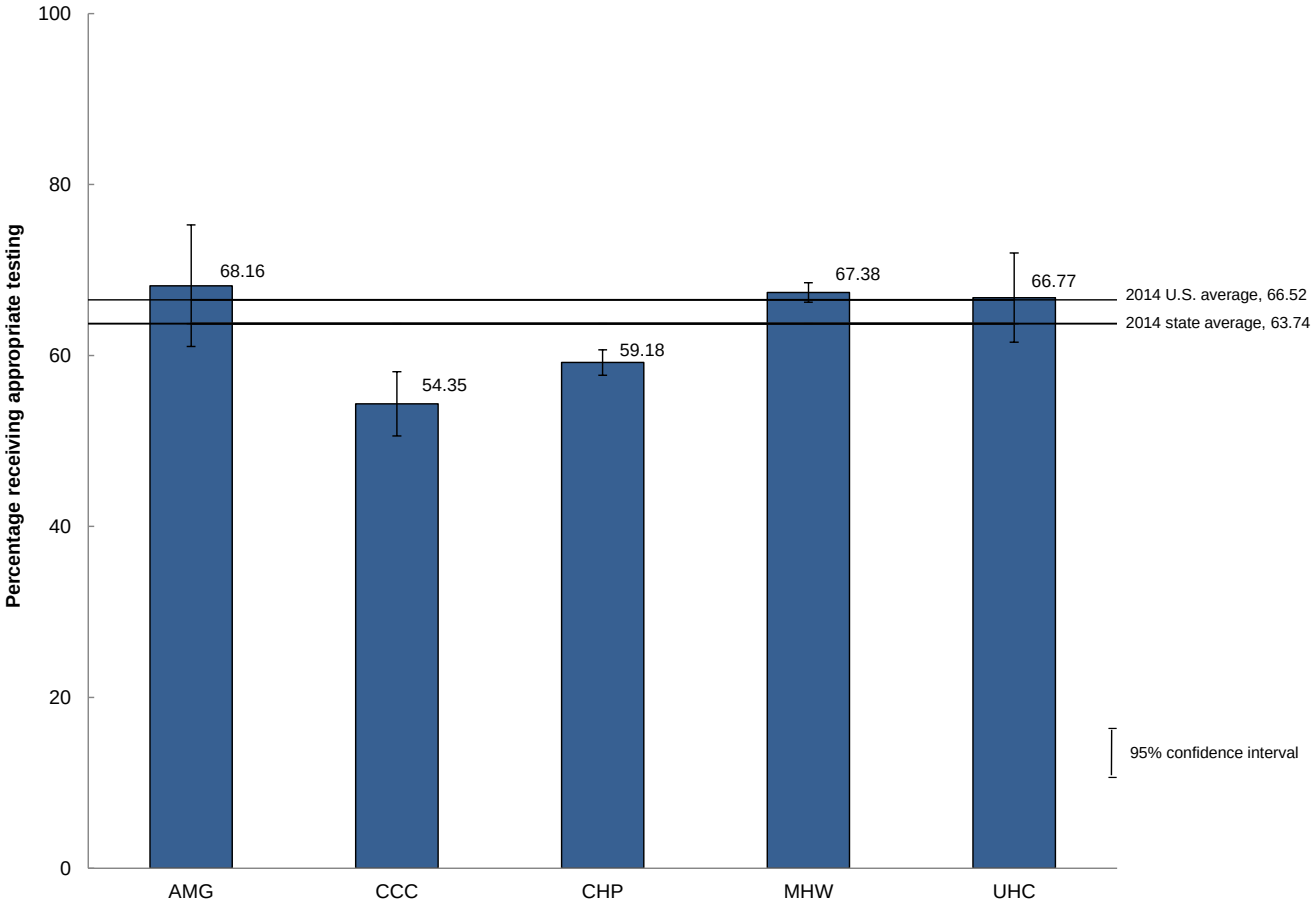

Figure 37. Pharyngitis testing for enrollees age 2–18, by health plan, reporting year 2014.

Use of Appropriate Medications for People with Asthma

This measure expresses the percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication (oral medication, inhaler, or injection).

Asthma-related suffering, costs, and death can be greatly reduced through effective treatment with long-term controller medications. In addition, patient education regarding medication use, symptom management, and avoidance of asthma attack triggers can greatly reduce the impact of the disease. The list of acceptable medications is derived from the National Heart, Lung, and Blood Institute's National Asthma Education Prevention Program guidelines.

Table 2 displays appropriate asthma medication rates by MCO for each of four age groups in 2014. Only CHP and MHW had reportable data in this reporting year; therefore, the reported state averages represent only those two MCOs. For each age group, the state average was significantly below the U.S. average.

Table 2. Enrollees appropriately prescribed asthma medication by health plan, reporting year 2014.

	Number and percentage prescribed by age group									
	5–11		12–18		19–50		51–64		Total	
Health plan	n	%	n	%	n	%	n	%	n	%
AMG	0	NA	0	NA	0	NA	0	NA	0	NA
CCC	0	NA	0	NA	0	NA	0	NA	0	NA
CHP	768	89.19	576	83.16	324	75.31	84	77.38	1,752	84.08
MHW	1,441	87.79	1,141	81.95	513	72.71	60	83.33	3,155	83.14
UHC	0	NA	0	NA	0	NA	0	NA	0	NA
State average	–	88.28	–	82.35	–	73.72	–	79.86	–	83.47
U.S. average	–	90.18	–	86.93	–	74.36	–	70.20	–	84.07

NA: Sample size was smaller than the minimum required during the reporting year; eligible population was zero.

Children's and Adolescents' Access to Primary Care Practitioners

This measure expresses the percentage of members 12 months to 19 years of age who had a visit with a PCP. The health plan reports separate percentages for:

- children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year
- children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year before the measurement year

As shown in Table 3, access rates by MCO ranged between 93% and 98% for children age 12–24 months, and between 77% and 89% for children age 25 months–6 years. For older children served by AMG, CCC, and UHC, sample sizes were not large enough for meaningful analysis. The statewide average access rates were significantly higher than the U.S. average rates for all age groups except 25 months–6 years.

Table 3. Access to primary care practitioners by health plan, reporting year 2014.

	Number and percentage who had a PCP visit by age group							
	12–24 months		25 months–6 years		7–11 years		12–19 years	
Health plan	n	%	n	%	n	%	n	%
AMG	626	93.45	1,873	77.52	0	NA	0	NA
CCC	2,204	97.19	7,619	86.13	0	NA	0	NA
CHP	8,647	97.14	46,878	86.22	27,547	89.39	31,243	88.49
MHW	15,654	97.78	77,081	89.04	49,347	92.24	51,848	92.12
UHC	1,468	93.94	4,838	82.20	0	NA	0	NA
State average	–	97.25	–	87.53	–	91.22	–	90.75
U.S. average	–	96.14	–	88.25	–	90.02	–	88.52

NA: Sample size was smaller than the minimum required during the reporting year; eligible population was zero.

Mental Health Utilization

Table 4 reports the frequency of mental health outpatient and ED services for enrollees of each MCO in 2014, broken out by enrollee age. Comparisons with the national NCQA averages are available only for total enrollees, not by age.

Table 4. Frequency of mental health outpatient and ED services by health plan, reporting year 2014.

	Service frequency by age group[a]							
	0–12 years		13–17 years		18–64 years		Total	
Health plan	n	%	n	%	n	%	n	%
AMG	116	1.01	55	1.54	339	2.35	510	1.73
CCC	274	0.78	153	1.57	740	2.99	1,167	1.67
CHP	1,956	1.33	1,156	2.64	2,913	3.93	6,025	2.27
MHW	261	2.91	229	6.15	727	5.19	1,217	4.56
UHC	168	0.75	119	1.82	546	2.61	833	1.67
State average	—	1.23	—	2.54	—	3.55	—	2.21
U.S. average	—	NA	—	NA	—	NA	—	12.27

NA: Not available in 2014 NCQA *Quality Compass*.
[a] Percentages are calculated using member years to standardize counts of members enrolled for fewer than 12 months.

Plan All-Cause Readmissions

This is a Medicare HEDIS measure that HCA has required the MCOs to report for the Medicaid population in Washington. For members 18 years of age and older, this measure expresses the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days. NCQA also specifies that plans calculate the predicted probability of an acute readmission in order to account for the prior and current health of the member and other risk factors. Plans average the predicted readmission probabilities to obtain risk-adjusted, or expected, readmission rates. Table 5 reports:

1. the Observed readmission ratio, equal to the percentage of index hospital stays that had a subsequent 30-day readmission
2. the Observed/Expected readmission ratio, equal to the observed readmission rate divided by the average risk-adjusted probability of readmission

A lower observed rate of readmission is considered better performance. The "expected" rate of readmission is the health plan's predicted readmission rate, given its case mix and how health plans across the nation treat similar cases. The observed/expected ratio shows the adjusted readmission rate relative to the national average. A ratio less than 1 indicates that the health plan has a lower than expected readmission rate based on its patient case mix.

Table 5. Plan all-cause readmissions by health plan[a], reporting year 2014.

	Observed[b] and Observed/Expected[c] readmission ratios by age group							
	18–44 years		45–54 years		55–64 years		Total	
Health plan	Observed	Observed/ Expected	Observed	Observed/ Expected	Observed	Observed/ Expected	Observed	Observed/ Expected
AMG	17.07	1.23	8.77	0.69	11.67	0.88	12.03	0.91
CCC	11.76	0.84	16.38	0.93	8.43	0.61	11.72	0.78
CHP	10.45	0.96	10.92	0.87	10.68	0.73	10.67	0.85
MHW	8.41	0.63	12.02	0.81	10.51	0.71	9.66	0.69
UHC	16.67	0.80	10.29	0.66	11.70	0.65	12.56	0.70
State average	—	0.81	—	0.85	—	0.72	—	0.79
U.S. average	—	NA	—	NA	—	NA	—	NA

[a] Medicare HEDIS measure that HCA requires as a reported measure for the Washington Medicaid population.

[b] Observed proportion of Index Hospital Stays that had a subsequent 30-day readmission.

[c] Ratio of the MCO's observed rate of readmission to its expected rate of readmission (average adjusted probability).

NA: Not available in 2014 NCQA *Quality Compass*.

Medical Care Services Measures

The Medical Care Services (MCS) program, previously called Disability Lifeline/GA-U, operated in all 39 Washington counties during 2013. HCA contracted with CHP to provide managed medical and mental health services for MCS recipients, including primary care, referral coordination, other medically necessary services, and pharmaceutical drugs.

MCS provided limited medical benefits to incapacitated eligible adults and to those eligible for state-funded alcohol and drug addiction treatment. Incapacitated adults are people between ages 18 and 65 who cannot work for short-term physical or mental reasons. Income and resource limits are more restrictive than for the family Categorically Needy medical program.

As of January 1, 2014, MCS recipients were rolled up into the larger Apple Health population. HCA required CHP to report three HEDIS measures for the MCS population in 2014, reflecting services provided during 2013:

- ambulatory care visits—outpatient and ER
- antidepressant medication management (AMM)
- race/ethnicity diversity of membership

The AMM measure examines

- the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for the treatment of major depression for at least 12 weeks (effective acute phase treatment)
- the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for the treatment of major depression for at least six months (effective continuation phase treatment)

Figures 38 and 39 depict the changes in these measures in the past two reporting years. The ambulatory care measures showed a positive trend, with ER visit rates declining significantly while outpatient visit rates increased significantly. AMM measures for this population also improved slightly in 2014 (not statistically significant).

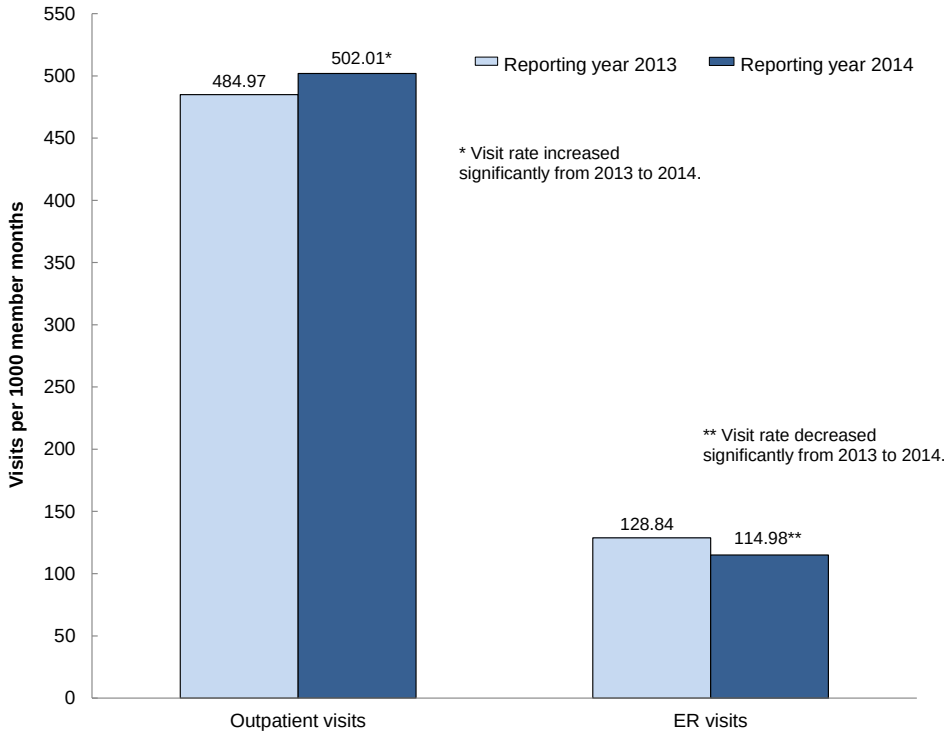

Figure 38. Ambulatory care visits for MCS enrollees, reporting years 2013–2014.

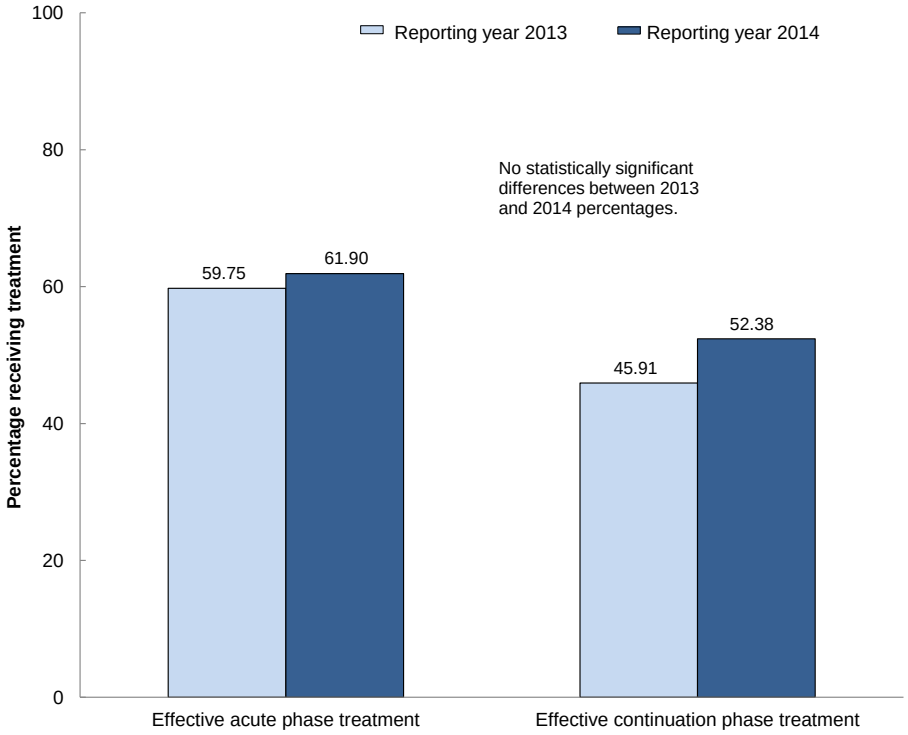

Figure 39. Antidepressant medication management for MCS enrollees, reporting years 2013–2014.

Table 6 presents race and ethnicity data reported for MCS enrollees in 2014. As shown, about 69% of the 19,184 enrollees were identified as White, with smaller percentages identified for other racial groups. Race was unknown for nearly 14% of MCS enrollees, and ethnicity was unknown for 93% of enrollees.

Table 6. Race/ethnicity diversity of MCS enrollees, reporting year 2014.

	Hispanic/Latino		Not Hispanic/Latino		Unknown Ethnicity		Total	
Race	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
White	22	1.58%	0	NR	13,232	74.38%	13,254	69.09%
Black/African American	2	0.14%	0	NR	1,974	11.10%	1,976	10.30%
American-Indian and Alaska Native	0	0.00%	0	NR	183	1.03%	183	0.95%
Asian	0	0.00%	0	NR	285	1.60%	285	1.49%
Native Hawaiian/Other Pacific Islander	2	0.14%	0	NR	236	1.33%	238	1.24%
Some other race	13	0.93%	0	NR	623	3.50%	636	3.32%
Two or more races	0	0.00%	0	NR	0	0.00%	0	0.00%
Unknown	1,356	97.20%	0	NR	1,256	7.06%	2,612	13.62%
Declined	0	0.00%	0	NR	0	0.00%	0	0.00%
Total	**1,395**	**100.00%**	**0**	**NR**	**17,789**	**100.00%**	**19,184**	**100.00%**

NR = Not reported.

Washington Medicaid Integration Partnership (WMIP)

HCA ended the WMIP as of June 30, 2014, after more than 9 years of operation. This pilot program sought to integrate medical, mental health, substance abuse, and long-term care services for categorically needy aged, blind, and disabled Medicaid beneficiaries with complex health conditions—the fastest growing and most expensive segment of the Medicaid client base. The program targeted improvements in diabetes care and in mental health and substance abuse services for this population, aimed at reducing ER visits and overall health care costs.

The state contracted with MHW to conduct the WMIP in Snohomish County. The WMIP target population was Medicaid enrollees age 21 or older who were aged, blind, or disabled, including Medicaid-only enrollees and those dually eligible for Medicare and Medicaid. WMIP excluded children under 21, Healthy Options enrollees, and recipients of Temporary Assistance for Needy Families. During 2013, about 3,000 individuals were enrolled.

In 2014, MHW reported nine HEDIS measures for the WMIP population:

- comprehensive diabetes care
- inpatient care utilization—general hospital/acute care
- ambulatory care utilization
- mental health utilization
- follow-up after hospitalization for mental illness
- antidepression medication management
- use of high-risk medications for the elderly
- identification of alcohol and other drug services
- initiation and engagement of alcohol and other drug dependence treatment

Because the WMIP population differs categorically from the Medicaid managed care population, it has not been feasible to compare the WMIP data meaningfully with the data reported by the MCOs or with national data for health plans serving traditional Medicaid recipients.

This final analysis of WMIP performance measures looks at long-term trends in diabetes care, antidepression medication management, follow-up after hospitalization for mental illness, and ambulatory care utilization (outpatient and ER visits) spanning the program's existence. Additional charts depict 5-year data for the remaining measures.

Long-term performance trends

Figure 40 presents the trends in HbA1c testing and control for the WMIP population since 2006. As shown, the percentage of enrollees with diabetes who received HbA1c testing remained flat during this period, fluctuating between 82% and 88%, while the trends in enrollees' HbA1c control moved in a negative direction (good control declining, poor control increasing). By the end of the program, only about 42% of enrollees had good control of HbA1c.

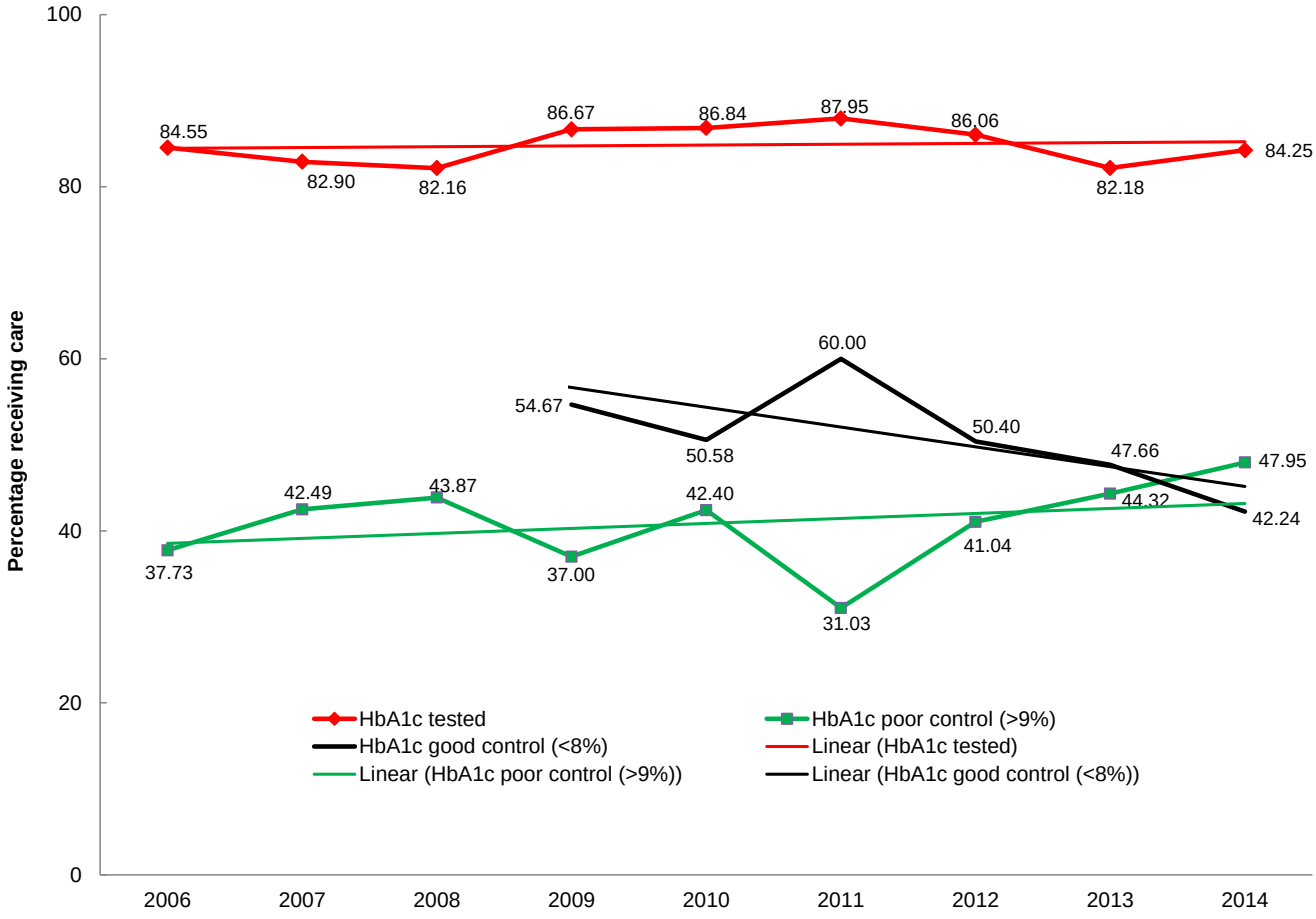

Figure 40. HbA1c testing and control for WMIP enrollees, reporting years 2006–2014.

Figure 41 shows the trends in screening measures (dilated retinal exams and monitoring for diabetic nephropathy) for WMIP enrollees with diabetes since 2006. Nephropathy monitoring improved significantly following the onset of the program, despite some fluctuation in recent years, while the percentage of enrollees receiving eye exams trended downward.

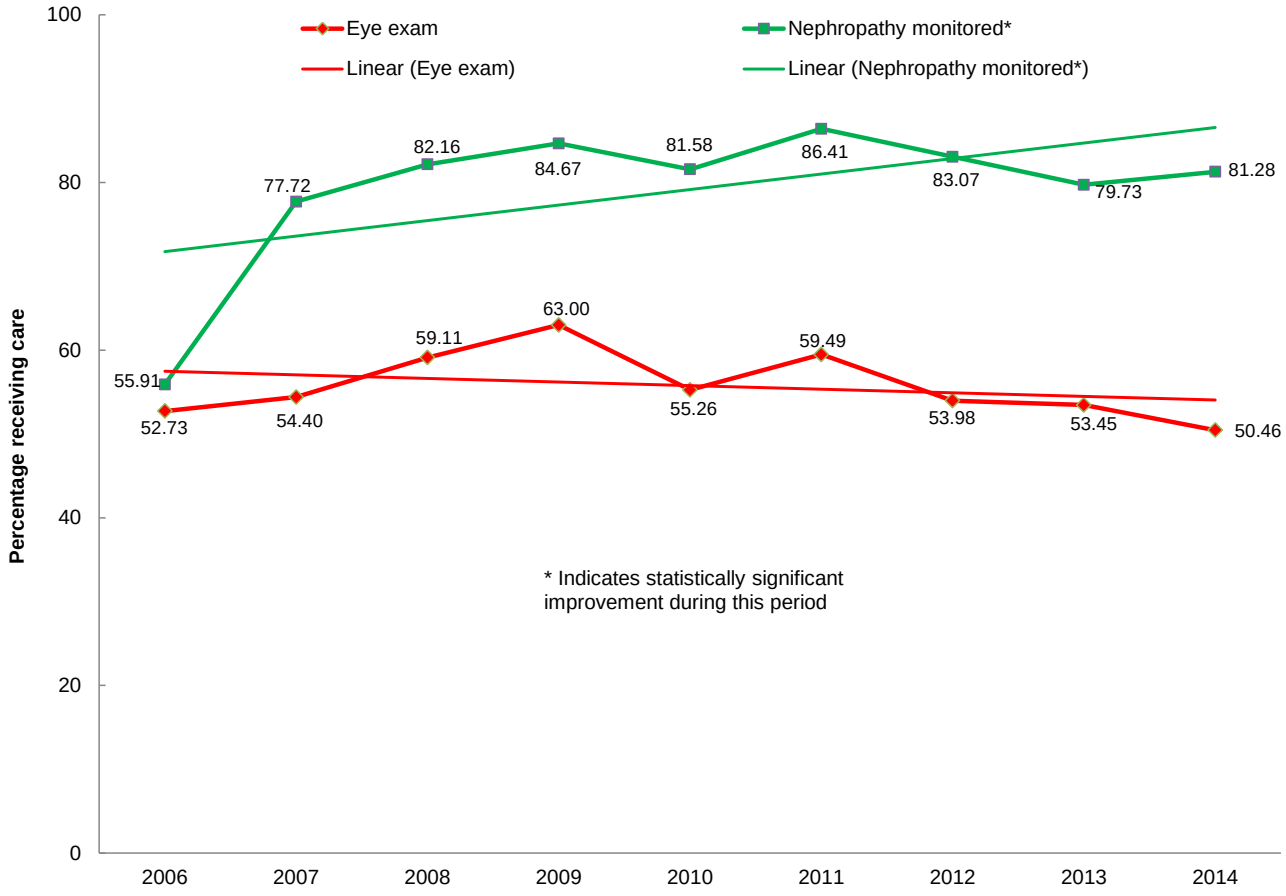

Figure 41. Diabetes screening measures for WMIP enrollees, reporting years 2006–2014.

Figure 42 shows the long-term trends in LDL-C screening, LDL-C control, and blood pressure control for WMIP enrollees. LDL-C screening trended gradually downward throughout the program, and the percentage of enrollees with good control of their LDL-C levels remained essentially flat despite year-to-year fluctuations. Blood pressure control dropped sharply in the program's final year, when only about 41% of enrollees had good control. None of these long-term changes were statistically significant.

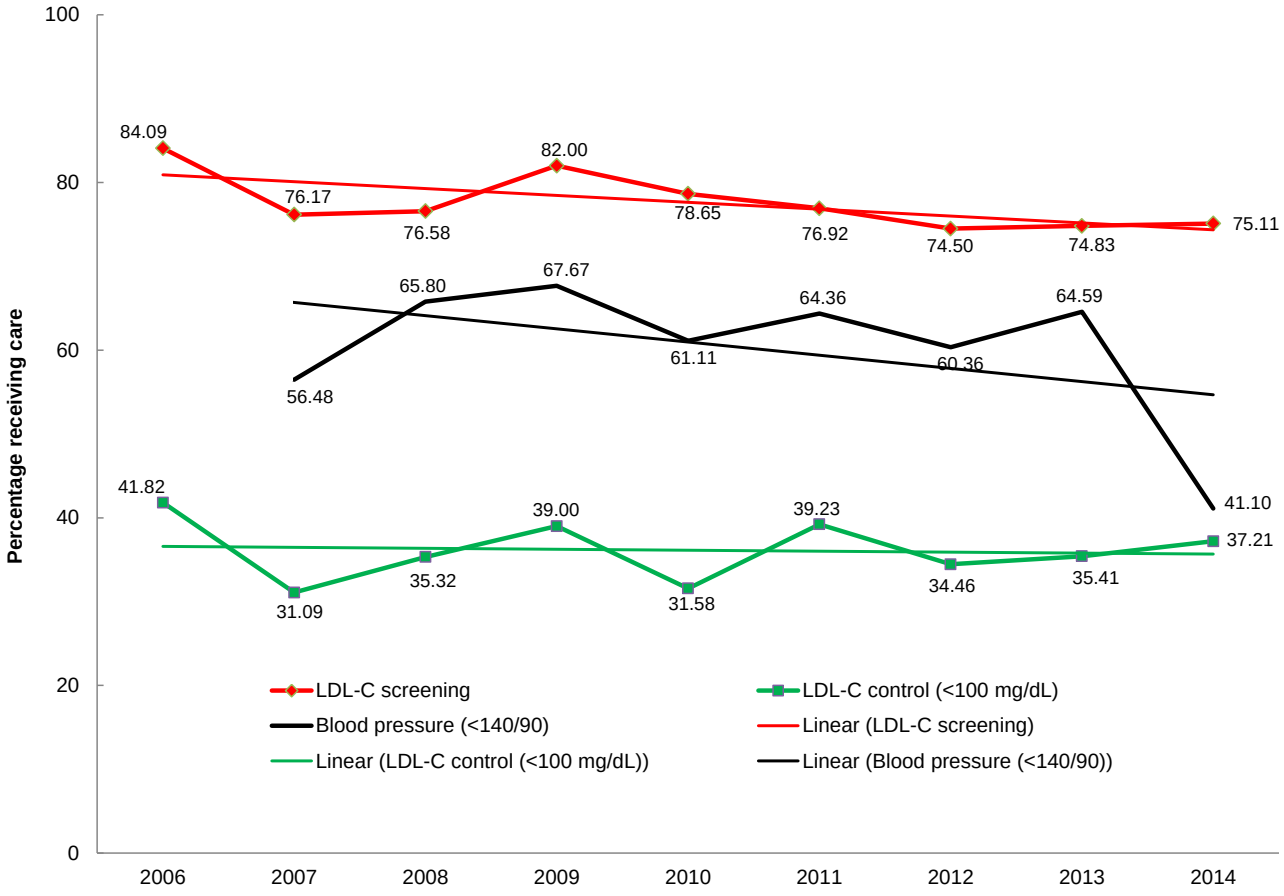

Figure 42. LDL-C screening, LDL-C control, and blood pressure control for WMIP enrollees, reporting years 2006–2014.

Figure 43 shows the trends in antidepressant medication management for WMIP enrollees since 2008. Both acute phase and continuation phase treatment moved in a positive direction during this period, though the improvement was not statistically significant.

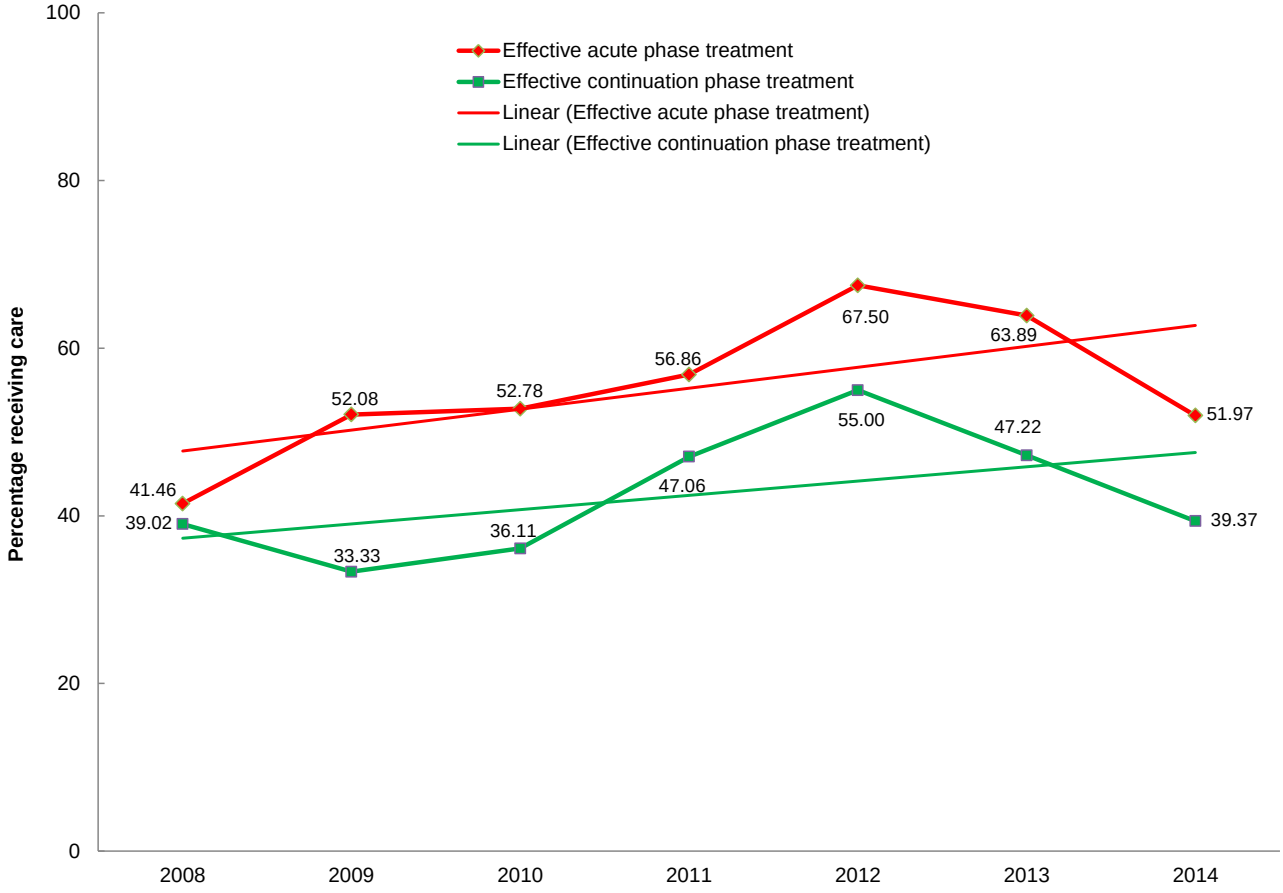

Figure 43. Antidepressant medication management for WMIP enrollees, reporting years 2008–2014.

As shown in Figure 44, the measures of timely follow-up treatment for WMIP enrollees after hospitalization for mental illness improved significantly from 2008 to 2013. (Sample sizes for these measures in 2014 were not large enough to support analysis.) Improvement in these measures has represented a notable success of the WMIP program.

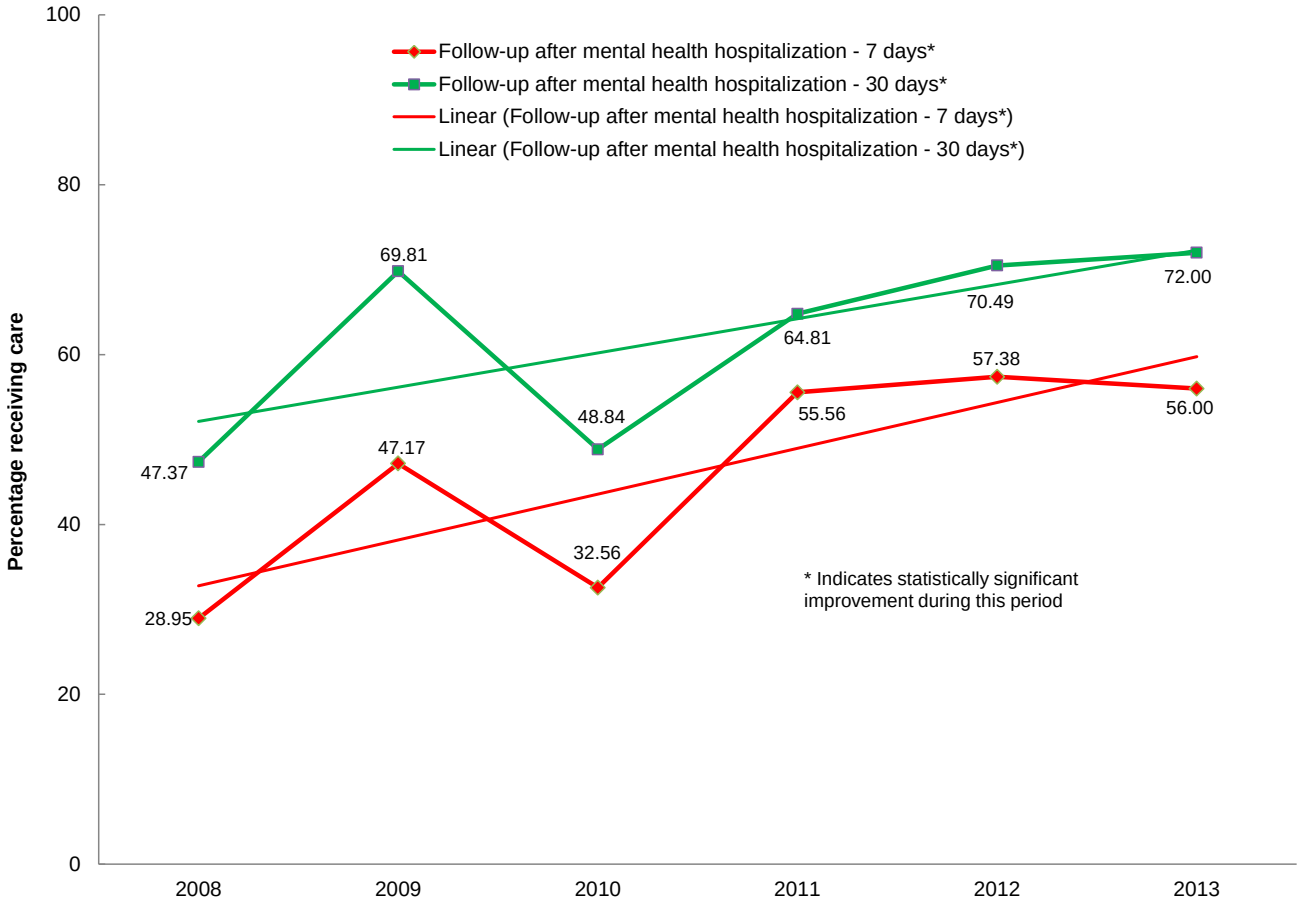

Figure 44. Follow-up after mental health hospitalization for WMIP enrollees, reporting years 2008–2013.

Figures 45 and 46 show the long-term trends in ambulatory care utilization for WMIP enrollees. As shown below, outpatient visit rates increased significantly during the program's existence.

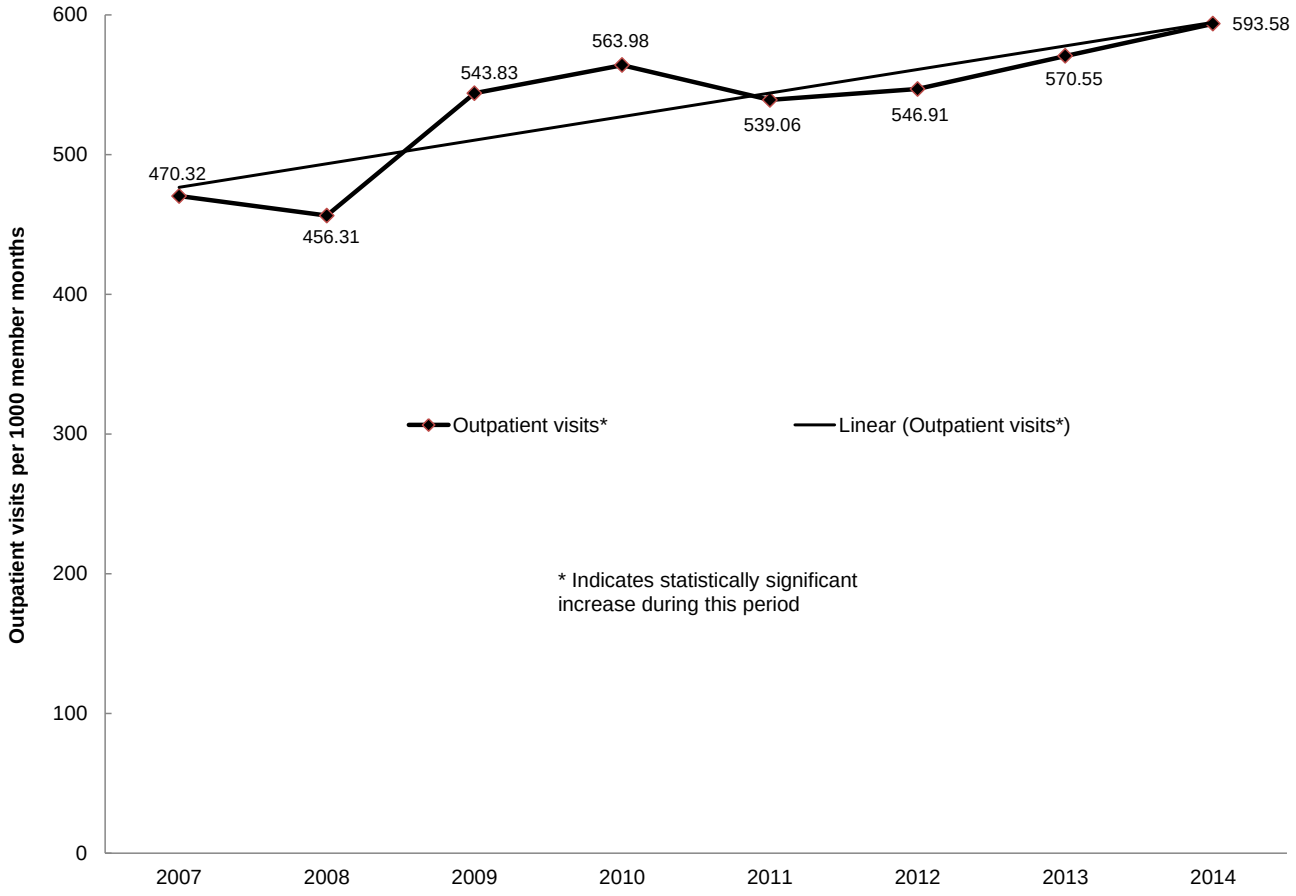

Figure 45. Outpatient visit rates for WMIP enrollees, reporting years 2007–2014.

As shown in Figure 46, ER visit rates for WMIP enrollees declined significantly during 2007–2014. Coupled with the long-term trend in outpatient visit rates, this suggests that the program succeeded in treating enrollees at less intensive levels of care over time.

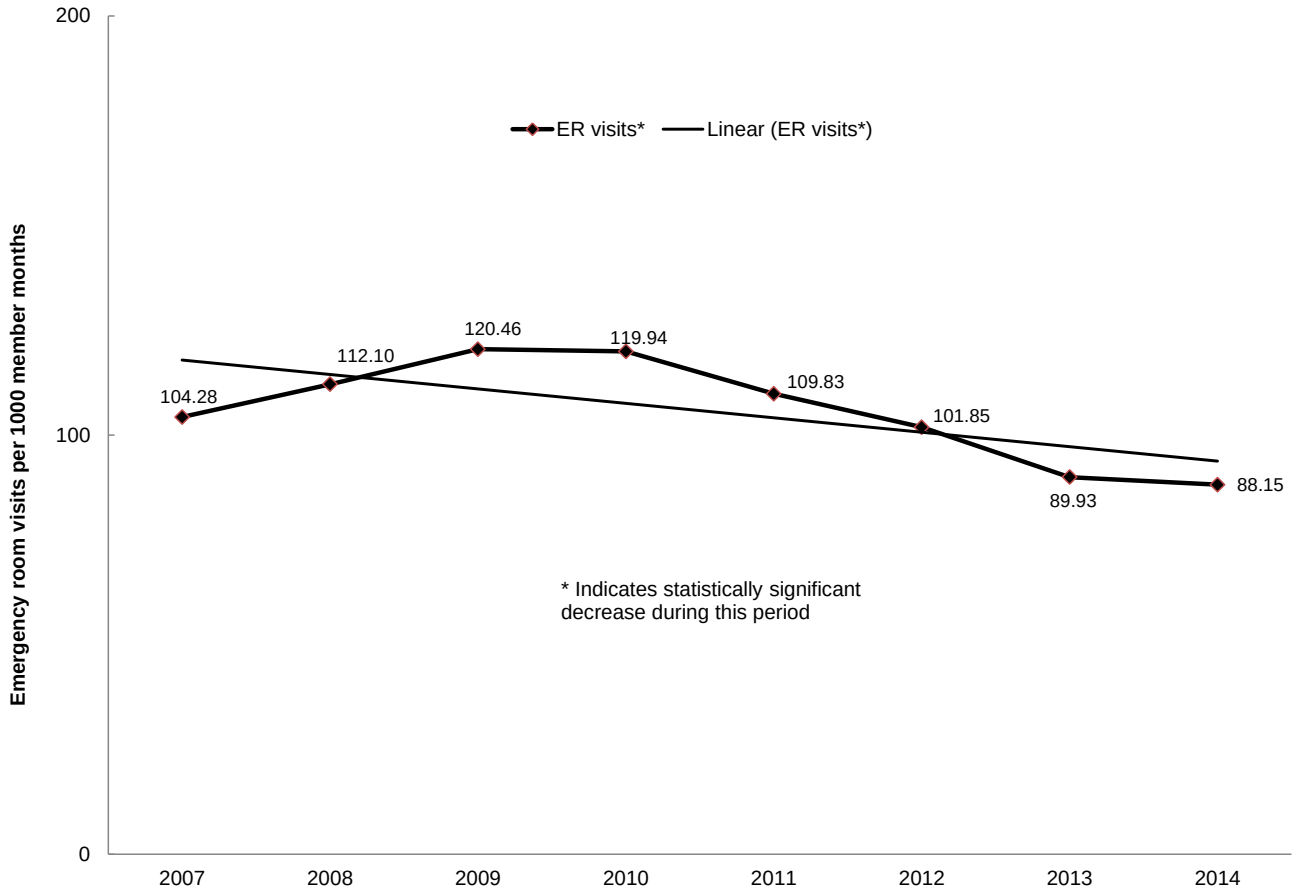

Figure 46. Emergency room visit rates for WMIP enrollees, reporting years 2007–2014.

Physical health care utilization

Figures 47–49 present the results of WMIP inpatient utilization measures (discharges, days, and average length of stay) since 2010.

Compared with the 2013 rates, discharge rates rose slightly in 2014 for medical care and for total inpatient care, but neither change was statistically significant (Figure 47).

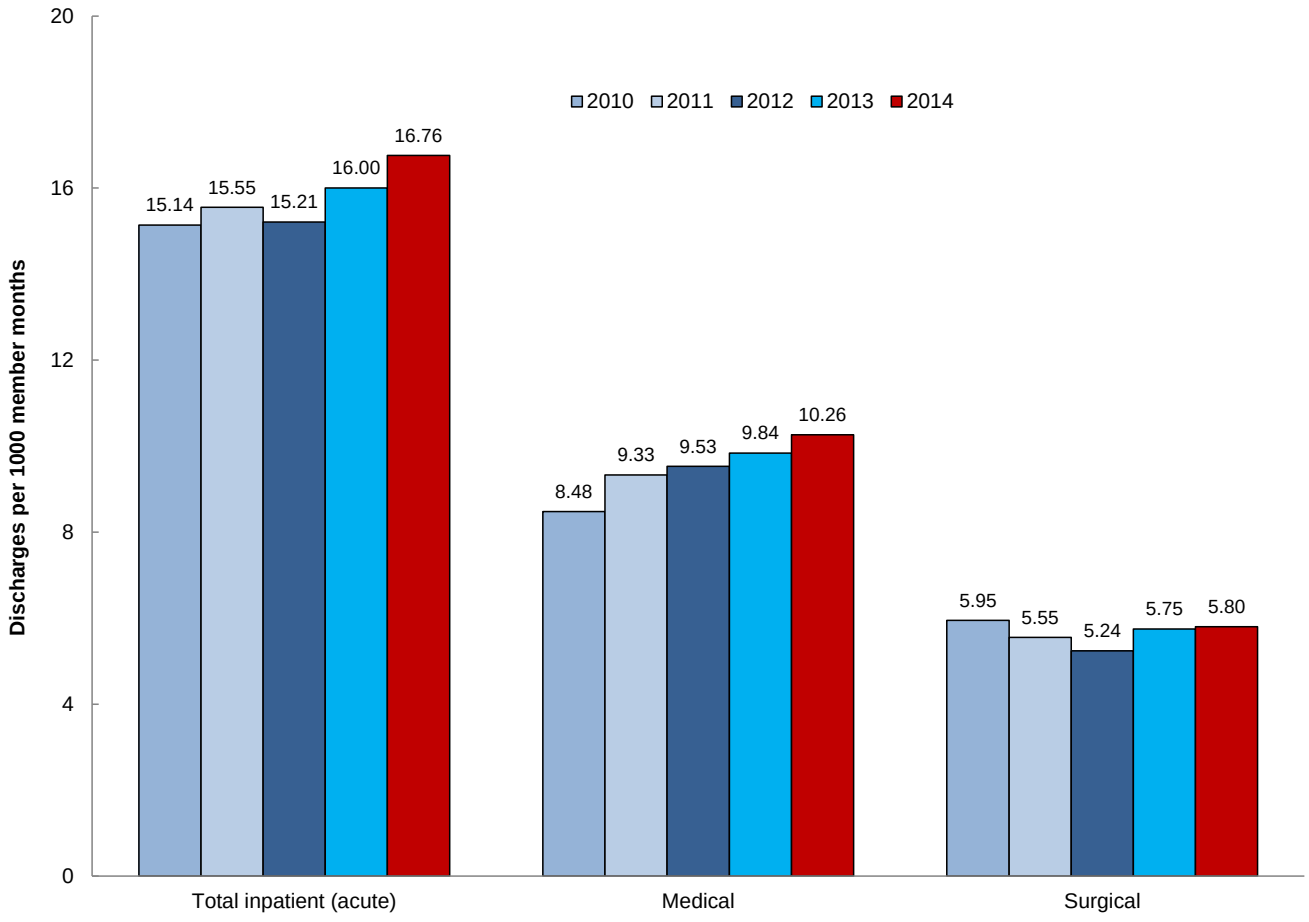

Figure 47. WMIP inpatient utilization discharges, reporting years 2010–2014.

From 2013 to 2014, medical inpatient days for WMIP enrollees rose significantly, while surgical inpatient days fell significantly (Figure 48).

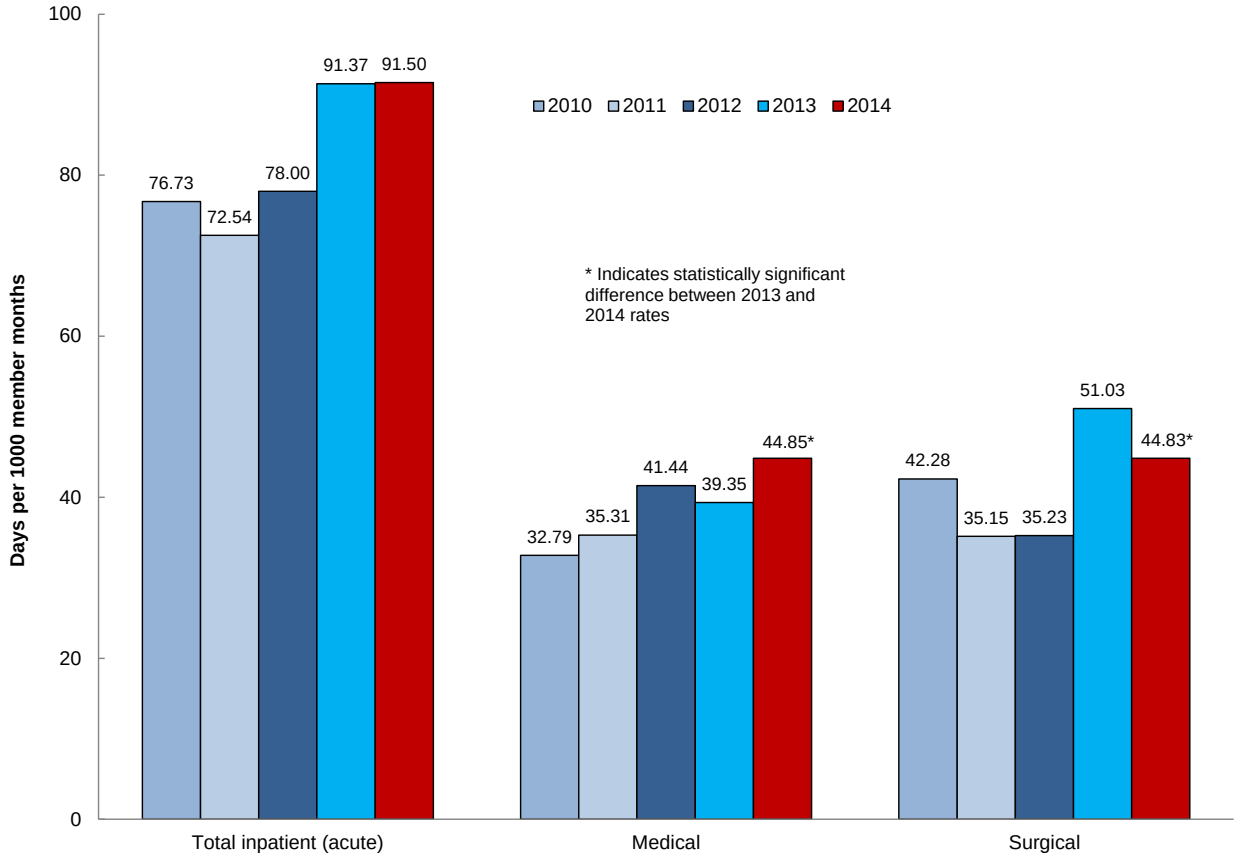

Figure 48. WMIP inpatient utilization days, reporting years 2010–2014.

WMIP enrollees' average length of stay (ALOS) for medical care rose slightly in 2014, while the ALOS for surgical care declined, but neither change was statistically significant (Figure 49).

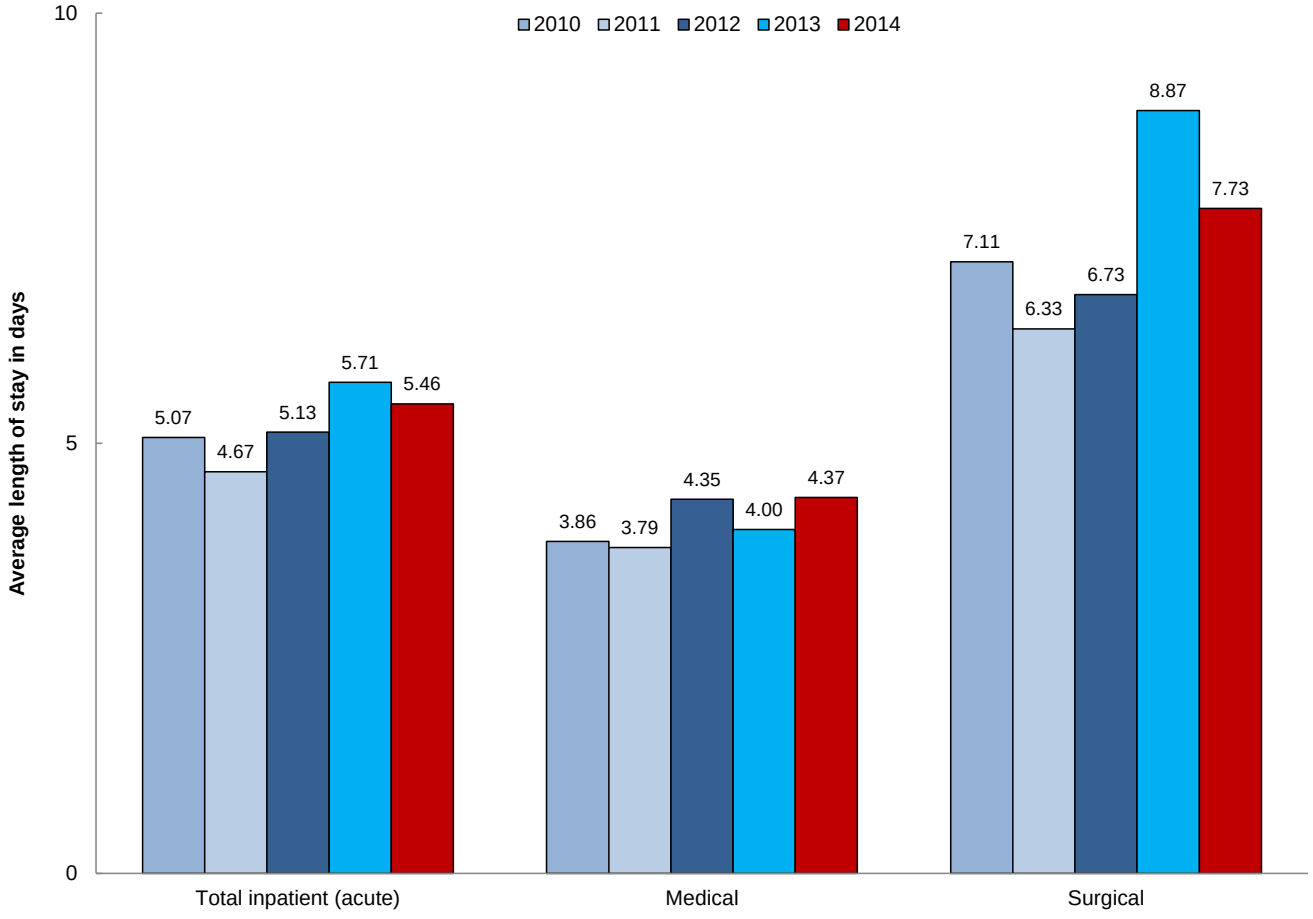

Figure 49. WMIP inpatient utilization average length of stay, reporting years 2010–2014.

Mental health care utilization

Figure 50 shows mental health care utilization for WMIP enrollees age 18 and older for the past three reporting years. "Any service" includes at least one of the following, and some enrollees received services in multiple categories:

- inpatient
- intensive outpatient (OP) or partial hospitalization
- outpatient or ER

Note: "Any" service is person-based; the other categories are visit-based.

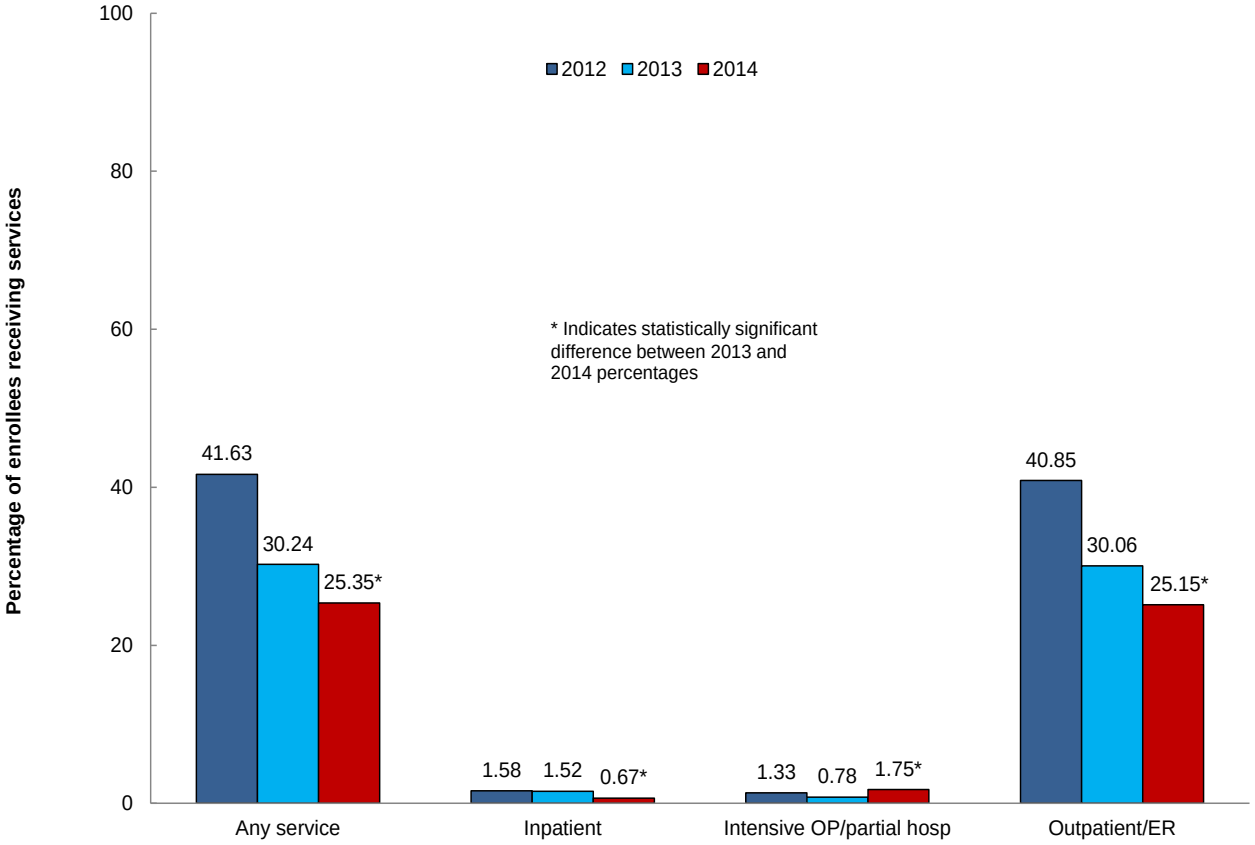

Figure 50. WMIP mental health utilization, reporting years 2012–2014.

Use of high-risk medications in the elderly

This measure expresses the percentage of elderly enrollees who received at least one high-risk prescription, or at least two different prescriptions. From 2008 through 2012, MHW reported increasingly positive results on this measure, pointing to better management of these medications for WMIP enrollees. In 2013, NCQA revised the methodology for calculating this measure, so that the 2013 and 2014 results are not comparable with data from previous years.

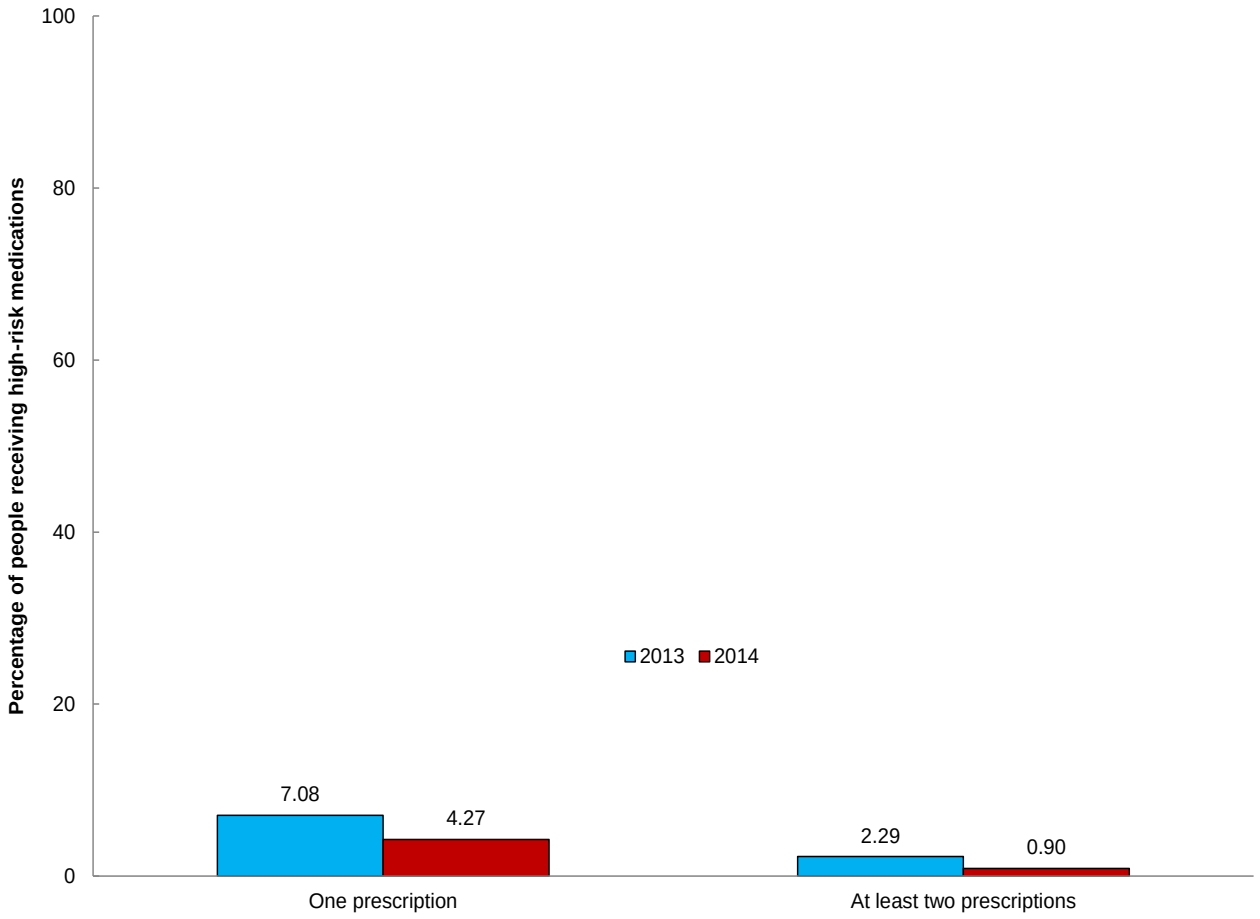

Figure 51. WMIP use of high-risk medications in the elderly, reporting years 2013–2014.

Dependence treatment

Figure 52 displays three years of data on identification of alcohol and other drug (AOD) services for WMIP enrollees. This utilization measure summarizes the percentage of enrollees with an AOD claim who received various types of chemical dependency services during the measurement year. An AOD claim contains a diagnosis of AOD abuse or dependence and a specific AOD-related service.

"Any service" includes at least one of the following, and some enrollees received services in multiple categories:

- Inpatient
- Intensive outpatient (OP) or partial hospitalization
- Outpatient or ER

Note: "Any" service is person-based; the other categories are visit-based.

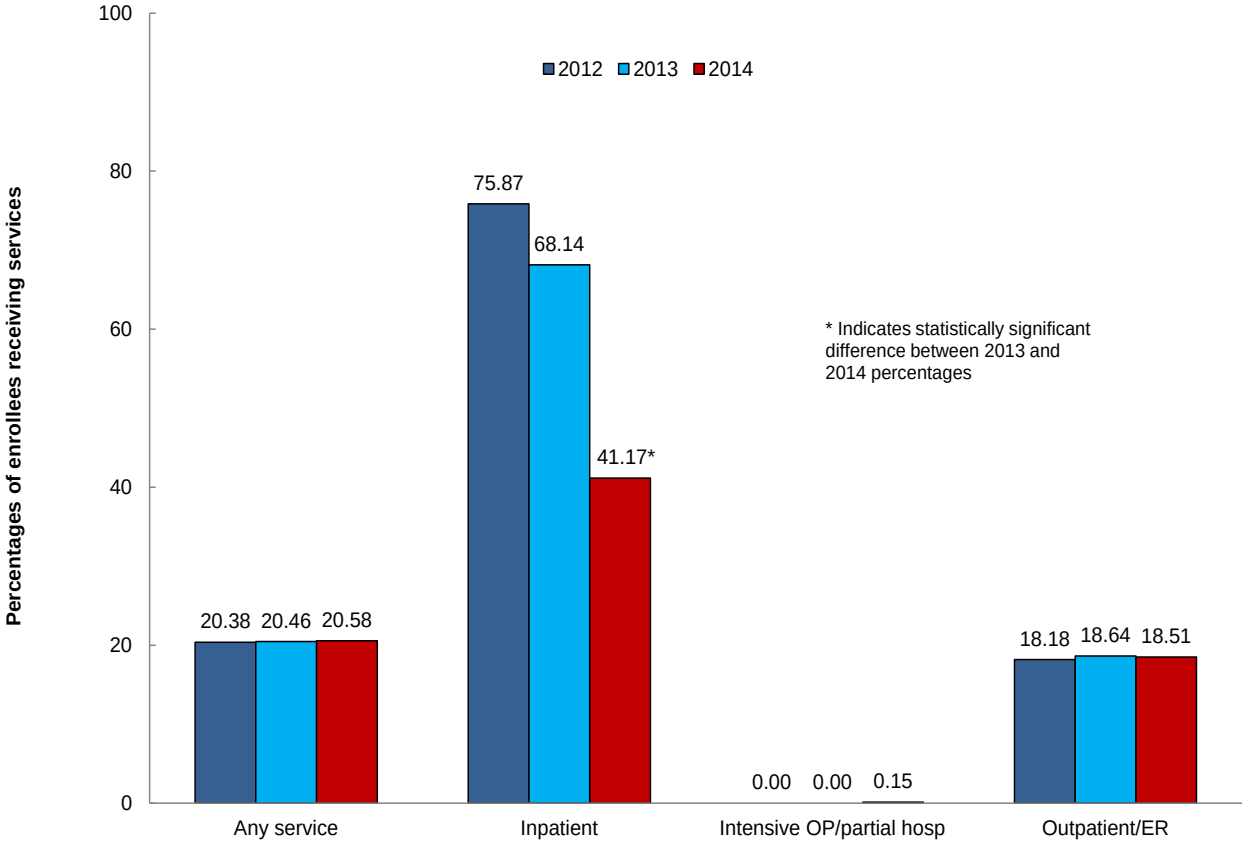

Figure 52. WMIP identification of alcohol and other drug services, reporting years 2012–2014.

Discussion

The WMIP program has pioneered the integration of primary, acute, behavioral, and long-term care for dual-eligible (Medicare and Medicaid) patients. As such, this program has served as a prototype for the future delivery of integrated care for Medicaid enrollees.

HCA has expanded the Medicaid benefit for WMIP enrollees over time, and has expanded the list of required performance measures accordingly. Although the results for this specific population in a single Washington county are not comparable with state or national Medicaid benchmarks for the same measures, the program's long-term performance trends point to issues that will apply to the expanded Medicaid population.

Considering *diabetes care*, our analysis shows little or no improvement in the required screening measures over time, except that monitoring of diabetic nephropathy improved significantly. Overall, the long-term trends in outcome measures have been discouraging. At the end of this program, only 42% of enrollees had good control of their HbA1c levels; 41% had good control of their blood pressure; and 37% had good control of their LDL-C levels.

More encouragingly, the measures of *timely follow-up treatment* after hospitalization for mental illness improved significantly from 2008 to 2014, representing a notable program success. *Antidepressant medication management* for WMIP enrollees also trended in a positive direction over time, though not significantly so.

Long-term trends in *ambulatory care utilization* for WMIP enrollees showed a significant increase in outpatient visit rates coupled with a significant decrease in ER visit rates, suggesting that the program succeeded in treating enrollees at less intensive levels of care over time.

With the inclusion of the blind and disabled population into managed care and mental health parity, the WMIP program ended June 30, 2014.

Conclusions

This report presents initial data in terms of analyzing the current MCOs' performance in serving the expanded range of enrollees under Apple Health. The measures reported in 2014 for measurement year 2013 likely reflect considerable "churn" in the state Medicaid program, as existing enrollees switched health plans and many enrollees entered managed care for the first time. Nevertheless, many of the statewide results are similar to those reported in 2012 and previous years.

As a group, the Washington MCOs continued to perform below the national benchmarks for many HEDIS measures. Scattered indicators such as influenza immunizations, HbA1c testing in diabetes care, and emergency room utilization showed more positive comparisons.

Considering measures that HCA required the MCOs to report for the first time in 2014, the MCOs performed below the U.S. averages for adolescent meningococcal immunizations, weight assessment and counseling for nutrition and physical activity for children and adolescents, pharyngitis testing for children, and use of appropriate asthma medications.

In contrast, access to primary care practitioners for children and adolescents was a bright spot for the Washington MCOs. The reported statewide access rates significantly exceeded the U.S. average rates for three of four age groups. In years before 2008 when the Washington MCOs were required to report this measure, access rates were similarly high.

As observed in previous years, service utilization rates for Washington Medicaid enrollees remain well below the U.S. average rates for both inpatient and ambulatory care.

CHP and MHW, the MCOs with most experience in serving Medicaid managed care enrollees in Washington, reported better performance than other MCOs on most HEDIS measures in 2014. This might have been expected, as the newer MCOs may not have fully established their delivery networks during the 2013 measurement year, and as a consequence, enrollee access issues may have contributed to low rates for these MCOs.

Previous years' reports have noted that the Apple Health MCOs would benefit from improving the accuracy and completeness of their encounter data. Health plans can minimize the cost of reporting many HEDIS measures by relying primarily on administrative data as opposed to chart extraction. However, reliance on administrative data can also result in lower HEDIS rates, if the encounter records in the administrative data do not capture all services provided.

Recommendations

To sustain long-term improvement in the delivery of managed care for Medicaid enrollees, Acumentra Health recommends that HCA

- seek to align performance measures with other state and federal reporting requirements to reduce burden on providers and promote efficient use of health system resources
- consider requiring the MCOs to engage in formal activity to share best practices aimed at reducing the performance gaps among health plans for specific measures
- help MCOs overcome barriers to collecting complete member-level encounter data, including race/ethnicity data, so that the MCOs can use these data to assess resources for improving the quality of care and establish appropriate interventions to address health care disparities. In previous years, the EQRO found gaps in immunization and well-child datasets that limit the ability to perform comprehensive analysis.
- set performance expectations for HEDIS measures, such as requiring MCOs to perform a PIP or focused improvement study for measures that fail to meet specific benchmarks
- designate incentive measures for which MCOs can receive quality incentive payments for top performance
- continue to provide EPSDT supplemental data to assist the MCOs in calculating HEDIS measures
- consider adding a contract requirement for the MCOs to provide HEDIS-specific performance feedback to clinics and providers on a frequent and regular schedule

Acumentra Health recommends that the contracted MCOs

- participate in public health initiatives and partnerships such as the Washington State Collaborative to Improve Care and the DOH's Washington State Immunization Information System (formerly called Child Profile)
- provide dashboard reporting on a routine basis to providers to highlight regional rates, since public reporting may promote more local control and better coordination among providers and other entities providing services
- monitor member-level data to improve the completeness of race and ethnicity information, to aid in establishing appropriate interventions to address health care disparities
- conduct validation studies to improve the quality of encounter data to ensure that enrollees are receiving appropriate interventions
- monitor their HEDIS rates at least quarterly, using administrative data

References

[1] National Committee for Quality Assurance. *NCQA HEDIS 2014 Technical Specifications. Volume 2*. Washington, DC. 2014.

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Appendix A. Washington MCO Summaries

	Page
Amerigroup Washington–AMG	A-2
Community Health Plan of Washington–CHP	A-3
Coordinated Care Corp.–CCC	A-4
Molina Healthcare of Washington–MHW	A-5
Molina Healthcare of Washington–MHW–Washington Medicaid Integration Partnership (WMIP)	A-6
UnitedHealthcare Community Plan–UHC	A-7
Comparison of Washington MCO and NCQA National Medicaid Averages	A-8

Amerigroup Washington—AMG

Effectiveness of Care

Childhood immunization status	%	
Combo 2 [a]	53.89	▼
Combo 3 [b]	50.30	▼

Adolescent immunization		
Combo 1 [c]	54.84	▼

Weight assessment/counseling for children/adolescents	
BMI total, (ages 3–17 years)	28.07
Nutrition total, (ages 3–17 years)	44.55
Physical activity total, (ages 3–17 years)	37.82

Appropriate testing for children with pharyngitis	
Children ages 2–18 diagnosed and treated	68.16

Comprehensive diabetes care	%	
HbA1c testing	81.64	▼
Poor HbA1c control [§]	53.76	
Good HbA1c control	37.17	
Eye exam	38.72	▼
LDL-C screening	70.80	
LDL-C level <100 mg/dL	27.21	
Monitoring for diabetic nephropathy	78.98	
Blood pressure <140/90 mm Hg	55.31	
Blood pressure <140/80 mm Hg	38.05	

Appropriate medications for people with asthma	
Total appropriately prescribed, (ages 5–64)	NA

Access/Availability of Care

Access to primary care practitioners	%	
Ages 12–24 months	93.45	▼
Ages 25 months–6 years	77.52	▼
Ages 7–11 years	NA	
Ages 12–19 years	NA	

Utilization

Inpatient—general hospital/acute care	Per 1000 MM[d]	
Total inpatient discharges	9.17	▲
Medical discharges	3.21	▲
Surgical discharges	1.81	▲
Maternity discharges	6.04	▲

	ALOS[e]	
Total inpatient	3.94	▲
Medical	4.02	▲
Surgical	7.29	▲
Maternity	2.43	

Adolescent well-care visits	%	
One or more visits during the year	34.95	

Well-child visits in 3rd, 4th, 5th, and 6th years of life		
One or more visits during the year	58.33	▼

Well-child visits in the first 15 months of life		
Six visits or more	45.26	▼

Ambulatory care	Per 1000 MM[d]	
Outpatient visits	331.57	▼
Emergency room visits	66.19	▲

Frequency of mental health outpatient/ED services		
Ages 0–12 years	1.01	▼
Ages 13–17 years	1.54	▼
Ages 18–64 years	2.35	▼

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 (p <0.05).

[§] Lower percentages indicate better performance for this measure.

[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.

[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.

[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.

[d] Per 1000 MM indicates the number of procedures, discharges, visits, etc. per 1000 member months.

[e] ALOS = average length of stay in days.

Amerigroup Washington works to improve health care access and quality for more than 114,000 Washingtonians through innovative care management programs and services. Through ongoing outreach and education, we encourage healthy behaviors that can reduce illness and improve quality of life. Amerigroup Washington believes that solutions to the health care challenges facing our members begin when we put our care and compassion to work, one individual at a time.

Community Health Plan of Washington—CHP

Effectiveness of Care

Childhood immunization status	%	
Combo 2 [a]	76.89	▲
Combo 3 [b]	73.48	▲

Adolescent immunization		
Combo 1 [c]	71.29	▲

Weight assessment/counseling for children/adolescents		
BMI total, (ages 3–17 years)	53.04	▲
Nutrition total, (ages 3–17 years)	52.80	▲
Physical activity total, (ages 3–17 years)	51.58	▲

Appropriate testing for children with pharyngitis		
Children ages 2–18 diagnosed and treated	59.18	▼

Comprehensive diabetes care	%	
HbA1c testing	91.79	▲
Poor HbA1c control [§]	33.94	▼
Good HbA1c control	58.58	▲
Eye exam	51.82	▲
LDL-C screening	75.91	
LDL-C level <100 mg/dL	34.31	▲
Monitoring for diabetic nephropathy	80.84	
Blood pressure <140/90 mm Hg	67.52	▲
Blood pressure <140/80 mm Hg	45.62	▲

Appropriate medications for people with asthma		
Total appropriately prescribed, (ages 5–64)	84.08	

Access/Availability of Care

Access to primary care practitioners	%			%	
Ages 12–24 months	97.14		Ages 7–11 years	89.39	▼
Ages 25 months–6 years	86.22	▼	Ages 12–19 years	88.49	▼

Utilization

Inpatient—general hospital/acute care	Per 1000 MM[d]			ALOS[e]	
Total inpatient discharges	5.59	▼	Total inpatient	3.29	▼
Medical discharges	1.96	▲	Medical	3.15	▼
Surgical discharges	1.13		Surgical	5.56	▼
Maternity discharges	4.48	▼	Maternity	2.36	

Adolescent well-care visits	%	
One or more visits during the year	42.34	

Well-child visits in 3rd, 4th, 5th, and 6th years of life		
One or more visits during the year	66.18	

Well-child visits in the first 15 months of life		
Six visits or more	60.10	

Ambulatory care	Per 1000 MM[d]	
Outpatient visits	319.95	▼
Emergency room visits	50.73	▼

Frequency of mental health outpatient/ED services		
Ages 0–12 years	1.33	▼
Ages 13–17 years	2.64	
Ages 18–64 years	3.93	▲

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p<0.05$).

[§] Lower percentages indicate better performance for this measure.

[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.

[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.

[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.

[d] Per 1000 MM indicates the number of procedures, discharges, visits, etc. per 1000 member months.

[e] ALOS = average length of stay in days.

Founded over 20 years ago by the state's community health centers, CHP is the state's only local, nonprofit health plan. Since 2011, the plan has been accredited by NCQA for Medicaid and Medicare products. CHP now provides managed care for more than 335,000 individuals throughout Washington. The plan's network includes more than 516 primary care clinics, 2,418 primary care providers, 13,827 specialists, and over 100 hospitals. CHP's innovative practices include programs that reward members for taking care of themselves, pay-for-performance models for network providers, and integrating clinical information across the care continuum.

Coordinated Care Corp.—CCC

Effectiveness of Care

Childhood immunization status	%	
Combo 2 [a]	64.35	
Combo 3 [b]	59.95	

Adolescent immunization		
Combo 1 [c]	69.21	

Weight assessment/counseling for children/adolescents		
BMI total, (ages 3–17 years)	19.91	▼
Nutrition total, (ages 3–17 years)	46.30	
Physical activity total, (ages 3–17 years)	45.14	

Appropriate testing for children with pharyngitis		
Children ages 2–18 diagnosed and treated	54.35	▼

Comprehensive diabetes care	%	
HbA1c testing	86.09	
Poor HbA1c control [§]	53.64	
Good HbA1c control	38.85	
Eye exam	47.24	
LDL-C screening	72.19	
LDL-C level <100 mg/dL	25.83	
Monitoring for diabetic nephropathy	80.57	
Blood pressure <140/90 mm Hg	60.71	▲
Blood pressure <140/80 mm Hg	39.74	

Appropriate medications for people with asthma		
Total appropriately prescribed, (ages 5–64)	NA	

Access/Availability of Care

Access to primary care practitioners	%	
Ages 12–24 months	97.19	
Ages 25 months–6 years	86.13	▼
Ages 7–11 years	NA	
Ages 12–19 years	NA	

Utilization

Inpatient—general hospital/acute care	Per 1000 MM[d]	
Total inpatient discharges	7.63	▲
Medical discharges	2.67	▲
Surgical discharges	1.44	▲
Maternity discharges	6.00	▲

	ALOS[e]	
Total inpatient	3.52	
Medical	3.38	
Surgical	6.73	▲
Maternity	2.31	

Adolescent well-care visits	%	
One or more visits during the year	38.19	

Well-child visits in 3rd, 4th, 5th, and 6th years		
One or more visits during the year	67.36	

Well-child visits in the first 15 months of life		
Six visits or more	43.06	▼

Ambulatory care	Per 1000 MM[d]	
Outpatient visits	345.94	▲
Emergency room visits	64.44	▲

Frequency of mental health outpatient/ED services		
Ages 0–12 years	0.78	▼
Ages 13–17 years	1.57	▼
Ages 18–64 years	2.99	▼

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p<0.05$).

[§] Lower percentages indicate better performance for this measure.

[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.

[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.

[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.

[d] Per 1000 MM indicates the number of procedures, discharges, visits, etc. per 1000 member months.

[e] ALOS = average length of stay in days.

Coordinated Care, a subsidiary of Centene Corporation, serves more than 170,000 members across Washington. The plan is NCQA-accredited for both its Medicaid and Ambetter products. Our mission is to improve the health of our beneficiaries through focused, compassionate, and coordinated care. This is based on the core belief that quality health care is best delivered locally.

Molina Healthcare of Washington—MHW

Effectiveness of Care

Childhood immunization status	%	
Combo 2 [a]	67.77	
Combo 3 [b]	64.24	

Adolescent immunization		
Combo 1 [c]	64.58	

Weight assessment/counseling for children/adolescents		
BMI total, (ages 3–17 years)	35.10	▲
Nutrition total, (ages 3–17 years)	45.03	
Physical activity total, (ages 3–17 years)	38.19	

Appropriate testing for children with pharyngitis		
Children ages 2–18 diagnosed and treated	67.38	▲

Comprehensive diabetes care	%	
HbA1c testing	87.61	
Poor HbA1c control [§]	44.14	▼
Good HbA1c control	45.95	▲
Eye exam	52.70	▲
LDL-C screening	71.17	
LDL-C level <100 mg/dL	30.41	
Monitoring for diabetic nephropathy	79.95	
Blood pressure <140/90 mm Hg	64.86	▲
Blood pressure <140/80 mm Hg	42.79	▲

Appropriate medications for people with asthma		
Total appropriately prescribed, (ages 5–64)	83.14	

Access/Availability of Care

Access to primary care practitioners	%			%	
Ages 12–24 months	97.78	▲	Ages 7–11 years	92.24	▲
Ages 25 months–6 years	89.04	▲	Ages 12–19 years	92.12	▲

Utilization

Inpatient—general hospital/acute care	Per 1000 MM[d]			ALOS[e]	
Total inpatient discharges	5.25	▼	Total inpatient	3.35	▼
Medical discharges	1.54	▼	Medical	3.27	▼
Surgical discharges	0.99	▼	Surgical	6.41	
Maternity discharges	5.15		Maternity	2.27	▼

Adolescent well-care visits	%	
One or more visits during the year	44.37	▲

Well-child visits in 3rd, 4th, 5th, and 6th years of life		
One or more visits during the year	64.60	

Well-child visits in the first 15 months of life		
Six visits or more	67.77	▲

Ambulatory care	Per 1000 MM[d]	
Outpatient visits	345.83	▲
Emergency room visits	48.06	▼

Frequency of mental health outpatient/ED services		
Ages 0–12 years	2.91	▲
Ages 13–17 years	6.15	▲
Ages 18–64 years	5.19	▲

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p<0.05$).

[§] Lower percentages indicate better performance for this measure.

[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.

[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.

[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.

[d] Per 1000 MM indicates the number of procedures, discharges, visits, etc. per 1000 member months.

[e] ALOS = average length of stay in days.

Established in 1995, Molina Healthcare of Washington (MHW) provides coverage for Medicaid enrollees in 34 counties across Washington. MHW insures approximately 483,000 lives, 98% of whom are covered by Medicaid. About 64% of Medicaid clients are 18 years of age or younger. MHW is accredited by NCQA for its Medicaid product lines.

Molina Healthcare of Washington—MHW—WMIP

Effectiveness of Care

Comprehensive diabetes care	%		%
HbA1c testing	84.25	LDL-C screening	75.11
Poor HbA1c control [§]	47.95	LDL-C level <100 mg/dL	37.21
Good HbA1c control	42.24	Blood pressure <140/90 mm Hg	58.90
Eye exam	50.46	Blood pressure <140/80 mm Hg	41.10
Monitoring for diabetic nephropathy	81.28		

Utilization

Inpatient—general hospital/acute care	Per 1000 MM[a]		ALOS[b]
Total inpatient discharges	16.76	Total inpatient	5.46
Medical discharges	10.26	Medical	4.37
Surgical discharges	5.80	Surgical	7.73

Ambulatory care	Per 1000 MM[a]	
Outpatient visits	593.58	↑
Emergency room visits	88.15	

Medication measures	%
Antidepressant medication management	
Effective acute-phase treatment	51.97
Effective continuation-phase treatment	39.37
Use of high-risk medications in the elderly	
One prescription	4.27
At least two prescriptions	0.90

Mental health care follow-up and utilization	%	
30-day follow-up	NA	
7-day follow-up	NA	
Any services total	25.35	↓
Inpatient total	0.67	↓
Intensive outpatient/partial hospitilization total	1.75	↑
Outpatient/ER total	25.15	↓

Dependence treatment measures	%		%	
Initiation/engagement of AOD dependence treatment		**Identification of alcohol and other drug services**		
Total initiation	NA	Any services total	20.58	
Total engagement	NA	Inpatient total	41.17	↓
		Outpatient/ER total	18.51	

NA: Sample size was smaller than the minimum required during the reporting year.

↑↓ Indicates statistically significant difference in rates from 2013 to 2014 ($p < 0.05$).

[§] Lower percentages indicate better performance for this measure.

[a] Per 1000 MM indicates the number of procedures, discharges, visits, etc. per 1000 member months.

[b] ALOS = average length of stay in days.

Established in 1995, Molina Healthcare of Washington (MHW) provides coverage for Medicaid enrollees in 34 counties across Washington. MHW insures approximately 483,000 lives, 98% of whom are covered by Medicaid. About 64% of Medicaid clients are 18 years of age or younger. MHW is accredited by NCQA for its Medicaid product lines.

UnitedHealthcare Community Plan—UHC

Effectiveness of Care

Childhood immunization status	%	
Combo 2 [a]	59.61	▼
Combo 3 [b]	57.66	

Adolescent immunization		
Combo 1 [c]	61.31	

Weight assessment/counseling for children/adolescents		
BMI total, (ages 3–17 years)	14.36	▼
Nutrition total, (ages 3–17 years)	39.90	▼
Physical activity total, (ages 3–17 years)	34.55	▼

Appropriate testing for children with pharyngitis		
Children ages 2–18 diagnosed and treated	66.77	

Comprehensive diabetes care	%	
HbA1c testing	82.73	
Poor HbA1c control [§]	87.83	▲
Good HbA1c control	11.19	▼
Eye exam	37.96	▼
LDL-C screening	68.61	
LDL-C level <100 mg/dL	9.98	▼
Monitoring for diabetic nephropathy	75.67	
Blood pressure <140/90 mm Hg	11.19	▼
Blood pressure <140/80 mm Hg	6.57	▼

Appropriate medications for people with asthma		
Total appropriately prescribed, (ages 5–64)	NA	

Access/Availability of Care

Access to primary care practitioners	%	
Ages 12–24 months	93.94	▼
Ages 25 months–6 years	82.20	▼
Ages 7–11 years	NA	
Ages 12–19 years	NA	

Utilization

Inpatient—general hospital/acute care	Per 1000 MM[d]	
Total inpatient discharges	7.30	▲
Medical discharges	2.49	▲
Surgical discharges	1.48	▲
Maternity discharges	5.24	

	ALOS[e]	
Total inpatient	4.03	▲
Medical	4.12	▲
Surgical	7.32	▲
Maternity	2.51	▲

Adolescent well-care visits	%	
One or more visits during the year	35.52	

Well-child visits in 3rd, 4th, 5th, and 6th years of life		
One or more visits during the year	62.77	

Well-child visits in the first 15 months of life		
Six visits or more	58.64	

Ambulatory care	Per 1000 MM[d]	
Outpatient visits	347.88	▲
Emergency room visits	58.73	▲

Frequency of mental health outpatient/ED services		
Ages 0–12 years	0.75	▼
Ages 13–17 years	1.82	▼
Ages 18–64 years	2.61	▼

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p<0.05$).

[§] Lower percentages indicate better performance for this measure.

[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.

[b] Combo 3 includes DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV immunizations.

[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.

[d] Per 1000 MM indicates the number of procedures, discharges, visits, etc. per 1000 member months.

[e] ALOS = average length of stay in days.

UHC is the largest Medicaid managed care plan in the United States, with more than 25 years of experience helping low-income adults and children and people with disabilities get access to personalized health care benefits and services. In Washington, UHC provides Medicaid coverage through Apple Health for more than 170,000 enrollees in 32 counties. UHC is also a lead entity for the Washington State Health Home Initiative and for the state's Medicare-Medicaid Eligible (MME) Demonstration Project in King and Snohomish counties.

Comparison of Washington Medicaid and NCQA National Medicaid Averages

Effectiveness of Care

Childhood immunization status	State %		NCQA %
Combo 2 [a]	65.96	▼	74.02
Combo 3 [b]	62.59	▼	70.85
Adolescent immunization			
Combo 1 [c]	65.44	▼	70.17
Weight assessment/counseling			
BMI total, (ages 3–17 years)	30.07	▼	56.92
Nutrition total, (ages 3–17 years)	45.70	▼	58.70
Physical activity total, (ages 3–17 years)	41.39	▼	50.50
Appropriate testing for pharyngitis			
Children ages 2–18 diagnosed/treated	63.74	▼	66.52

Comprehensive diabetes care	State %		NCQA %
HbA1c testing	86.27	▲	83.81
Poor HbA1c control [§]	53.25	▲	45.57
Good HbA1c control	39.64	▼	45.52
Eye exam	46.06	▼	53.53
LDL-C screening	71.97	▼	75.97
LDL-C level <100 mg/dL	26.17	▼	33.91
Monitoring for diabetic nephropathy	79.33		79.02
Blood pressure <140/90 mm Hg	53.25	▼	60.49
Blood pressure <140/80 mm Hg	35.49	▼	39.24
Appropriate asthma medications			
Total, (ages 5–64)	83.47		84.07

Access/Availability of Care

Access to primary care practitioners	%		%
Ages 12–24 months	97.25	▲	96.14
Ages 25 months–6 years	87.53	▼	88.25
Ages 7–11 years	91.22	▲	90.02
Ages 12–19 years	90.75	▲	88.52

Utilization

Inpatient—general hospital/acute care	Per 1000 MM[d]		
Total inpatient discharges	5.83	▼	8.88
Medical discharges	1.89	▼	4.51
Surgical discharges	1.14	▼	1.60
Maternity discharges	5.05	▲	4.80

	ALOS[e]		
Total inpatient	3.43	▼	3.81
Medical	3.36	▼	3.67
Surgical	6.29	▼	6.41
Maternity	2.33	▼	2.61

Adolescent well-care visits	%		%
One or more visits during the year	39.13	▼	50.03
Well-child visits in 3rd, 4th, 5th, and 6th years			
One or more visits during the year	63.84	▼	71.49
Well-child visits in the first 15 months of life			
Six visits or more	56.25	▼	61.55

Ambulatory care	Per 1000 MM[d]		
Outpatient visits	337.04	▼	364.38
Emergency room visits	51.64	▼	62.89
Frequency of mental health outpatient/ED services			
Ages 0–12 years	1.23		NA
Ages 13–17 years	2.54		NA
Ages 18–64 years	3.55		NA

▲▼ State average is significantly higher or lower than NCQA *Quality Compass* average (p <0.05).

[§] Lower percentages indicate better performance for this measure.

[a] Combo 2 includes DTaP, IPV, MMR, HiB, Hep B, and VZV immunizations.

[b] Combo 3 includes DTaP, MMR, IPV, HiB, Hep B, VZV, and PCV immunizations.

[c] Adolescent Combo 1 includes Meningococcal conjugate vaccine and Tetanus, Diphtheria, and Pertussis (Tdap) vaccine.

[d] Per 1000 MM indicates the number of procedures, discharges, visits, etc. per 1000 member months.

[e] ALOS = average length of stay in days.

NA: not available from the NCQA *Quality Compass* for Medicaid in the reporting year.

Appendix B. HEDIS Data Tables for All Measures

Table	Title	Page
Table B-1	DTaP immunizations by health plan, reporting years 2010–2014	B-1
Table B-2	IPV immunizations by health plan, reporting years 2010–2014	B-2
Table B-3	MMR immunizations by health plan, reporting years 2010–2014	B-3
Table B-4	HiB immunizations by health plan, reporting years 2010–2014	B-4
Table B-5	Hepatitis B immunizations by health plan, reporting years 2010–2014	B-5
Table B-6	VZV immunizations by health plan, reporting years 2010–2014	B-6
Table B-7	PCV immunizations by health plan, reporting years 2010–2014	B-7
Table B-8	Hepatitis A immunizations by health plan, reporting years 2010–2014	B-8
Table B-9	Rotavirus immunizations by health plan, reporting years 2010–2014	B-9
Table B-10	Influenza immunizations by health plan, reporting years 2010–2014	B-10
Table B-11	Combination 2 immunizations by health plan, reporting years 2010–2014	B-11
Table B-12	Combination 3 immunizations by health plan, reporting years 2010–2014	B-12
Table B-13	Combination 4 immunizations by health plan, reporting years 2010–2014	B-13
Table B-14	Combination 5 immunizations by health plan, reporting years 2010–2014	B-14
Table B-15	Combination 6 immunizations by health plan, reporting years 2010–2014	B-15
Table B-16	Combination 7 immunizations by health plan, reporting years 2010–2014	B-16
Table B-17	Combination 8 immunizations by health plan, reporting years 2010–2014	B-17
Table B-18	Combination 9 immunizations by health plan, reporting years 2010–2014	B-18
Table B-19	Combination 10 immunizations by health plan, reporting years 2010–2014	B-19
Table B-20	HbA1c tests by health plan, reporting years 2010–2014	B-20
Table B-21	Enrollees with poor control of HbA1c levels by health plan, reporting years 2010–2014	B-21
Table B-22	Enrollees with good control of HbA1c levels by health plan, reporting years 2010–2014	B-22
Table B-23	Dilated retinal exams by health plan, reporting years 2010–2014	B-23
Table B-24	Lipid profile (LDL-C) screening performed by health plan, reporting years 2010–2014	B-24
Table B-25	Lipids controlled (<100 mg/dL) by health plan, reporting years 2010–2014	B-25
Table B-26	Nephropathy monitored annually by health plan, reporting years 2010–2014	B-26
Table B-27	Blood pressure controlled (<140/80 mm Hg) by health plan, reporting years 2010–2014	B-27
Table B-28	Blood pressure controlled (<140/90 mm Hg) by health plan, reporting years 2010–2014	B-28
Table B-29	Six or more well-child visits in the first 15 months of life by health plan, reporting years 2010–2014	B-29
Table B-30	Five well-child visits in the first 15 months of life by health plan, reporting years 2010–2014	B-30
Table B-31	Four well-child visits in the first 15 months of life by health plan, reporting years 2010–2014	B-31
Table B-32	Three well-child visits in the first 15 months of life by health plan, reporting years 2010–2014	B-32

Table B-33	Two well-child visits in the first 15 months of life by health plan, reporting years 2010–2014	B-33
Table B-34	One well-child visit in the first 15 months of life by health plan, reporting years 2010–2014	B-34
Table B-35	Zero well-child visits in the first 15 months of life by health plan, reporting years 2010–2014	B-35
Table B-36	Well-child visits in the 3rd, 4th, 5th, and 6th years of life by health plan, reporting years 2010–2014	B-36
Table B-37	Adolescents ages 12–21 with one or more well-care visits by health plan, reporting years 2010–2014	B-37
Table B-38	Adolescents meningococcal immunizations, by health plan, reporting year 2014	B-38
Table B-39	Adolescents Tdap immunizations, by health plan, reporting year 2014	B-39
Table B-40	Adolescents Combo1 immunizations, by health plan, reporting year 2014	B-40
Table B-41	Weight assessment and counseling for nutrition and physical activity for children and adolescents, BMI total, by health plan, reporting year 2014	B-41
Table B-42	Weight assessment and counseling for nutrition and physical activity for children and adolescents, BMI, age 3–11 years, by health plan, reporting year 2014	B-42
Table B-43	Weight assessment and counseling for nutrition and physical activity for children and adolescents, BMI, age 12–17 years, by health plan, reporting year 2014	B-43
Table B-44	Weight assessment and counseling for nutrition and physical activity for children and adolescents, nutrition total, by health plan, reporting year 2014	B-44
Table B-45	Weight assessment and counseling for nutrition and physical activity for children and adolescents, nutrition, age 3–11 years, by health plan, reporting year 2014	B-45
Table B-46	Weight assessment and counseling for nutrition and physical activity for children and adolescents, nutrition, age 12–17 years, by health plan, reporting years 2010–2014	B-46
Table B-47	Weight assessment and counseling for nutrition and physical activity for children and adolescents, activity total, by health plan, reporting year 2014	B-47
Table B-48	Weight assessment and counseling for nutrition and physical activity for children and adolescents, physical activity, age 3–11 years, by health plan, reporting year 2014	B-48
Table B-49	Weight assessment and counseling for nutrition and physical activity for children and adolescents, physical activity, age 12–17 years, by health plan, reporting year 2014	B-49
Table B-50	Access to primary care practitioners, 12–24 months, by health plan, reporting year 2014	B-50
Table B-51	Access to primary care practitioners, 25 months–6 years, by health plan, reporting year 2014	B-51
Table B-52	Access to primary care practitioners, 7–11 years, by health plan, reporting year 2014	B-52
Table B-53	Access to primary care practitioners, 12–19 years, by health plan, reporting year 2014	B-53
Table B-54	Children 2–18 years, diagnosed and treated for pharyngitis, by health plan, reporting year 2014	B-54
Table B-55	Total appropriate prescribed asthma medication, by health plan, reporting year 2014	B-55
Table B-56	Age 5–11 years, prescribed asthma medication, by health plan, reporting year 2014	B-56
Table B-57	Age 12–18 years, prescribed asthma medication, by health plan, reporting year 2014	B-57

Table B-58	Age 19–50 years, prescribed asthma medication, by health plan, reporting year 2014	B-58
Table B-59	Age 51–64 years, prescribed asthma medication, by health plan, reporting year 2014	B-59
Table B-60	Frequency of mental health outpatient and ED Services, total, by health plan, reporting year 2014.	B-60
Table B-61	Frequency of mental health outpatient and ED Services, 0–12 years, by health plan, reporting year 2014.	B-61
Table B-62	Frequency of mental health outpatient and ED Services, 13–17 years, by health plan, reporting year 2014.	B-62
Table B-63	Frequency of mental health outpatient and ED Services, 18–64 years, by health plan, reporting year 2014.	B-63
Table B-64	General hospital/acute care total inpatient discharges by health plan, reporting years 2010–2014	B-64
Table B-65	General hospital/acute care total inpatient days by health plan, reporting years 2010–2014	B-65
Table B-66	General hospital/acute care medical discharges by health plan, reporting years 2010–2014	B-66
Table B-67	General hospital/acute care medical days by health plan, reporting years 2010–2014	B-67
Table B-68	General hospital/acute care surgical discharges by health plan, reporting years 2010–2014	B-68
Table B-69	General hospital/acute care surgical days by health plan, reporting years 2010–2014	B-69
Table B-70	General hospital/acute care maternity discharges by health plan, reporting years 2010–2014	B-70
Table B-71	General hospital/acute care maternity days by health plan, reporting years 2010–2014	B-71
Table B-72	Ambulatory care, outpatient visits provided by health plan, reporting years 2010–2014	B-72
Table B-73	Ambulatory care, emergency room visits provided by health plan, reporting years 2010–2014	B-73
Table B-74	Plan all-cause readmissions, total, reporting year 2014	B-74
Table B-75	Plan all-cause readmissions, 18–44 years, reporting year 2014	B-75
Table B-76	Plan all-cause readmissions, 45–54 years, reporting year 2014	B-76
Table B-77	Plan all-cause readmissions, 55–64 years, reporting year 2014	B-77
Table B-78	WMIP comprehensive diabetes care measures, reporting years 2010–2014	B-78
Table B-79	WMIP inpatient utilization measures, reporting years 2010–2014	B-79
Table B-80	WMIP ambulatory care measures, reporting years 2010–2014	B-80
Table B-81	WMIP mental health care follow-up and utilization measures, reporting years 2010–2014	B-81
Table B-82	WMIP medication measures, reporting years 2010–2014	B-82
Table B-83	WMIP identification and initiation of dependence treatment, reporting years 2010-2014	B-83

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Table B-1. DTaP immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	61.68	▼
CCC	—	—	—	—	—	—	NR		432	72.92	
CHP	411	82.24	411	83.70	411	80.54	NR		411	79.81	▲
MHW	432	81.25	432	75.23	432	77.08	NR		453	74.17	
UHC	—	—	—	—	—	—	NR		411	66.18	▼
State average		80.74		74.76		74.95				72.25	*↓
NCQA average										79.03	
NCQA 90th percentile[a]										87.90	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA *Quality Compass* for Medicaid in the reporting year.

Table B-2. IPV immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	77.84	▼
CCC	—	—	—	—	—	—	NR		432	83.33	
CHP	411	92.21	411	93.67	411	92.21	NR		411	91.24	▲
MHW	432	91.67	432	90.51	432	88.89	NR		453	89.18	▲
UHC	—	—	—	—	—	—	NR		411	80.05	▼
State average		90.68		89.45		88.39				85.27	*↓
NCQA average										90.04	
NCQA 90th percentile[a]										95.38	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-3. MMR immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	79.64	▼
CCC	—	—	—	—	—	—	NR		432	86.57	
CHP	411	91.97	411	92.70	411	91.48	NR		411	90.51	▲
MHW	432	90.97	432	88.43	432	87.73	NR		453	88.96	
UHC	—	—	—	—	—	—	NR		411	81.51	▼
State average		90.39		88.49		87.38				86.29	*↓
NCQA average										90.54	
NCQA 90th percentile[a]										94.89	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-4. HiB immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	82.63	
CCC	—	—	—	—	—	—	NR		432	85.65	
CHP	411	95.62	411	91.48	411	92.21	NR		411	91.73	▲
MHW	432	95.60	432	87.96	432	89.81	NR		453	89.18	
UHC	—	—	—	—	—	—	NR		411	80.29	▼
State average		94.37		87.48		89.02				86.39	*↓
NCQA average										90.66	
NCQA 90th percentile[a]										95.60	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-5. HepB immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	83.23	
CCC	—	—	—	—	—	—	NR		432	81.25	
CHP	411	93.67	411	94.65	411	91.73	NR		411	90.75	▲
MHW	432	91.90	432	89.81	432	88.19	NR		453	87.20	
UHC	—	—	—	—	—	—	NR		411	76.40	▼
State average		92.24		89.79		85.79				83.88	*↓
NCQA average										88.57	
NCQA 90th percentile[a]										94.91	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-6. VZV immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	77.84	▼
CCC	—	—	—	—	—	—	NR		432	86.11	
CHP	411	90.27	411	92.21	411	90.02	NR		411	89.05	
MHW	432	89.58	432	86.11	432	86.81	NR		453	87.64	
UHC	—	—	—	—	—	—	NR		411	82.48	
State average		89.21		86.51		85.98				85.59	*↓
NCQA average										90.19	
NCQA 90th percentile[a]										94.68	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-7. PCV immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	62.87	▼
CCC	—	—	—	—	—	—	NR		432	72.92	
CHP	411	82.24	411	81.75	411	82.24	NR		411	79.32	▲
MHW	432	82.41	432	79.40	432	78.01	NR		453	75.28	
UHC	—	—	—	—	—	—	NR		411	71.29	
State average		79.46		77.12		77.50				73.64	*↓
NCQA average										79.22	
NCQA 90th percentile[a]										88.19	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-8. Hepatitis A immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized[a]											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	—	—	—	—	—	—	NR		167	67.07		▼
CCC	—	—	—	—	—	—	NR		432	82.41		▲
CHP	411	42.09	411	39.42	411	36.50	NR		411	83.45	↑	▲
MHW	432	34.03	432	26.39	432	32.87	NR		453	75.28	↑	
UHC	—	—	—	—	—	—	NR		411	71.78		▼
State average		39.96		26.30		28.37				77.21	*↑	
NCQA average										81.89		
NCQA 90th percentile[b]										91.73		

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a]Hepatitis A – 2014 measure required one dose for compliance; 2012 measure required two doses.

[b] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-9. Rotavirus immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	53.89	▼
CCC	—	—	—	—	—	—	NR		432	66.20	
CHP	411	31.14	411	60.58	411	71.78	NR		411	70.80	▲
MHW	432	29.63	432	55.79	432	61.34	NR		453	68.43	↑
UHC	—	—	—	—	—	—	NR		411	60.34	
State average		26.03		53.28		63.87				65.37	*↑
NCQA average										67.73	
NCQA 90th percentile[a]										79.90	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-10. Influenza immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	38.92	▼
CCC	—	—	—	—	—	—	NR		432	55.79	
CHP	411	45.01	411	47.45	411	45.50	NR		411	58.88	↑
MHW	432	44.21	432	51.39	432	44.91	NR		453	53.42	↑
UHC	—	—	—	—	—	—	NR		411	53.28	
State average		40.51		42.34		43.21				53.84	*↑
NCQA average										50.00	
NCQA 90th percentile[a]										65.97	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-11. Combo 2 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	53.89	▼
CCC	—	—	—	—	—	—	NR		432	64.35	
CHP	411	78.10	411	78.35	411	77.37	NR		411	76.89	▲
MHW	432	77.31	432	70.60	432	72.22	NR		453	67.77	
UHC	—	—	—	—	—	—	NR		411	59.61	▼
State average		76.72		69.27		69.70				65.96	*↓
NCQA average										74.02	
NCQA 90th percentile[a]										83.33	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-12. Combo 3 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	50.30	▼
CCC	—	—	—	—	—	—	NR		432	59.95	
CHP	411	74.70	411	73.72	411	72.75	NR		411	73.48	▲
MHW	432	73.61	432	68.29	432	68.98	NR		453	64.24	
UHC	—	—	—	—	—	—	NR		411	57.66	
State average		71.60		65.94		66.71				62.59	*↓
NCQA average										70.85	
NCQA 90th percentile[a]										80.86	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-13. Combo 4 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	48.50	▼
CCC	—	—	—	—	—	—	NR		432	57.87	
CHP	411	38.44	411	36.50	411	33.82	NR		411	71.53	↑ ▲
MHW	432	31.71	432	24.07	432	30.32	NR		453	59.60	↑
UHC	—	—	—	—	—	—	NR		411	50.61	▼
State average		33.36		23.55		26.01				58.86	*↑
NCQA average										64.87	
NCQA 90th percentile[a]										77.04	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-14. Combo 5 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	40.72	▼
CCC	—	—	—	—	—	—	NR		432	48.84	
CHP	411	27.01	411	51.34	411	61.56	NR		411	62.77	▲
MHW	432	26.39	432	46.76	432	52.78	NR		453	54.53	
UHC	—	—	—	—	—	—	NR		411	45.74	▼
State average		22.76		43.26		53.18				51.87	*↓
NCQA average										56.38	
NCQA 90th percentile[a]										70.61	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-15. Combo 6 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	28.74	▼
CCC	—	—	—	—	—	—	NR		432	42.82	
CHP	411	39.17	411	39.42	411	40.88	NR		411	52.55	↑ ▲
MHW	432	40.51	432	43.75	432	39.58	NR		453	42.60	
UHC	—	—	—	—	—	—	NR		411	40.15	
State average		35.68		34.20		37.09				43.06	
NCQA average										42.21	
NCQA 90th percentile[a]										59.37	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-16. Combo 7 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	39.52	▼
CCC	—	—	—	—	—	—	NR		432	47.69	
CHP	411	14.84	411	26.52	411	29.68	NR		411	61.80	↑ ▲
MHW	432	12.73	432	17.36	432	24.54	NR		453	51.66	↑
UHC	—	—	—	—	—	—	NR		411	42.34	▼
State average		11.45		16.28		21.72				49.84	*↑
NCQA average										53.41	
NCQA 90th percentile[a]										67.36	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-17. Combo 8 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	—	—	—	—	—	—	NR		167	28.14		▼
CCC	—	—	—	—	—	—	NR		432	42.13		
CHP	411	20.68	411	22.14	411	21.17	NR		411	51.34	↑	▲
MHW	432	19.44	432	15.51	432	19.68	NR		453	41.72	↑	
UHC	—	—	—	—	—	—	NR		411	36.74		
State average		19.21		13.82		16.38				41.62	↑	
NCQA average										40.34		
NCQA 90th percentile[a]										57.02		

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-18. Combo 9 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		167	25.15	▼
CCC	—	—	—	—	—	—	NR		432	36.57	
CHP	411	14.60	411	30.17	411	36.98	NR		411	46.23	↑ ▲
MHW	432	16.44	432	33.10	432	32.18	NR		453	36.87	
UHC	—	—	—	—	—	—	NR		411	34.31	
State average		12.97		25.19		31.02				37.25	
NCQA average										35.90	
NCQA 90th percentile[a]										51.34	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-19. Combo 10 immunizations by health plan, reporting years 2010–2014.

Health plan	Number and percentage immunized											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	—	—	—	—	—	—	NR		167	24.55		▼
CCC	—	—	—	—	—	—	NR		432	36.11		
CHP	411	7.79	411	17.03	411	19.71	NR		411	45.50	↑	▲
MHW	432	8.10	432	11.57	432	16.44	NR		453	36.20	↑	
UHC	—	—	—	—	—	—	NR		411	32.36		
State average		7.05		10.40		14.16				36.34	↑	
NCQA average										34.67		
NCQA 90th percentile[a]										49.67		

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-20. HbA1c tests by health plan, reporting years 2010–2014.

Health plan	Number and percentage tested													
	2010		2011		2012		2013		2014					
	n	%	n	%	n	%	n	%	n	%				
AMG	—	—	—	—	—	—	NR		452	81.64				▼
CCC	—	—	—	—	—	—	NR		453	86.09				
CHP	411	83.45	411	87.10	411	82.97	NR		548	91.79			↑	▲
MHW	429	82.05	430	83.49	447	83.45	NR		444	87.61				
UHC	—	—	—	—	—	—	NR		411	82.73				
State average		83.67		83.61		82.84				86.27			*↑	
NCQA average										83.81				
NCQA 90th percentile[a]										91.73				

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-21. Enrollees with poor control of HbA1c levels by health plan, reporting years 2010–2014.

Health plan	Number and percentage with HbA1c level at >9.0 percent [a]										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		452	53.76	
CCC	—	—	—	—	—	—	NR		453	53.64	
CHP	411	47.93	411	50.61	411	46.47	NR		548	33.94	↓ ▼
MHW	429	46.39	430	41.16	447	45.86	NR		444	44.14	▼
UHC	—	—	—	—	—	—	NR		411	87.83	▲
State average		45.77		47.92		47.62				53.25	*↑
NCQA average										45.57	
NCQA 90th percentile[b]										30.28	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Lower percentages indicate better performance for this measure.

[b] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-22. Enrollees with good control of HbA1c levels by health plan, reporting years 2010–2014.

Health plan	Number and percentage with HbA1c level at <8.0 percent											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	—	—	—	—	—	—	NR		452	37.17		
CCC	—	—	—	—	—	—	NR		453	38.85		
CHP	411	41.12	411	39.66	411	41.36	NR		548	58.58	↑	▲
MHW	429	44.76	430	47.44	447	44.07	NR		444	45.95		▲
UHC	—	—	—	—	—	—	NR		411	11.19		▼
State average		44.33		42.51		43.02				39.64	*	
NCQA average										45.52		
NCQA 90th percentile[a]										59.37		

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-23. Dilated retinal exams by health plan, reporting years 2010–2014.

Health plan	Number and percentage examined										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		452	38.72	▼
CCC	—	—	—	—	—	—	NR		453	47.24	
CHP	411	54.01	411	57.18	411	50.12	NR		548	51.82	▲
MHW	429	60.37	430	60.93	447	51.68	NR		444	52.70	▲
UHC	—	—	—	—	—	—	NR		411	37.96	▼
State average		58.21		58.67		49.33				46.06	*↓
NCQA average										53.53	
NCQA 90th percentile[a]										68.04	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-24. Lipid profile (LDL-C screening) performed by health plan, reporting years 2010–2014.

Health plan	Number and percentage profiled										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		452	70.80	
CCC	—	—	—	—	—	—	NR		453	72.19	
CHP	411	68.37	411	66.67	411	63.99	NR		548	75.91	↑
MHW	429	66.67	430	67.21	447	68.01	NR		444	71.17	
UHC	—	—	—	—	—	—	NR		411	68.61	
State average		68.78		65.41		65.23				71.97	*↑
NCQA average										75.97	
NCQA 90th percentile[a]										83.71	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-25. Lipids controlled (<100 mg/dL) by health plan, reporting years 2010–2014.

Health plan	Number and percentage with LDL level <100 mg/dL										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		452	27.21	
CCC	—	—	—	—	—	—	NR		453	25.83	
CHP	411	21.90	411	24.09	411	22.14	NR		548	34.31	↑ ▲
MHW	429	25.41	430	26.74	447	27.29	NR		444	30.41	
UHC	—	—	—	—	—	—	NR		411	9.98	▼
State average		23.86		22.59		24.44				26.17	*↑
NCQA average										33.91	
NCQA 90th percentile[a]										45.59	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-26. Nephropathy monitored annually by health plan, reporting years 2010–2014.

Health plan	Number and percentage monitored for nephropathy										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		452	78.98	
CCC	—	—	—	—	—	—	NR		453	80.57	
CHP	411	70.32	411	71.78	411	70.80	NR		548	80.84	↑
MHW	429	73.66	430	73.49	447	71.81	NR		444	79.95	↑
UHC	—	—	—	—	—	—	NR		411	75.67	
State average		72.42		72.08		72.66				79.33	↑
NCQA average										79.02	
NCQA 90th percentile[a]										86.86	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-27. Blood pressure controlled (<140/80 mm Hg), by health plan, reporting years 2010–2014.

Health plan	Number and percentage with blood pressure <140/80 mm Hg[a]										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		—	—	—	—	NR		452	38.05	
CCC	NR		—	—	—	—	NR		453	39.74	
CHP	NR		411	36.98	411	42.58	NR		548	45.62	▲
MHW	NR		430	44.19	447	44.74	NR		444	42.79	▲
UHC	NR		—	—	—	—	NR		411	6.57	▼
State average				41.02		43.54				35.49	*↓
NCQA average										39.24	
NCQA 90th percentile[a]										53.20	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-28. Blood pressure controlled (<140/90 mm Hg), by health plan, reporting years 2010–2014.

Health plan	Number and percentage with blood pressure <140/90 mm Hg										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		452	55.31	
CCC	—	—	—	—	—	—	NR		453	60.71	▲
CHP	411	67.64	411	64.72	411	69.34	NR		548	67.52	▲
MHW	429	69.93	430	70.93	447	70.25	NR		444	64.86	▲
UHC	—	—	—	—	—	—	NR		411	11.19	▼
State average		69.97		67.92		68.50				53.25	*↓
NCQA average										60.49	
NCQA 90th percentile[a]										75.18	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-29. Six or more well-child visits in the first 15 months of life by health plan, reporting years 2010–2014.

Health plan	Number and percentage with six or more visits											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	—	—	—	—	—	—	NR		190	45.26		▼
CCC	—	—	—	—	—	—	NR		432	43.06		▼
CHP	411	47.93	411	51.09	411	54.26	NR		411	60.10		
MHW	432	59.95	431	61.25	432	59.03	NR		453	67.77	↑	▲
UHC	—	—	—	—	—	—	NR		411	58.64		
State average		52.57		53.73		58.09				56.25	*	
NCQA average										61.55		
NCQA 90th percentile[a]										76.92		

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-30. Five well-child visits in the first 15 months of life by health plan, reporting years 2010–2014.

Health plan	Number and percentage with five visits										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		190	19.47	
CCC	—	—	—	—	—	—	NR		432	28.24	▲
CHP	411	21.41	411	21.65	411	22.14	NR		411	19.95	
MHW	432	18.06	431	20.42	432	20.37	NR		453	16.34	▼
UHC	—	—	—	—	—	—	NR		411	19.95	
State average		21.36		18.94		18.55				20.93	*
NCQA average										16.01	
NCQA 90th percentile[a]										22.22	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-31. Four well-child visits in the first 15 months of life by health plan, reporting years 2010–2014.

Health plan	Number and percentage with four visits										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		190	14.21	
CCC	—	—	—	—	—	—	NR		432	15.05	
CHP	411	16.79	411	14.11	411	12.17	NR		411	10.71	
MHW	432	12.50	431	9.98	432	11.34	NR		453	9.27	
UHC	—	—	—	—	—	—	NR		411	10.71	
State average		13.23		13.45		11.51				11.70	*
NCQA average										9.75	
NCQA 90th percentile[a]										15.00	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-32. Three well-child visits in the first 15 months of life by health plan, reporting years 2010–2014.

Health plan	Number and percentage with three visits										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		190	5.26	
CCC	—	—	—	—	—	—	NR		432	6.48	
CHP	411	6.33	411	5.11	411	6.08	NR		411	4.38	
MHW	432	5.09	431	2.78	432	5.32	NR		453	3.09	
UHC	—	—	—	—	—	—	NR		411	2.92	
State average		7.61		6.07		6.02				4.32	↓
NCQA average										5.30	
NCQA 90th percentile[a]										8.99	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-33. Two well-child visits in the first 15 months of life by health plan, reporting years 2010–2014.

Health plan	Number and percentage with two visits									
	2010		2011		2012		2013		2014	
	n	%	n	%	n	%	n	%	n	%
AMG	—	—	—	—	—	—	NR		190	5.26
CCC	—	—	—	—	—	—	NR		432	3.24
CHP	411	3.41	411	4.14	411	2.43	NR		411	2.43
MHW	432	2.78	431	3.71	432	2.08	NR		453	2.65
UHC	—	—	—	—	—	—	NR		411	1.95
State average		2.95		4.19		3.42				2.85
NCQA average										2.94
NCQA 90th percentile[a]										5.20

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-34. One well-child visit in the first 15 months of life by health plan, reporting years 2010–2014.

Health plan	Number and percentage with one visit													
	2010		2011		2012		2013		2014					
	n	%	n	%	n	%	n	%	n	%				
AMG	—	—	—	—	—	—	NR		190	2.63				
CCC	—	—	—	—	—	—	NR		432	2.31				
CHP	411	3.16	411	1.70	411	1.70	NR		411	1.46				
MHW	432	1.16	431	0.93	432	1.39	NR		453	0.00	↓	▼		
UHC	—	—	—	—	—	—	NR		411	1.46				
State average		1.67		2.22		1.64				1.42				
NCQA average										1.80				
NCQA 90th percentile[a]										3.42				

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-35. Zero well-child visits in the first 15 months of life by health plan, reporting years 2010–2014.

Health plan	Number and percentage with zero visits										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		190	7.89	▲
CCC	—	—	—	—	—	—	NR		432	1.62	
CHP	411	0.97	411	2.19	411	1.22	NR		411	0.97	
MHW	432	0.46	431	0.93	432	0.46	NR		453	0.88	▼
UHC	—	—	—	—	—	—	NR		411	4.38	▲
State average		0.62		1.40		0.77				2.53	↑
NCQA average										2.65	
NCQA 90th percentile[a]										4.12	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

↑↓ Indicates statistically significant difference in percentages from 2012 to 2014 ($p < 0.05$); measures are not directly comparable due to changes in the Medicaid program.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-36. Well-child visits in the 3rd, 4th, 5th, and 6th years of life by health plan, reporting years 2010–2014.

Health plan	Number and percentage with visits										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		432	58.33	▼
CCC	—	—	—	—	—	—	NR		432	67.36	
CHP	411	66.42	411	64.23	411	63.75	NR		411	66.18	
MHW	432	67.36	432	68.75	432	65.51	NR		435	64.60	
UHC	—	—	—	—	—	—	NR		411	62.77	
State average		62.15		61.50		62.38				63.84	*
NCQA average										71.49	
NCQA 90th percentile[a]										82.69	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-37. Adolescents, 12–21 years, one or more well-care visits by health plan, reporting years 2010–2014.

Health plan	Number and percentage with visits										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	—	—	—	—	—	—	NR		432	34.95	
CCC	—	—	—	—	—	—	NR		432	38.19	
CHP	411	32.60	411	39.42	411	39.90	NR		411	42.34	
MHW	432	38.19	432	43.98	432	45.83	NR		453	44.37	▲
UHC	—	—	—	—	—	—	NR		411	35.52	
State average		36.62		36.51		39.25				39.13	*
NCQA average										50.03	
NCQA 90th percentile[a]										65.56	

— MCO was not under contract with HCA in this reporting year.

NR: HCA did not require public reporting of this measure in 2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-38. Adolescent meningococcal immunizations by health plan, reporting year 2014.

Health plan	Number and percentage immunized											
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		186	55.38	▼
CCC	NR		NR		NR		NR		432	73.38	▲
CHP	NR		NR		NR		NR		411	72.51	▲
MHW	NR		NR		NR		NR		432	66.44	
UHC	NR		NR		NR		NR		411	62.53	
State average										67.41	*
NCQA average										71.94	
NCQA 90th percentile[a]										88.27	

NR: HCA did not require public reporting of this measure during this year.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-39. Adolescent Tdap immunizations by health plan, reporting year 2014.

Health plan	Number and percentage immunized											
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		186	78.49	
CCC	NR		NR		NR		NR		432	88.66	▲
CHP	NR		NR		NR		NR		411	88.32	▲
MHW	NR		NR		NR		NR		432	86.81	
UHC	NR		NR		NR		NR		411	74.21	▼
State average										83.97	
NCQA average										83.58	
NCQA 90th percentile[a]										92.94	

NR: HCA did not require public reporting of this measure during this year.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-40. Adolescent Combo 1 immunizations by health plan, reporting year 2014.

Health plan	Number and percentage immunized											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	NR		NR		NR		NR		186	54.84		▼
CCC	NR		NR		NR		NR		432	69.21		
CHP	NR		NR		NR		NR		411	71.29		▲
MHW	NR		NR		NR		NR		432	64.58		
UHC	NR		NR		NR		NR		411	61.31		
State average										65.44	*	
NCQA average										70.17		
NCQA 90th percentile[a]										86.46		

NR: HCA did not require public reporting of this measure during this year.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-41. Weight assessment and counseling for nutrition and physical activity for children and adolescents, BMI total, by health plan, reporting year 2014.

Health plan	Number and percentage counseled											
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		431	28.07	
CCC	NR		NR		NR		NR		432	19.91	▼
CHP	NR		NR		NR		NR		200	53.04	▲
MHW	NR		NR		NR		NR		453	35.10	▲
UHC	NR		NR		NR		NR		411	14.36	▼
State average										30.07	*
NCQA average										56.92	
NCQA 90th percentile[a]										82.46	

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-42. Weight assessment and counseling for nutrition and physical activity for children and adolescents, BMI, age 3–11 years, by health plan, reporting year 2014.

Health plan	Number and percentage counseled											
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		283	26.50	
CCC	NR		NR		NR		NR		287	17.42	▼
CHP	NR		NR		NR		NR		273	49.82	▲
MHW	NR		NR		NR		NR		304	32.89	
UHC	NR		NR		NR		NR		272	12.13	▼
State average										27.77	*
NCQA average										56.38	
NCQA 90th percentile[a]										83.39	

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-43. Weight assessment and counseling for nutrition and physical activity for children and adolescents, BMI, age 12–17 years, by health plan, reporting year 2014.

Health plan	Number and percentage counseled										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		148	31.08	
CCC	NR		NR		NR		NR		145	24.83	▼
CHP	NR		NR		NR		NR		138	59.42	▲
MHW	NR		NR		NR		NR		149	39.60	
UHC	NR		NR		NR		NR		139	18.71	▼
State average										34.63	*
NCQA average										57.89	
NCQA 90th percentile[a]										82.73	

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-44. Weight assessment and counseling for nutrition and physical activity for children and adolescents, nutrition total, by health plan, reporting year 2014.

Health plan	Number and percentage counseled											
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		431	44.55	
CCC	NR		NR		NR		NR		432	46.30	
CHP	NR		NR		NR		NR		411	52.80	▲
MHW	NR		NR		NR		NR		453	45.03	
UHC	NR		NR		NR		NR		411	39.90	▼
State average										45.70	*
NCQA average										58.70	
NCQA 90th percentile[a]										77.47	

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-45. Weight assessment and counseling for nutrition and physical activity for children and adolescents, nutrition, age 3–11 years, by health plan, reporting year 2014.

Health plan	Number and percentage counseled										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		283	47.00	
CCC	NR		NR		NR		NR		287	51.92	
CHP	NR		NR		NR		NR		273	52.01	
MHW	NR		NR		NR		NR		304	45.39	
UHC	NR		NR		NR		NR		272	42.28	
State average										47.71	*
NCQA average										60.41	
NCQA 90th percentile[a]										79.42	

NR: HCA did not require public reporting of this measure in 2010–2013.

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-46. Weight assessment and counseling for nutrition and physical activity for children and adolescents, nutrition, age 12–17 years, by health plan, reporting year 2014.

Health plan	Number and percentage counseled										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		148	39.86	
CCC	NR		NR		NR		NR		145	35.17	
CHP	NR		NR		NR		NR		138	54.35	▲
MHW	NR		NR		NR		NR		149	44.30	
UHC	NR		NR		NR		NR		139	35.25	
State average										41.72	*
NCQA average										55.15	
NCQA 90th percentile[a]										74.68	

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-47. Weight assessment and counseling for nutrition and physical activity for children and adolescents, physical activity total, by health plan, reporting year 2014.

Health plan	Number and percentage counseled											
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		431	37.82	
CCC	NR		NR		NR		NR		432	45.14	
CHP	NR		NR		NR		NR		411	51.58	▲
MHW	NR		NR		NR		NR		453	38.19	
UHC	NR		NR		NR		NR		411	34.55	▼
State average										41.39	*
NCQA average										50.50	
NCQA 90th percentile[a]										69.76	

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-48. Weight assessment and counseling for nutrition and physical activity for children and adolescents, physical activity age 3–11 years, by health plan, reporting year 2014.

Health plan	Number and percentage counseled										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		283	34.28	
CCC	NR		NR		NR		NR		287	44.25	
CHP	NR		NR		NR		NR		273	45.79	▲
MHW	NR		NR		NR		NR		304	34.87	
UHC	NR		NR		NR		NR		272	34.19	
State average										38.62	*
NCQA average										49.06	
NCQA 90th percentile[a]										67.65	

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-49. Weight assessment and counseling for nutrition and physical activity for children and adolescents, physical activity age 12–17 years, by health plan, reporting year 2014.

Health plan	Number and percentage counseled											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	NR		NR		NR		NR		148	44.59		
CCC	NR		NR		NR		NR		145	46.90		
CHP	NR		NR		NR		NR		138	63.04	▲	
MHW	NR		NR		NR		NR		149	44.97		
UHC	NR		NR		NR		NR		139	35.25	▼	
State average										46.87		*
NCQA average										53.40		
NCQA 90th percentile[a]										72.79		

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-50. Access to primary care practitioners, 12–24 months, by health plan, reporting year 2014.

Health plan	Number and percentage who had a visit with a PCP											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	NR		NR		NR		NR		626	93.45		▼
CCC	NR		NR		NR		NR		2,204	97.19		
CHP	NR		NR		NR		NR		8,647	97.14		
MHW	NR		NR		NR		NR		15,654	97.78		▲
UHC	NR		NR		NR		NR		1,468	93.94		▼
State average										97.25	*	
NCQA average										96.14		
NCQA 90th percentile[a]										98.53		

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-51. Access to primary care practitioners, 25 months to 6 years, by health plan, reporting year 2014.

Health plan	Number and percentage who had a visit with a PCP											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	NR		NR		NR		NR		1,873	77.52	▼	
CCC	NR		NR		NR		NR		7,619	86.13	▼	
CHP	NR		NR		NR		NR		46,878	86.22	▼	
MHW	NR		NR		NR		NR		77,081	89.04	▲	
UHC	NR		NR		NR		NR		4,838	82.20	▼	
State average										87.53		*
NCQA average										88.25		
NCQA 90th percentile[a]										93.58		

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-52. Access to primary care practitioners, 7–11 years, by health plan, reporting year 2014.

Health plan	Number and percentage who had a visit with a PCP										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		NA	NA	
CCC	NR		NR		NR		NR		NA	NA	
CHP	NR		NR		NR		NR		27,547	89.39	▼
MHW	NR		NR		NR		NR		49,347	92.24	▲
UHC	NR		NR		NR		NR		NA	NA	
State average										91.22	*
NCQA average										90.02	
NCQA 90th percentile[a]										95.19	

NA: Sample size was smaller than the minimum required during the reporting year.

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-53. Access to primary care practitioners, 12–19 years, by health plan, reporting year 2014.

Health plan	Number and percentage who had a visit with a PCP										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		NA	NA	
CCC	NR		NR		NR		NR		NA	NA	
CHP	NR		NR		NR		NR		31,243	88.49	▼
MHW	NR		NR		NR		NR		51,848	92.12	▲
UHC	NR		NR		NR		NR		NA	NA	
State average										90.75	*
NCQA average										88.52	
NCQA 90th percentile[a]										94.42	

NA: Sample size was smaller than the minimum required during the reporting year.

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-54. Children 2–18 diagnosed and treated for pharyngitis, by health plan, reporting year 2014.

Health plan	Number and percentage tested[a]											
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		179	68.16	
CCC	NR		NR		NR		NR		701	54.35	▼
CHP	NR		NR		NR		NR		4,258	59.18	▼
MHW	NR		NR		NR		NR		6,664	67.38	▲
UHC	NR		NR		NR		NR		331	66.77	
State average										63.74	*
NCQA average										66.52	
NCQA 90th percentile[b]										83.66	

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Higher rates represent better performance (i.e., appropriate testing).

[b] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-55. Total appropriately prescribed asthma medication, by health plan, reporting year 2014.

Health plan	Number and percentage prescribed									
	2010		2011		2012		2013		2014	
	n	%	n	%	n	%	n	%	n	%
AMG	NR		NR		NR		NR		0	NA
CCC	NR		NR		NR		NR		0	NA
CHP	NR		NR		NR		NR		1,752	84.08
MHW	NR		NR		NR		NR		3,155	83.14
UHC	NR		NR		NR		NR		0	NA
State average										83.47
NCQA average										84.07
NCQA 90th percentile[a]										91.47

NA: Sample size was smaller than the minimum required during the reporting year and the eligible population was zero.

NR: HCA did not require public reporting of this measure in 2013.

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-56. Age 5–11 years, prescribed asthma medication, by health plan, reporting year 2014.

Health plan	Number and percentage prescribed											
	2010		2011		2012		2013		2014			
	n	%	n	%	n	%	n	%	n	%		
AMG	NR		NR		NR		NR		0	NA		
CCC	NR		NR		NR		NR		0	NA		
CHP	NR		NR		NR		NR		768	89.19		
MHW	NR		NR		NR		NR		1,441	87.79		
UHC	NR		NR		NR		NR		0	NA		
State average										88.28	*	
NCQA average										90.18		
NCQA 90th percentile[a]										95.16		

NA: Sample size was smaller than the minimum required during the reporting year and the eligible population was zero.

NR: HCA did not require public reporting of this measure in 2010–2013.

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-57. Age 12–18 years, prescribed asthma medication, by health plan, reporting year 2014.

Health plan	Number and percentage prescribed										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		0	NA	
CCC	NR		NR		NR		NR		0	NA	
CHP	NR		NR		NR		NR		576	83.16	
MHW	NR		NR		NR		NR		1,141	81.95	
UHC	NR		NR		NR		NR		0	NA	
State average										82.35	*
NCQA average										86.93	
NCQA 90th percentile[a]										92.99	

NA: Sample size was smaller than the minimum required during the reporting year and the eligible population was zero.

NR: HCA did not require public reporting of this measure in 2010–2013.

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-58. Age 19–50 years, prescribed asthma medication, by health plan, reporting year 2014.

Health plan	Number and percentage prescribed									
	2010		2011		2012		2013		2014	
	n	%	n	%	n	%	n	%	n	%
AMG	NR		NR		NR		NR		0	NA
CCC	NR		NR		NR		NR		0	NA
CHP	NR		NR		NR		NR		324	75.31
MHW	NR		NR		NR		NR		513	72.71
UHC	NR		NR		NR		NR		0	NA
State average										73.72
NCQA average										74.36
NCQA 90th percentile[a]										84.49

NA: Sample size was smaller than the minimum required during the reporting year and the eligible population was zero.

NR: HCA did not require public reporting of this measure in 2010–2013.

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-59. Age 51–64 years, prescribed asthma medication, by health plan, reporting year 2014.

Health plan	Number and percentage prescribed										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		0	NA	
CCC	NR		NR		NR		NR		0	NA	
CHP	NR		NR		NR		NR		84	77.38	
MHW	NR		NR		NR		NR		60	83.33	
UHC	NR		NR		NR		NR		0	NA	
State average										79.86	*
NCQA average										70.20	
NCQA 90th percentile[a]										80.00	

NA: Sample size was smaller than the minimum required during the reporting year and the eligible population was zero.

NR: HCA did not require public reporting of this measure in 2010-2013.

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-60. Frequency of mental health outpatient and ED services, total, by health plan, reporting year 2014.

Health plan	Number and percentage of members receiving services[a]										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		510	1.73	▼
CCC	NR		NR		NR		NR		1,167	1.67	▼
CHP	NR		NR		NR		NR		6,025	2.27	
MHW	NR		NR		NR		NR		1,217	4.56	▲
UHC	NR		NR		NR		NR		833	1.67	▼
State average										2.21	*
NCQA average										12.27	
NCQA 90th percentile[b]										21.77	

NR: HCA did not require public reporting of this measure in 2010–2013.
▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).
* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).
[a]Percentages are calculated using member years to standardize counts of members enrolled for fewer than 12 months.
[b]90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-61. Frequency of mental health outpatient and ED services, 0–12 years, by health plan, reporting year 2014.

Health plan	Number and percentage of members receiving services[a]										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		116	1.01	▼
CCC	NR		NR		NR		NR		274	0.78	▼
CHP	NR		NR		NR		NR		1,956	1.33	▼
MHW	NR		NR		NR		NR		261	2.91	▲
UHC	NR		NR		NR		NR		168	0.75	▼
State average										1.23	
NCQA average										NA	
NCQA 90th percentile										NA	

NA: not available from the NCQA Quality Compass for Medicaid in the reporting year.

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a]Percentages are calculated using member years to standardize counts of members enrolled for fewer than 12 months.

Table B-62. Frequency of mental health outpatient and ED services, 13–17 years, by health plan, reporting year 2014.

Health plan	Number and percentage of members receiving services[a]										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		55	1.54	▼
CCC	NR		NR		NR		NR		153	1.57	▼
CHP	NR		NR		NR		NR		1,156	2.64	
MHW	NR		NR		NR		NR		229	6.15	▲
UHC	NR		NR		NR		NR		119	1.82	▼
State average										2.54	
NCQA average										NA	
NCQA 90th percentile										NA	

NA: not available from the NCQA Quality Compass for Medicaid in the reporting year.

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a]Percentages are calculated using member years to standardize counts of members enrolled for fewer than 12 months.

Table B-63. Frequency of mental health outpatient and ED services, 18–64 years, by health plan, reporting year 2014.

Health plan	Number and percentage of members receiving services[a]										
	2010		2011		2012		2013		2014		
	n	%	n	%	n	%	n	%	n	%	
AMG	NR		NR		NR		NR		339	2.35	▼
CCC	NR		NR		NR		NR		740	2.99	▼
CHP	NR		NR		NR		NR		2,913	3.93	▲
MHW	NR		NR		NR		NR		727	5.19	▲
UHC	NR		NR		NR		NR		546	2.61	▼
State average										3.55	
NCQA average										NA	
NCQA 90th percentile										NA	

NA: not available from the NCQA Quality Compass for Medicaid in the reporting year.

NR: HCA did not require public reporting of this measure in 2010–2013.

▲▼ Indicates statistically significant difference in plan vs. state percentage in 2014 ($p < 0.05$).

[a]Percentages are calculated using member years to standardize counts of members enrolled for fewer than 12 months.

Table B-64. General hospital/acute care total inpatient discharges by health plan, reporting years 2010–2014.

Health plan	Number of discharges and discharges/1000 member months[a]										
	2010		2011		2012		2013[b]		2014[c]		
	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	
AMG	—	—	—	—	—	—	813	6.97	3,247	9.17	↑ ▲
CCC	—	—	—	—	—	—	1,836	6.82	6,399	7.63	↑ ▲
CHP	12,604	5.72	22,701	8.97	28,375	10.59	9,523	5.52	17,787	5.59	▼
MHW	21,754	6.20	22,697	5.76	21,637	5.46	12,882	5.37	25,249	5.25	↓ ▼
UHC	—	—	—	—	—	—	1,256	6.47	4,378	7.30	↑ ▲
State average		6.05		6.85		7.12		5.59		5.83	*↑
NCQA average										8.88	
NCQA 90th percentile[d]										10.92	

— MCO was not under contract with HCA in this reporting year.
↑↓ Indicates statistically significant difference in rates from 2013 to 2014 ($p < 0.05$).
▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p < 0.05$).
* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).
[a] Discharges/MM is discharges per 1000 member months.
[b] 2013 data set contained 6 months worth of data.
[c] 2014 data set contained 12 months worth of data.
[d] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-65. General hospital/acute care total inpatient days by health plan, reporting years 2010–2014.

Health plan	Number of days and days/1000 member months, and average length of stay[a,b]																
	2010			2011			2012			2013[c]			2014[d]				
	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS		
AMG	—	—	—	—	—	—	—	—	—	3,022	25.89	3.72	12,806	36.17	3.94		▲
CCC	—	—	—	—	—	—	—	—	—	5,955	22.12	3.24	22,511	26.85	3.52	↑	
CHP	34,993	15.88	2.78	48,932	19.33	2.16	61,233	22.85	2.16	30,694	17.80	3.22	58,450	18.38	3.29		▼
MHW	61,420	17.50	2.82	63,587	16.14	2.80	60,465	15.27	2.79	39,528	16.47	3.07	84,546	17.56	3.35	↑	▼
UHC	—	—	—	—	—	—	—	—	—	4,204	21.66	3.35	17,658	29.43	4.03	↑	▲
State average		16.74	2.77		17.09	2.50		17.43	2.45		17.73	3.17		20.03 *	3.43	*↑	
NCQA average														34.10	3.81		
NCQA 90th percentile[e]														48.15	4.57		

— MCO was not under contract with HCA in this reporting year.

↑↓ Indicates statistically significant difference in ALOS from 2013 to 2014 ($p < 0.05$).

▲▼ Indicates statistically significant difference in plan vs. state ALOS in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Days/MM is the number of days per 1000 member months.

[b] ALOS is the average length of stay.

[c] 2013 data set contained 6 months worth of data.

[d] 2014 data set contained 12 months worth of data.

[e] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-66. General hospital/acute care medical discharges by health plan, reporting years 2010–2014.

Health plan	Number of discharges and discharges/1000 member months[a]										
	2010		2011		2012		2013[b]		2014[c]		
	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	
AMG	—	—	—	—	—	—	325	2.78	1135	3.21	↑ ▲
CCC	—	—	—	—	—	—	675	2.51	2236	2.67	▲
CHP	2,915	1.32	2,917	1.15	3,363	1.25	2,785	1.62	6,245	1.96	↑ ▲
MHW	5,207	1.48	5,554	1.41	5,211	1.32	3,284	1.37	7,392	1.54	↑ ▼
UHC	—	—	—	—	—	—	458	2.36	1492	2.49	▲
State average		1.48		1.37		1.37		1.60		1.89	*↑
NCQA average										4.51	
NCQA 90th percentile[d]										6.16	

— MCO was not under contract with HCA in this reporting year.

↑↓ Indicates statistically significant difference in rates from 2013 to 2014 ($p < 0.05$).

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Discharges/MM is the number of discharges per 1000 member months.

[b] 2013 data set contained 6 months worth of data.

[c] 2014 data set contained 12 months worth of data.

[d] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-67. General hospital/acute care medical days by health plan, reporting years 2010–2014.

Health plan	Number of days and days/1000 member months, and average length of stay[a,b]																
	2010			2011			2012			2013[c]			2014[d]				
	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS		
AMG	—	—	—	—	—	—	—	—	—	1,192	10.21	3.67	4,558	12.87	4.02		▲
CCC	—	—	—	—	—	—	—	—	—	2,142	7.95	3.17	7,560	9.02	3.38		
CHP	7,478	3.39	2.57	7,685	3.04	2.63	8,979	3.35	2.67	9,875	5.73	3.55	19,699	6.19	3.15	↓	▼
MHW	13,793	3.93	2.65	15,080	3.83	2.72	15,054	3.80	2.89	10,460	4.36	3.19	24,149	5.02	3.27		▼
UHC	—	—	—	—	—	—	—	—	—	1,512	7.79	3.30	6,142	10.24	4.12	↑	▲
State average		3.87	2.61		3.66	2.68		3.75	2.75		5.35	3.35		6.35 *	3.36	*	
NCQA average														16.01	3.67		
NCQA 90th percentile[e]														23.17	4.41		

— MCO was not under contract with HCA in this reporting year.

↑↓ Indicates statistically significant difference in ALOS from 2013 to 2014 ($p < 0.05$).

▲▼ Indicates statistically significant difference in plan vs. state ALOS in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Days/MM is the number of days per 1000 member months.

[b] ALOS is the average length of stay.

[c] 2013 data set contained 6 months worth of data.

[d] 2014 data set contained 12 months worth of data.

[e] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-68. General hospital/acute care surgical discharges by health plan, reporting years 2010–2014.

Health plan	Number of discharges and discharges/1000 member months[a]										
	2010		2011		2012		2013[b]		2014[c]		
	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	
AMG	—	—	—	—	—	—	177	1.52	640	1.81	↑ ▲
CCC	—	—	—	—	—	—	363	1.35	1,208	1.44	▲
CHP	1,718	0.78	6,679	2.64	9,016	3.36	1,653	0.96	3,604	1.13	↑
MHW	2,806	0.80	3,084	0.78	2,970	0.75	2,129	0.89	4,787	0.99	↑ ▼
UHC	—	—	—	—	—	—	261	1.34	890	1.48	▲
State average		0.79		1.39		1.61		0.97		1.14	*↑
NCQA average										1.60	
NCQA 90th percentile[d]										2.47	

— MCO was not under contract with HCA in this reporting year.

↑↓ Indicates statistically significant difference in rates from 2013 to 2014 ($p < 0.05$).

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Discharges/MM is the number of discharges per 1000 member months.

[b] 2013 data set contained 6 months worth of data.

[c] 2014 data set contained 12 months worth of data.

[d] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-69. General hospital/acute care surgical days by health plan, reporting years 2010–2014.

Health plan	Number of days and days/1000 member months, and average length of stay[a,b]																
	2010			2011			2012			2013[c]			2014[d]				
	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS		
AMG	—	—	—	—	—	—	—	—	—	992	8.50	5.60	4,667	13.18	7.29	↑	▲
CCC	—	—	—	—	—	—	—	—	—	1,886	7.00	5.20	8,130	9.70	6.73	↑	▲
CHP	8,551	3.88	4.98	13,194	5.21	1.98	19,774	7.38	2.19	8,601	4.99	5.20	20,045	6.30	5.56	↑	▼
MHW	14,354	4.09	5.12	14,010	3.56	4.54	13,866	3.50	4.67	12,128	5.05	5.70	30,678	6.37	6.41	↑	
UHC	—	—	—	—	—	—	—	—	—	1,364	7.03	5.23	6,515	10.86	7.32	↑	▲
State average		3.82	4.81		3.99	2.86		4.55	2.83		5.31	5.45		7.16 *	6.29	*↑	
NCQA average														10.98	6.41		
NCQA 90th percentile[e]														18.02	8.58		

— MCO was not under contract with HCA in this reporting year.

↑↓ Indicates statistically significant difference in ALOS from 2013 to 2014 ($p < 0.05$).

▲▼ Indicates statistically significant difference in plan vs. state ALOS in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Days/MM is the number of days/1000 member months.

[b] ALOS is the average length of stay.

[c] 2013 data set contained 6 months worth of data.

[d] 2014 data set contained 12 months worth of data.

[e] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-70. General hospital/acute care maternity discharges by health plan, reporting years 2010–2014.

Health plan	Number of discharges and discharges/1000 member months[a]										
	2010		2011		2012		2013[b]		2014[c]		
	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	Discharges	Discharges/MM	
AMG	—	—	—	—	—	—	311	3.99	1,472	6.04	↑ ▲
CCC	—	—	—	—	—	—	798	4.85	2,955	6.00	↑ ▲
CHP	7,967	7.70	13,097	10.84	15,943	12.33	5,084	5.50	7,935	4.48	↓ ▼
MHW	13,741	8.50	14,059	7.63	13,456	7.16	7,469	6.00	13,070	5.15	↓
UHC	—	—	—	—	—	—	537	4.42	1,996	5.24	↑
State average		8.00		8.54		8.58		3.02		5.05	*↑
NCQA average										4.80	
NCQA 90th percentile[d]										8.29	

— MCO was not under contract with HCA in this reporting year.

↑↓ Indicates statistically significant difference in rates from 2013 to 2014 ($p < 0.05$).

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Discharges/MM is the number of discharges per 1000 member months.

[b] 2013 data set contained 6 months worth of data.

[c] 2014 data set contained 12 months worth of data.

[d] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-71. General hospital/acute care maternity days by health plan, reporting years 2010–2014.

Health plan	Number of days and days/1000 member months, and average length of stay[a,b]															
	2010			2011			2012			2013[c]			2014[d]			
	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	Days	Days/MM	ALOS	
AMG	—	—	—	—	—	—	—	—	—	838	10.75	2.69	3,581	14.70	2.43	
CCC	—	—	—	—	—	—	—	—	—	1,927	11.71	2.41	6,821	13.85	2.31	
CHP	18,958	18.33	2.38	28,040	23.21	2.14	32,284	24.98	2.02	12,217	13.21	2.40	18,701	10.55	2.36	
MHW	33,273	20.58	2.42	34,497	18.71	2.45	31,545	16.80	2.34	16,940	13.61	2.27	29,719	11.71	2.27	▼
UHC	—	—	—	—	—	—	—	—	—	1,328	10.94	2.47	5,001	13.14	2.51	▲
State average		19.22	2.40		19.73	2.31		18.85	2.20		7.07	2.34		11.76 *	2.33	*
NCQA average														12.22	2.61	
NCQA 90th percentile[e]														20.36	2.93	

— MCO was not under contract with HCA in this reporting year.

▲▼ Indicates statistically significant difference in plan vs. state ALOS in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Days/MM is the number of days/1000 member months.

[b] ALOS is the average length of stay.

[c] 2013 data set contained 6 months worth of data.

[d] 2014 data set contained 12 months worth of data.

[e] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-72. Ambulatory care, outpatient visits provided by health plan, reporting years 2010–2014.

Health plan	Number of outpatient visits and outpatient visits/1000 member months[a]											
	2010		2011		2012		2013[b]		2014[c]			
	Visits	Visits/MM	Visits	Visits/MM	Visits	Visits/MM	Visits	Visits/MM	Visits	Visits/MM		
AMG	—	—	—	—	—	—	29,004	248.50	117,404	331.57	↑	▼
CCC	—	—	—	—	—	—	76,243	283.15	290,045	345.94	↑	▲
CHP	644,813	292.65	670,534	264.93	734,776	274.20	581,348	337.16	1,017,513	319.95	↓	▼
MHW	1,223,373	348.49	1,355,139	344.04	1,343,689	339.38	833,307	347.27	1,664,681	345.83	↓	▲
UHC	—	—	—	—	—	—	49,118	253.06	208,710	347.88	↑	▲
State average		325.37		313.72		314.32		333.55		337.04	*↑	
NCQA average										364.38		
NCQA 90th percentile[d]										461.19		

— MCO was not under contract with HCA in this reporting year.

↑↓ Indicates statistically significant difference in rates from 2013 to 2014 ($p < 0.05$).

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Visits/MM is visits per 1000 member months.

[b] 2013 data set contained 6 months worth of data.

[c] 2014 data set contained 12 months worth of data.

[d] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-73. Ambulatory care, emergency department visits by health plan, reporting years 2010–2014.

Health plan	Number of ED visits and ED visits/1000 member months[a]										
	2010		2011		2012		2013[b]		2014[c]		
	Visits	Visits/MM	Visits	Visits/MM	Visits	Visits/MM	Visits	Visits/MM	Visits	Visits/MM	
AMG	—	—	—	—	—	—	7,120	61.00	23,436	66.19	↑ ▲
CCC	—	—	—	—	—	—	16,182	60.10	54,024	64.44	↑ ▲
CHP	145,359	65.97	146,859	58.03	142,079	53.02	81,030	46.99	161,324	50.73	↑ ▼
MHW	201,923	57.52	205,904	52.28	193,499	48.87	109,224	45.52	231,318	48.06	↑ ▼
UHC	—	—	—	—	—	—	10,478	53.98	35,232	58.73	↑ ▲
State average		59.75		53.54		49.50		47.63		51.64	*↑
NCQA average										62.89	
NCQA 90th percentile[d]										81.24	

— MCO was not under contract with HCA in this reporting year.

↑↓ Indicates statistically significant difference in rates from 2013 to 2014 ($p < 0.05$).

▲▼ Indicates statistically significant difference in plan rate vs. state average in 2014 ($p < 0.05$).

* Indicates statistically significant difference in state vs. NCQA average in 2014 ($p < 0.05$).

[a] Visits/MM is visits per 1000 member months.

[b] 2013 data set contained 6 months worth of data.

[c] 2014 data set contained 12 months worth of data.

[d] 90th percentile statistics are from the NCQA Quality Compass for Medicaid in the reporting year.

Table B-74. Plan all-cause readmissions[a] total, by health plan, reporting year 2014.

Health plan	Observed Readmission[b] and Observed/Expected Readmission Ratio[c]									
	2010		2011		2012		2013		2014	
	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio
AMG	NR		NR		NR		NR		12.03	0.91
CCC	NR		NR		NR		NR		11.72	0.78
CHP	NR		NR		NR		NR		10.67	0.85
MHW	NR		NR		NR		NR		9.66	0.69
UHC	NR		NR		NR		NR		12.56	0.70
State average										0.79

NR: HCA did not require public reporting of this measure in 2010–2013.

[a] This is a Medicare HEDIS measure which HCA has elected as a required reported measure for the Medicaid population in WA.

[b] The observed proportion of Index Hospital Stays that had a subsequent 30-day readmission. A lower observed rate of readmission is considered better performance.

[c] The ratio of the MCO's observed rate of readmission to its expected rate of readmission (average adjusted probability).

Table B-75. Plan all-cause readmissions[a] age 18–44 years, by health plan, reporting year 2014.

Health plan	Observed Readmission[b] and Observed/Expected Readmission Ratio[c]									
	2010		2011		2012		2013		2014	
	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio
AMG	NR		NR		NR		NR		17.07	1.23
CCC	NR		NR		NR		NR		11.76	0.84
CHP	NR		NR		NR		NR		10.45	0.96
MHW	NR		NR		NR		NR		8.41	0.63
UHC	NR		NR		NR		NR		16.67	0.80
State average										0.81

NR: HCA did not require public reporting of this measure in 2010–2013.

[a] This is a Medicare HEDIS measure which HCA has elected as a required reported measure for the Medicaid population in WA.

[b] The observed proportion of Index Hospital Stays that had a subsequent 30-day readmission. A lower observed rate of readmission is considered better performance.

[c] The ratio of the MCO's observed rate of readmission to its expected rate of readmission (average adjusted probability).

Table B-76. Plan all-cause readmissions[a] age 45–54 years, by health plan, reporting year 2014.

Health plan	Observed Readmission[b] and Observed/Expected Readmission Ratio[c]									
	2010		2011		2012		2013		2014	
	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio
AMG	NR		NR		NR		NR		8.77	0.69
CCC	NR		NR		NR		NR		16.38	0.93
CHP	NR		NR		NR		NR		10.92	0.87
MHW	NR		NR		NR		NR		12.02	0.81
UHC	NR		NR		NR		NR		10.29	0.66
State average										0.85

NR: HCA did not require public reporting of this measure in 2010–2013.

[a] This is a Medicare HEDIS measure which HCA has elected as a required reported measure for the Medicaid population in WA.

[b] The observed proportion of Index Hospital Stays that had a subsequent 30-day readmission. A lower observed rate of readmission is considered better performance.

[c] The ratio of the MCO's observed rate of readmission to its expected rate of readmission (average adjusted probability).

Table B-77. Plan all–cause readmissions[a] age 55–64 years, by health plan, reporting year 2014.

Health plan	Observed Readmission[b] and Observed/Expected Readmission Ratio[c]									
	2010		2011		2012		2013		2014	
	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio	Observed Readmission	Observed/Expected Ratio
AMG	NR		NR		NR		NR		11.67	0.88
CCC	NR		NR		NR		NR		8.43	0.61
CHP	NR		NR		NR		NR		10.68	0.73
MHW	NR		NR		NR		NR		10.51	0.71
UHC	NR		NR		NR		NR		11.70	0.65
State average										0.72

NR: HCA did not require public reporting of this measure in 2010–2013.

[a] This is a Medicare HEDIS measure which HCA has elected as a required reported measure for the Medicaid population in WA.

[b] The observed proportion of Index Hospital Stays that had a subsequent 30-day readmission. A lower observed rate of readmission is considered better performance.

[c] The ratio of the MCO's observed rate of readmission to its expected rate of readmission (average adjusted probability).

Table B-78. WMIP comprehensive diabetes care measures, reporting years 2010–2014.

	2010		2011		2012		2013		2014	
Measure	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
HbA1c tests	342	86.84	390	87.95	502	86.06	449	82.18	438	84.25
Enrollees with HbA1c levels poor control (>9.0%)	342	42.40	390	31.03	502	41.04	449	44.32	438	47.95
Enrollees with HbA1c levels good control (<8.0%)[a]	342	50.58	390	60.00	502	50.40	449	47.66	438	42.24
Enrollees with HbA1c levels good control (<7.0%)	191	35.60	225	46.22	286	37.41	+	+	+	+
Dilated retinal exams	342	55.26	390	59.49	502	53.98	449	53.45	438	50.46
Lipid profile (LDL-C) performed	342	78.65	390	76.92	502	74.50	449	74.83	438	75.11
Lipids controlled (<100mg/dL)	342	31.58	390	39.23	502	34.46	449	35.41	438	37.21
Nephropathy monitored annually	342	81.58	390	86.41	502	83.07	449	79.73	438	81.28
Blood pressure control (<130/80 mm Hg)	342	32.46	+	+	+	+	+	+	+	+
Blood pressure control (<140/80 mm Hg)		—	390	43.59	502	38.84	449	41.43	438	41.10
Blood pressure control (<140/90 mm Hg)	342	61.11	390	64.36	502	60.36	449	64.59	438	58.90

[a] HCA required reporting for this indicator for the first time in 2010.
— Definition and methodology changed in 2007, 2010; therefore, data from previous years are not comparable.
+ Measure not conducted in this reporting year.

Table B-79. WMIP inpatient utilization measures, reporting years 2010–2014.

Measure	2010	2011	2012	2013	2014	
General hospital/acute care						
Total inpatient discharges and days						
Discharges/1000MM[a]	15.14	15.55	15.21	16.00	16.76	
Days/1000MM[a]	76.73	72.54	78.00	91.37	91.50	
Average length of stay (days)	5.07	4.67	5.13	5.71	5.46	
Medical discharges and days						
Discharges/1000MM[a]	8.48	9.33	9.53	9.84	10.26	
Days/1000MM[a]	32.79	35.31	41.44	39.35	44.85	↑
Average length of stay (days)	3.86	3.79	4.35	4.00	4.37	
Surgical discharges and days						
Discharges/1000MM[a]	5.95	5.55	5.24	5.75	5.80	
Days/1000MM[a]	42.28	35.15	35.23	51.03	44.83	↓
Average length of stay (days)	7.11	6.33	6.73	8.87	7.73	
Nonacute care						
Inpatient discharges and days						
Discharges/1000MM[a]	0.76	+	+	+	+	
Days/1000MM[a]	14.78	+	+	+	+	
Average length of stay (days)	19.36	+	+	+	+	

[a] 1000 MM = 1000 member months.
↓↑ Indicates statistically significant difference in rates from previous year ($p < 0.05$).
+ Measure not conducted in this reporting year.

Table B-80. WMIP ambulatory care measures, reporting years 2010–2014.

Measure	2010	2011	2012	2013	2014
Outpatient visits/1000MM[a]	563.98	539.06	546.91	570.55	593.58 ↑
Emergency room visits/1000MM[a]	119.94	109.83	101.85	89.93	88.15
Surgery or procedures performed/1000MM[a]	24.09	+	35.23	+	+
Observation room stays/1000MM[a]	0.46	+	+	+	+

[a] 1000 MM = 1000 member months.
↓↑ Indicates statistically significant difference in rates from previous year ($p < 0.05$).
+ Measure not conducted in this reporting year.

Table B-81. WMIP mental health care follow-up and utilization measures, reporting years 2010–2014.

Measure	2010	2011	2012	2013	2014
Follow-up after hospitalization for mental illness					
30-day follow-up	48.84	64.81	70.49	72.00	NA
7-day follow-up	32.56	55.56	57.38	56.00	NA
Mental health utilization: total [a,b]					
Any services total	+	+	41.63	30.24	25.35 ↓
Inpatient total	+	+	1.58	1.52	0.67 ↓
Intensive outpatient/partial hospitalization total	+	+	1.33	0.78	1.75 ↑
Outpatient/ER total	+	+	40.85	30.06	25.15 ↓

NA: Sample size was smaller than the minimum required during the reporting year.
↓↑ Indicates statistically significant difference in percentages from previous year ($p < 0.05$).

[a] HCA required reporting for this indicator for the first time in 2012.
[b] Aggregate includes ages 18–64 and 65+.
+ Measure not conducted in this reporting year.

Table B-82. WMIP medication measures, reporting years 2010–2014.

Measure	2010	2011	2012	2013	2014
Antidepressant medication management					
Effective acute-phase treatment	52.78	56.86	67.50	63.89	51.97
Effective continuation-phase treatment	36.11	47.06	55.00	47.22	39.37
Use of high-risk medications in the elderly					
One prescription	12.81	11.94	10.94	7.08	4.27
At least two prescriptions	2.23	2.11	1.72	2.29	0.90

Table B-83. WMIP identification and initiation of dependence treatment, reporting years 2010–2014.

Measure	2010	2011	2012	2013	2014
Initiation and engagement of AOD dependence treatment [a]					
Total initiation	+	+	26.32	NA	NA
Total engagement	+	+	2.63	NA	NA
Identification of alcohol and other drug services [a,b]					
Any services total	+	+	20.38	20.46	20.58
Inpatient total	+	+	75.87	68.14	41.17 ↓
Intensive outpatient/partial hospitalization total	+	+	0.00	0.0	0.15
Outpatient/ER total	+	+	18.18	18.64	18.51

NA: Sample size was smaller than the minimum required during the reporting year.
↓↑ Indicates statistically significant difference in percentages from previous year ($p < 0.05$).

[a] HCA required reporting for this indicator for the first time in 2012.
[b] Aggregate includes ages 18–24, 25–34, 35–64, and 65+.
+ Measure not conducted in this reporting year.

Appendix C: Comparison of Molina Healthcare of Washington and Community Health Plan of Washington performance on NCQA accreditation measures, 2013–2014

HEDIS measures	MHW 2013	MHW 2014		CHP 2013	CHP 2014		NCQA average	NCQA 75th percentile	NCQA 90th percentile
Adult BMI Assessment	74.02	74.01		NR	82.73▲		75.96	85.23	90.82
Appropriate Treatment for Children with Upper Respiratory Infection	92.00	91.82		91.07	91.21▼		85.15	91.21	94.39
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	21.08	26.40↑		25.52	31.09↑▲		26.55	30.54	38.66
Breast Cancer Screening	50.22	59.81↑		56.14	63.83↑		57.88	65.12	71.35
Cervical Cancer Screening	72.92	62.27↓		66.18	54.74↓▼		NC	NC	NC
Chlamydia Screening in Women – Total Rate	53.03	50.49↓		50.05	48.58▼		54.89	62.75	67.19
Cholesterol Management for Patients with Cardiovascular Conditions – LDL-C Screening	81.25	78.33		81.51	81.75		81.11	84.91	87.84
Controlling High Blood Pressure	53.49	53.49		56.20	60.58▲		56.51	63.76	69.79
Follow-up for Children Prescribed ADHD Medication – Initiation Phase	45.41	44.42		41.25	36.91↓▼		39.56	46.99	53.03
Follow-up for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	51.96	52.50		48.10	46.27		46.35	57.55	63.10
Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid	73.73	77.19		NR	72.31		65.73	74.94	78.20
Pharmacotherapy Management of COPD Exacerbation – Bronchodilator	87.29	83.64		NR	83.96		80.88	87.61	90.32
Prenatal and Postpartum Care – Timeliness of Prenatal Care	88.50	79.90↓		81.51	82.97		81.93	89.62	93.10
Prenatal and Postpartum Care – Postpartum Care	67.38	62.31		61.80	61.31		61.29	69.47	74.03
Use of Imaging Studies for Low Back Pain	79.26	78.63		80.72	79.51		75.44	78.53	84.03
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	27.08	22.92		33.04	24.21		31.10	36.73	42.37

Molina Healthcare of Washington Consumer report measures	2013	2014	NCQA average	NCQA 75th percentile	NCQA 90th percentile
Lead Screening in Children	9.26	10.82◐	66.46	80.83	85.84
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	84.91	88.21↑	87.84	89.94	92.01
Digoxin	n.a.	87.50	91.12	94.12	95.65
Diuretics	84.03	89.00↑	87.84	90.57	92.11
Anticonvulsants	51.33	61.50↑◐	66.11	69.53	74.70
Total	82.43	85.83↑	86.03	88.25	89.81

↑↓ 2014 rate is significantly higher or lower than 2013 rate ($p<0.05$).
▲▼ 2014 rate is significantly higher or lower than the other MCOs' rate ($p<0.05$), reported in CHP column only.
◐◐ 2014 rate is significantly higher or lower than NCQA national Medicaid average ($p<0.05$).
◖ 2014 rate is significantly higher than NCQA 75th percentile rate ($p<0.05$).
NB – No benefit.
NR – Not reported.
NC – Not comparable.
n.a. – Sample size too small.

Home and Community-Based Services Survey Administration and Analysis

DRAFT

February 2016

Contract #142877-1

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Home and Community-Based Services Survey Administration and Analysis

February 2016

Presented by Acumentra Health

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Table of Contents

Background 1
Mailing lists 1
Mailings 2
Phone calls 3
OHA/DHS communication 3
Data entry 4
Response rates 4
Data notes 6
Analysis and reporting notes 7
Tableau dashboards 8
Appendix A: HCBS Survey Instruments ..... following page 12

Index of Tables

Table 1. HCBS survey mailings....3
Table 2. Methods of HCBS survey response....4
Table 3. Final response rates by survey population and OHA/DDS division....5
Table 4. Adult provider survey disposition....5
Table 5. Adult consumer survey disposition....5
Table 6. Youth provider survey disposition....5
Table 7. Youth consumer survey disposition....6
Table 8. Adult consumer and provider survey dashboards....9
Table 9. Youth consumer and provider survey dashboards....11

HCBS SURVEY ADMINISTRATION AND ANALYSIS

Background

In August 2015, the Oregon Health Authority (OHA) and the Department of Human Services (DHS) contracted with Acumentra Health to administer surveys to consumers and providers of home and community-based services (HCBS), funded by the divisions of Addictions and Mental Health (AMH), Aging and People with Disabilities (APD), and Oregon Developmental Disabilities Services (ODDS). This survey is the first step in the State of Oregon's efforts to align HCBS practices with new regulations of the Centers for Medicare & Medicaid Services.

OHA/DHS convened a workgroup to develop four surveys, one each for providers of HCBS services to adults, providers of HCBS services to youth, adults receiving HCBS services, and youth receiving HCBS services. The workgroup included department and division heads from AMH, APD, and ODDS. Acumentra Health was not involved in the survey creation. The final HCBS survey instruments appear in Appendix A.

All provider surveys were distributed in English. Consumer surveys were translated into any language spoken by more than 35 consumers—i.e., into Spanish and Vietnamese.

All providers and consumers could complete the survey by one of two methods: (1) complete a paper survey and return it in a postage-paid envelope to Acumentra Health, or (2) complete the survey online by entering a unique password.

Mailing lists

OHA/DHS provided Acumentra Health with a list of adult consumers to receive the Individual Experience Survey from APD, AMH, and ODDS.

- Acumentra Health merged APD, AMH, and ODDS consumers into a single mailing list. Mailing was halted due to last-minute legislative review, and all ODDS consumers were pulled out. A revised letter was sent to ODDS consumers instead. APD and AMH consumers received the original materials.
- AMH and APD consumers were identified with their service providers' physical sites. ODDS consumers were identified with their service providers' corporate offices.

OHA/DHS provided a list of adult providers to receive the Provider Self-Assessment from APD, AMH, and ODDS.

- ODDS supportive living and group home provider information was available only for corporate offices. An Acumentra project assistant called 106 provider offices to collect contact information for all sites associated with corporate offices. In all, 1,003 sites were added to the list of adult providers initially sent by OHA/DHS.

ODDS provided a list of youth consumers to receive the Youth Individual Experience Survey and a list of youth service providers to receive the Youth Provider Self-Assessment.

Mailings

Mailings were processed by the mail service vendor with the following exceptions.

- Mailings to ODDS provider sites whose information had been collected by Acumentra Health from their corporate offices were processed in-house by Acumentra Health, and the surveys were sent directly to the corporate offices for distribution to their provider sites.
- Spanish and Vietnamese versions of the consumer surveys were mailed directly from Acumentra Health.
- Providers who self-identified by calling Acumentra Health were mailed a survey directly from Acumentra Health.

Providers received two separate mailings: (1) an introductory letter explaining the purpose of the survey and providing information necessary to complete the survey online, and (2) a subsequent mailing that included a hard copy of the survey as well as information for completing the survey online.

Adult and child consumers received an introductory letter and two follow-up mailings that included hard copies of the survey. Adult consumers also received a postcard reminder.

Table 1 shows the mailing dates and the number of recipients in each mailing. Mailing lists were updated before each subsequent mailing by removing survey respondents, opt-outs, and individuals with bad addresses from the list.

Table 1. HCBS survey mailings.

Type of survey	Date mailed	Number of recipients
Adult Consumer Intro (ODDS removed)	8/28/2015	12,407
Adult Provider Intro	9/4/2015	3,025
ODDS Adult Consumer Intro	9/11/2015	7,254
Adult Provider Survey Mailing	9/21/2015	2,865
Adult Consumer 1st Survey Mailing	9/30/2015	11,405
ODDS Adult Consumer 1st Survey Mailing	10/12/2015	6,911
Child Consumer 1st Survey Mailing	10/21/2015	695
Adult Provider Additional Mailing	10/29/2015	250
Adult Consumer 2nd survey Mailing	11/5/2015	10,694
ODDS Adult Consumer 2nd Survey Mailing	11/17/2015	6,597
Child Consumer 2nd Survey Mailing	12/1/2015	628
Consumer Postcard reminder mailing	12/1/2015	15,871

Mailings to the 106 ODDS provider agencies contacted directly by Acumentra Health were sent on an ongoing basis as information for their 1,003 sites became available. These providers received one mailing with both a hard copy of the survey and information to complete the survey online for each site. The initial phone call with the provider agency took the place of the introductory letter. Providers who self-identified were also sent one mailing each directly from Acumentra Health on an ongoing basis.

Phone calls

In addition to the initial calls to ODDS provider agencies, Acumentra Health staff, with the aid of volunteers at OHA, followed up with *all* providers prompting them to complete the survey. Lists of providers who had completed the survey were updated daily. Over the course of the survey, Acumentra Health staff responded to approximately 1,300 incoming calls from consumers and providers.

OHA/DHS communication

Prior to the start of the survey, OHA/DHS sent letters to all providers informing them of the purpose of the survey and advising them of informational forums that were scheduled across the state during August and September. The forums gave providers an opportunity to discuss the survey with OHA/DHS staff. These forums were followed by several email blasts from AMH, APD, and ODDS to their providers reminding them to complete the survey, and one email blast to the entire DHS community.

Data entry

Paper surveys received by Acumentra Health were entered directly into StatPac software or into the online website. Table 2 presents the proportion of providers and consumers who responded by paper or online.

Table 2. Methods of HCBS survey response.

	Web	Paper	Total
Adult Consumer	1675 (24.0%)	5308 (76.0%)	6983
Adult Provider	1643 (52.8%)	1469 (47.2%)	3112
Youth Consumer	61 (25.5%)	178 (74.5%)	239
Youth Provider	67 (29.0%)	164 (71.0%)	231
Total	3446 (31.4%)	7119 (68.6%)	10565

Acumentra Health tracked individuals who opted out of the survey either by mail or by phone, or whose mail was returned with a bad address. Providers could opt out if they were closed or no longer served ODDS, AMH, or APD consumers. Consumers could opt out for any reason (e.g., refusal, inability to comprehend or respond, etc.).

Response rates

Acumentra Health provided DHS/OHA with four "total response" files, one for each survey population (adult provider, adult consumer, youth provider, youth consumer), each containing a full list of everyone who was sent a survey, along with an indication as to whether:

- the recipient opted out
- mail was returned with a bad address
- the recipient completed the survey
- the recipient did not complete the survey

These files also include a comment field indicating the reason why the recipient opted out (if provided by the recipient).

Acumentra Health calculated response rates for each population, excluding opt-outs and bad addresses from the denominator. That is, the response rate is the number of people who completed a survey divided by the total number of people who either completed a survey or did not complete a survey. Results are presented in Table 3.

Table 3. Final response rates by survey population and OHA/DHS division.

	AMH	APD	ODDS	Total
Adult Consumer	405 (29.8%)	3225 (34.0%)	3353 (49.7%)	6983 (39.7%)
Adult Provider	181 (72.7%)	1334 (60.1%)	1797 (81.8%)	3112 (71.8%)
Youth Consumer	n/a	n/a	239 (38.5%)	239 (38.5%)
Youth Provider	n/a	n/a	231 (56.3%)	231 (56.3%)

Tables 4–7 report the disposition of all surveys mailed to providers and consumers, including bad addresses, opt-outs, and complete and incomplete surveys. Note that the percentages shown are not survey response rates, but the percentage of each population to whom a survey was sent.

Table 4. Adult provider survey disposition.

	AMH	APD	ODDS	Total
Bad Address	0 (0.0%)	33 (1.7%)	4 (0.2%)	37 (0.8%)
Opt-Out	4 (1.6%)	37 (1.9%)	22 (1.0%)	63 (1.4%)
Complete	181 (71.5%)	1134 (58.0%)	1797 (80.8%)	3112 (70.2%)
Incomplete	68 (26.9%)	752 (38.5%)	400 (18.0%)	1220 (27.5%)
Total	253	1956	2223	4432

Table 5. Adult consumer survey disposition.

	AMH	APD	ODDS	Total
Bad Address	234 (14.5%)	1135 (10.3%)	462 (6.3%)	1831 (9.2%)
Opt-Out	20 (1.2%)	408 (3.7%)	136 (1.9%)	564 (2.8%)
Complete	405 (25.1%)	3225 (29.3%)	3353 (45.6%)	6983 (34.9%)
Incomplete	954 (59.1%)	6258 (56.8%)	3400 (46.3%)	10612 (53.1%)
Total	1613	11026	7351	19990

Table 6. Youth provider survey disposition.

	ODDS/Total
Bad Address	2 (0.5%)
Opt-Out	5 (1.2%)
Complete	231 (55.4%)
Incomplete	179 (42.9%)
Total	417

Table 7. Youth consumer survey disposition.

	ODDS/Total
Bad Address	73 (10.5%)
Opt-Out	3 (0.4%)
Complete	239 (34.3%
Incomplete	382 (54.8%)
Total	697

Data notes

Consumers were linked with their providers according to the provider's ID number ("BillProv" or "Perf_Prov_ID") supplied in the consumer lists from APD, AMH, and ODDS. While the list from AMH also included the provider's name, the lists from APD and ODDS included only the ID number. Where the BillProv ID was also in the provider mailing list, the provider's name was available, and results for the provider and consumer were compared in the data analysis (assuming that both the provider and the consumer returned a survey). If the provider's BillProv ID was not included in the provider mailing list, the client was associated only with the ID number as no name was available (and no survey results were available because the provider was not on the survey mailing list).

Some providers self-identified by contacting Acumentra Health directly to request a survey. These providers had no consumers associated with them for comparison of provider and consumer results. Likewise, providers who self-identified did not provide a BillProv ID.

Within the ODDS consumer population, the BillProv ID identified only the corporate office, not the specific site. Therefore, consumer results could only be rolled up to the corporate level. The Tableau workbook contains results from sites that were identified through phone calls (see above) and returned surveys, but no consumers are associated with the specific sites for comparison.

Within the youth ODDS foster care provider group, the provider self-assessment *and* the consumer survey were sent to the provider, because the provider was listed as the "authorized representative" for the consumer. As many of the youth were unable to complete their own surveys because of developmental disabilities or age, we presume that within this population, the provider completed both the provider and consumer survey.

The address on file for many ODDS consumers was their service provider's corporate office. It is unknown who completed these surveys and what their relationship was with individual consumers. In many cases, even if the consumer

was present, he or she may not have been able to comprehend the questions or communicate answers due to age or disabilities. While one question on the survey asked for the name and relationship of the person filling out the survey (if not the consumer), these were open-text fields, requiring a prohibitive amount of time to categorize and analyze results according to respondent.

Race and age on the adult consumer surveys are self-reported, as is age on the youth consumer survey. Missing age and race information is due to respondents leaving the question(s) blank.

Analysis and reporting notes

Acumentra Health provided OHA/DHS with four components of analysis: raw data files for each consumer and provider population, a response rate report, a Tableau workbook with all survey results, and this narrative overview of the survey process.

The structure of the consumer and provider surveys includes many hierarchical question lines, where respondents are instructed to answer subsequent questions only if the previous question was answered in a certain way. Many respondents did not follow these instructions, but answered following questions when they should not have, based on their previous answer. At the direction of OHA/DHS, all survey responses were included in the analysis.

OHA/DHS provided Acumentra Health with a scoring guide for the adult consumer and provider surveys, in which every question was assigned a value of -1 (red), 0 (yellow), or 1 (green). “Red” answers were concerning, “yellow” answers were neutral or slightly concerning, and “green” answers were positive. Acumentra Health analysts used this document to create a scoring guide for the youth provider and consumer surveys, which DHS/OHA reviewed and approved. Nearly all analysis in the Tableau workbook was presented according to these scoring guides, which appear in Appendix B.

OHA/DHS also provided Acumentra Health with a list of questions with a “red flag,” indicating questions and topic areas that required special scrutiny. Red Flag dashboards present survey results for these questions only. Questions with a red flag are also included in dashboards for general survey results. Red flag questions appear in Appendix C.

Some consumers were associated with more than one provider (e.g., a residential service provider and a day service provider). In this case, results are presented in two ways: (1) the end user can stratify results according to respondent demographics (age, race), and see results with one record per respondent; or (2) the end user can stratify results according to provider and site, and see results

according to provider, where respondents' records are duplicated for each provider with which they are associated.

Tableau dashboards

Acumentra Health provided OHA/DHS with two Tableau workbooks, with all survey results analyzed as requested. Each workbook contains a number of dashboards. Tables 8 and 9 list the dashboards and describe their contents.

Each dashboard contains several graphs or tables with filters on the right side of the screen. Filters can be used to show only results the user is interested in. Filters also contain a search function—simply click in the open text box to search within the filter.

The following filters are available on all *provider dashboards*:

- Program (AMH, APD, ODDS)
- Program Type (group home, supportive living, etc.)
- Provider Name ID (provider agency name)
- Site Name ID (provider agency's site name)

The following filters are available on all *consumer dashboards*:

- Program Type (AMH, APD, ODDS)
- Provider Name ID (provider agency name)
- Reported Provider Name (usually the site name, open text response to question #2 on the adult and youth survey)
- Age (response to question # 3 on the adult survey or question #3 on the youth survey)
- Race (response to question # 4, only on the adult survey)

Each graph and table in Tableau can be sorted by the user. Hover the curser over the column label (e.g., "question" or "section") and this icon ( ) will appear. Clicking this icon will sort the questions according to ascending or descending question or section number. If the user clicks on the ascending or descending sort icons on the top bar, results will be sorted by ascending or descending results order (see below).

Table 8. Adult consumer and provider survey dashboards.

Tableau dashboard	Data source	Description
Provider General	Adult Provider Survey	List of questions with the number and percentage of respondents who answered with a "green," "yellow," or "red" response according to the scoring guide. The "Provider Average Response" table lists the average score (-1 to 1) for each survey section.
Consumer General	Adult Consumer Survey	List of questions with the number and percentage of respondents who answered with a green, yellow, or red response. The "Consumer Average Response" table lists the average score (-1 to 1) for each survey section. Duplicate consumer results are present, one for each provider with whom the consumer is linked. Only provider-related filers are available.
Consumer Nodup General	Adult Consumer Survey – no duplicates	Same as "Consumer General" dashboard, except that there are no duplicate responses. Only consumer-related filters are available.
Comparison Provider and Co	Adult Provider Survey Adult Consumer Survey	Side-by-side tables presenting the average number of green, yellow, or red responses per question in each section, for providers and consumers. There are what appear to be duplicate filters: the top filters are for the provider results; the bottom filters are for the consumer results. The user must apply both the consumer and provider filter to see comparable results. Duplicate consumer results are present, one for each provider with whom the consumer is linked. Only provider-related filters are available.
Comparison Provider and Co	Adult Provider Survey Adult Consumer Survey – no duplicates	Same as the "Comparison Provider and Co" dashboard, except that there are no duplicate responses. Only consumer-related filters are available.
Provider Red General	Adult Provider Survey	For questions with a Red Flag only, the number and percentage of respondents who answered with a green, yellow, or red response. The "Provider Red Average Response" table lists the average score (-1 to 1) for each survey section, where only Red Flag questions are included.
Consumer Red General	Adult Consumer Survey	Same as the "Provider Red General" dashboard, but for the consumer population. Only questions from Sections 2 and 4 were indicated as Red Flag questions. Duplicate consumer results are present, one for each provider with whom the consumer is linked. Only provider-related filters are available.

Table 8. Adult consumer and provider survey dashboards (cont.).

Tableau dashboard	Data source	Description
Consumer Nodup Red General	Adult Consumer Survey – no duplicates	Same as the Consumer Red General dashboard, except that there are no duplicate responses. Only consumer-related filters are available.
Comparison Provider and Co	Adult Consumer Survey Adult Provider Survey	Side-by-side tables presenting the average number of green, yellow, or red responses per question in each section, for providers and consumers, restricted to only Red Flag questions. There are what appear to be duplicate filters: the top filters are for the provider results; the bottom filters are for the consumer results. The user must apply both the consumer and provider filter to see comparable results. Duplicate consumer results are present, one for each provider with whom the consumer is linked. Only provider-related filters are available.
Comparison Provider and Co	Adult Provider Survey Adult Consumer Survey – no duplicates	Same as the Comparison Provider and Co dashboard, except that there are no duplicate responses. Only consumer-related filters are available.

Table 9. Youth consumer and provider survey dashboards.

Tableau dashboard	Data source	Description
Provider General	Youth Provider Survey	List of questions with the number and percentage of respondents who answered with a “green,” “yellow,” or “red” response according to the scoring guide. The “Provider Average Response” table lists the average score (-1 to 1) for each survey section.
Consumer General	Youth Consumer Survey	List of questions with the number and percentage of respondents who answered with a green, yellow, or red response. The “Consumer Average Response” table lists the average score (-1 to 1) for each survey section.
Comparison Provider and Con	Youth Provider Survey Youth Consumer Survey	Side-by-side tables presenting the average number of green, yellow, or red responses per question in each section, for providers and consumers. There are what appear to be duplicate filters: the top filters are for the provider results; the bottom filters are for the consumer results. The user must apply both the consumer and provider filter to see comparable results. Only provider-related filters are available.
Provider Red General	Youth Provider Survey	For questions with a Red Flag only, the number and percentage of respondents who answered with a green, yellow, or red response. The “Provider Red Average Response” table lists the average score (-1 to 1) for each survey section, where only Red Flag questions are included.
Consumer Red General	Youth Consumer Survey	Same as the “Provider Red General” dashboard, but for the consumer population. Only questions from Sections 2 and 4 were indicated as Red Flag questions.
Comparison Provider and Co	Youth Consumer Survey Youth Provider Survey	Side-by-side tables presenting the average number of green, yellow, or red responses per question in each section, for providers and consumers, restricted to only Red Flag questions. There are what appear to be duplicate filters: the top filters are for the provider results; the bottom filters are for the consumer results. The user must apply both the consumer and provider filter to see comparable results. Only provider-related filters are available.

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APPENDIX A. HCBS SURVEY INSTRUMENTS

Individual Experience Survey - Where I Live and Get Services

Survey ID#: [Survey_ID]

1. **Date:** _____

2. **Name of Individual Living in the Setting:** [FirstName LastName]

3. **Age of Individual Living in the Setting:**

☐ 18-24 years old
☐ 25-34 years old
☐ 35-44 years old
☐ 45-54 years old
☐ 55-64 years old
☐ 65-74 years old
☐ 75-84 years old
☐ 85 or older

4. **With which race or ethnic group do you (individual living in the setting) *most* identify?**

☐ Asian
☐ Black/African American
☐ Hispanic
☐ Native American/Alaskan Native
☐ Pacific Islander
☐ White
☐ Other

5. **Residential Setting Name**: _____

6. **Residential Setting Address**: _____

7. **Person helping me to complete the survey (Name)**: _____

7a. Best description of the role of the person helping me to complete the survey:

☐ Legal Representative
☐ Survey Hotline/Peer Advocate
☐ Family Member/Friend
☐ Not Applicable
☐ Other; Explain: _____

8. **Reason somebody is helping me to complete the survey:**

☐ I require assistance ☐ I requested assistance ☐ Not Applicable

☐ Other; Explain _____

9. **Is someone other than [FIRST_NAME] completing this survey?** ☐ Yes ☐ No

10. **If yes, please provide your name:**_____

Section 1: Where I live supports access to the broader community

11. **Please choose the description that best describes how the location of your home or residential setting supports your access to the community (Pick the best answer):**

☐ Where I live makes it **EASY** for me to be part of the community where I am located.

☐ Where I live makes it **HARD** for me to be part of the community where I am located.

Where I live makes it easy for me to:

12. **Participate in community activities**

☐ Always ☐ Usually ☐ Sometimes ☐ Never

13. **Get around in the community as I desire**

☐ Always ☐ Usually ☐ Sometimes ☐ Never

14. **Look for a job in the community where I can make at least minimum wage, if I want to work:**

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I do not want to work at this time

Section 2: I am supported where I live to be part of the community

15. I have regular opportunities be part of the broader community. The following are some examples that help explain what this means: working in the community, going to the park, the library, church, shopping for food, clothing or other items, getting my hair cut at a beauty or barber shop, going out for coffee, going to the movies, fairs, rodeos, or other community events.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 3: Choosing where I live

16. Before I moved to where I live now, I was told about or able to visit other places to live.

☐ Yes ☐ No

17. I was offered the choice to live in a place that is not only for people who have disabilities.

☐ Yes ☐ No

18. If I live in a shared room, I was offered the choice of a private bedroom or living unit.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

19. I have a choice in who my roommate is.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

Section 4: Where I live supports my independence and making life choices

Employment

20. My provider/setting supports me with my daily needs in order for me to work.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I do not want to work at this time

Personal Finances (Resources)

21. The provider/staff where I live support me in managing my money.

☐ Yes ☐ No, I manage my own money

☐ No, my guardian or representative manages my money

☐ I have a Social Security Representative Payee, or I am a beneficiary of a Special Needs Trust or Discretionary Trust.

22. I can easily get my money and spend my money as I wish.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 5: I am supported where I live to make my own scheduling decisions

23. I create my own schedule. For example, I decide when to go to bed or when I get up. I can go out alone, with friends or family as I wish. My provider/staff work around my activities. If my activities cause me to miss a scheduled mealtime, laundry time, or bath time, I can get the meal or service when convenient for me.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 6: Where I live ensures my rights of privacy, dignity and respect, and freedom from coercion (strong-arm) and restraint

Coercion

24. **Where I live now, my provider/staff has never threatened me with physical harm, or used restraints, or punished me, to force me to make a decision I did not want to make.**

    ☐ True – I **HAVE NOT** been forced to make decisions against my will

    ☐ False – I **HAVE** been forced to make decisions against my will

Restraint

25. **Where I live now, I have never been given a medication against my will to control my behavior.**

    ☐ True – I **HAVE NOT** been forced to take medication to control my behavior against my will.

    ☐ False - I **HAVE** been forced to take medication to control my behavior against my will.

26. **Where I live now, I have never been held or tied down by a person or object against my will.**

    ☐ True – I **HAVE NOT** been held or tied down against my will

    ☐ False - I **HAVE** been held or tied down against my will

27. **Where I live now, I have never been kept or locked in a room against my will.**

    ☐ True – I **HAVE NOT** been kept or locked in a room against my will

    ☐ False - I **HAVE** been kept or locked in a room against my will

Communication

28. I feel free to openly discuss any of my concerns with my provider/staff.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

29. I have access to a phone or to other methods of communicating with others outside of where I live. I can talk to anyone I want at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Access in all areas where I live

30. I have full access to the following areas where I live any time I want or need: kitchen; dining room; living/family room; bedroom; and bathroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 7: Staff where I live respect my personal privacy

31. I may lock my bedroom or living unit door for privacy.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

32. I have privacy when I use the bathroom. People do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

33. I may take a shower or bath privately. People do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 8: Where I live allows me to decorate and furnish my bedroom or living unit

34. I may decorate my bedroom or living unit the way I choose.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

35. I may furnish my bedroom or living unit with my own furniture.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 9: Where I live allows me to have access to food at any time

36. In addition to the meals and snacks provided to me by my provider, I can purchase food and have access to my food at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 10: Where I live allows me to have visitors at any time

37. I may have visitors at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 11: Services outside of where I live

38. I work or use employment services outside of where I live.

☐ Yes ☐ No

39. **If yes: I work or use employment services in a typical community setting where my co-workers come from a variety of different backgrounds and do not necessarily have disabilities (not including paid support staff):** ☐ Yes ☐ No

40. **I work or use employment services in a setting where most of my coworkers are people who also have some type of disability:**

    ☐ Yes ☐ No

41. **If yes: I had an option to work or use services in a place where I could meet and form relationships with people from a variety of different backgrounds, and not only with other people who have disabilities:** ☐ Yes ☐ No

42. **I am paid for my work:**

    ☐ Yes ☐ No

43. **If yes: I am paid minimum wage or better:** ☐ Yes ☐ No

44. **I would like to work more hours:**

    ☐ Yes ☐ No

45. **I would like to be able to have a job where I could make more money.**

    ☐ Yes ☐ No

You have completed the survey questions for where you live.

We would now like to ask some questions about services you might get outside of where you live. Not everyone has these services and that is ok. Please answer the best that you can.

46. DAY SERVICES ONLY: I use other services in a provider setting (such as Outpatient Mental Health Services, Adult Day Care, Day Services, or Community Inclusion/Alternative to Employment) outside of the place where I live: ☐ Yes ☐ No

47. If yes: When I use these services, I feel I am part of my community:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

48. I participate in activities with people I chose to spend time with:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

49. When I use these services, I have opportunities to interact with people from the community, who come from a variety of different backgrounds, and not only people who have disabilities (this does not include paid support staff):

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Is there any other information that you would like to share about where you live or receive services?

Thank you for completing this Survey.

Survey ID# [Survey_ID]

1. Date_____

2. Provider Name: [SiteName]

3. Person completing Survey and Title/Position _____

   _____

4. Medicaid Provider Number_____

5. Type of License or certification _____

6. Licensing or Certification Agency_____

7. Primary Population(s) Served_____

8. Physical Address of Service Site _____

9. Mailing Address (if different)_____

   _____

10. Phone_____

11. Email_____

12. Total number of sites you will be completing surveys on_____

Section 1: The residential setting is integrated and supports full access to the greater community and does not isolate individuals

SECTION A:

13. **Please choose the best option from the choices below.**

☐ Individuals have full access to the community. The residential setting does not specialize in, or target, a specific disability or diagnosis type and may have a mix of people with and without disabilities. The residential setting may have a mix of private pay and Medicaid. The setting may include room and board, bathing and other personal assistance while Individuals are supported to obtain many other services outside of the residential setting in the broader community. Off-site services may include competitive integrated employment, day services, beautician services, community activities, gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ Individuals receive some services in-house and others in the broader community. The residential setting may include room and board, bathing and other personal assistance services. The additional services on-site are intended to be convenient for individual access, yet, they may have the unintended consequence of isolation from the broader community. On-site and off-site services may include competitive integrated employment, day services, beautician services, community activities gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ The residential setting is designed for people with disabilities and often for people with a certain type of disability. The individuals in the residential setting are primarily or exclusively people with disabilities and on-site staff provides many of the services. The residential setting services include community access and individuals have regular opportunities to engage in the broader community.

☐ The residential setting is designed to provide people with disabilities multiple types of services on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities and people in the residential setting have limited, if any, interaction with the broader community.

Survey ID# [Survey_ID]

SECTION B: Please indicate whether the below statement is true for this setting.

14. The residential setting is a locked facility. ☐ Yes ☐ No

15. The residential setting is one of the following: ☐ Yes ☐ No

- Farmstead or disability specific farm community located in rural residential setting on a large parcel of land with little ability to access the broader community outside of the farm.
- Gated/secured "community" for people with disabilities where services are provided on-site and individuals rarely leave the gated community.
- Residential school where individuals receive both education and residential services in one setting and do not go into the broader community for education.
- Multiple residential settings co-located and operationally related (operated by the same provider) where services are provided on campus with individuals rarely accessing the broader community.

Section 2: Optimizes autonomy and independence in making life choices

Employment

16. Please choose the option that best describes the services and supports for employment:

☐ For individuals who want to work, the residential setting/provider encourages the individual's opportunities to seek employment and work in integrated settings and for competitive wages (minimum wage or better). Working individuals who live in this residential setting have supports from the provider in planning and meeting their daily needs in order to access and maintain employment. Individuals who live in this residential setting have frequent opportunities throughout the year to discuss career goals, including career advancement, career changes, increased wages, or increased hours. Individuals who want to work are working or using employment services in an integrated employment setting where there are opportunities to interact with people who do not have disabilities (not including paid staff).

☐ For individuals who want to work, the residential setting/provider encourages opportunities to seek employment and work in integrated employment for competitive wages (minimum wage or better). Individuals might have opportunities to talk about employment goals once a year or so. Those who want to work are working; however, it may not be in an integrated employment setting where individuals interact with people who do not have disabilities (not including paid staff). Individuals who are working in less integrated or segregated settings continue to be supported in career goals relating to obtaining integrated employment at a competitive wage.

☐ The residential setting/provider supports individuals in getting ready for work each day, but does not necessarily encourage individuals in seeking employment and working in integrated competitive settings.

☐ Individuals who reside in this residential setting and want to work are not encouraged or emotionally supported by the provider to do so.

Survey ID# [Survey_ID]

Personal Finances (Resources)

17. Please choose the option that best describes the services and supports for personal resources:

☐ Individuals may or may not have a Social Security designated Representative Payee. Individual may or may not be beneficiaries of a Special Needs Trust or Discretionary Trust. The existence of one of these is not a considered a limitation by the residential setting/provider.

☐ The residential setting/provider places no limitations to an individual's, or their designated representatives, ability to access personal financial resources (personal spending monies, personal property, real estate, assets, savings, etc.). Personal resources may be safeguarded but individuals have easy access to, experience no barriers, and are supported in obtaining and using personal resources as desired.

☐ There may be some limitations based on the safeguarding of personal resources. Individuals, or their designated representatives, can typically access funds in the same day, or within 24 hours for larger sums. Individuals are supported in obtaining and using their personal resources as desired.

☐ Limitations are placed on an individual's, or their designated representatives, access to their personal resources.

18. If you selected "Limitations are placed on an individual's, or their designated representatives, access to their personal resources" above, are the limits universally applied to everyone living in the residential setting? ☐ Yes ☐ No

19. Are the limits only applied to those who need them? ☐ Yes ☐ No

20. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

21. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

22. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

---

Section 3: The individual controls his/her own schedule

23. Please choose the option that best describes the services and supports for controlling one's own schedule:

☐Individuals are supported to control their own schedules. Services such as bathing and mealtimes are flexible and work around the individual's personal schedule. Requests for engaging in the broader community such as going shopping or to the movies are routinely supported and accommodated. When individuals work, their schedules are supported.

☐Individuals generally control their own schedules. Services such as mealtimes and bathing are scheduled. If individuals miss a scheduled service activity, such as a bath, meal or laundry, because of their personal schedule, it is not automatically rescheduled or replaced unless the individuals request or otherwise indicate they want the missed service activity.

☐ Most activities are scheduled by the provider, including services such as mealtimes and bathing and social and recreation opportunities. If individuals miss a scheduled activity, such as a bath, meal or laundry, because of their personal schedule, it is not replaced, or if replaced, with a lesser quality alternative.

☐ There are residential setting/provider limits to the amount of control individuals have over their own schedules.

24. If you selected "There are residential setting/provider limits to the amount of control individuals have over their own schedule" above, are the limits universally applied to everyone living in the residential setting?
    ☐Yes ☐No
25. Are the limits only applied to those who need them? ☐Yes ☐No
26. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No
27. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No
28. If limits are used, they are primarily used to (select the best answer):

    ☐Protect the individual or others ☐Efficiently manage operation

---

Section 4: Setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

Freedom from Coercion

29. Are individuals free from coercion as defined below? ☐Yes ☐No

    i. Threats of serious harm to or physical restraint against any person;
    ii. Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
    iii. The abuse or threatened abuse of the legal process.

30. Do the provider/staff utilize any of the following restraints on individuals receiving services in this residential setting to address or control behavior?

☐ Yes ☐ No

- Chemical restraints
- Mechanical restraints, such as devices that limit an individual's ability to freely move their body, **not part of the person's formal behavior support plan**
- Physical restraints, such as using a physical maneuver to limit an individual's ability to freely move, where the maneuver is weight-bearing and/or **not part of the person's formal behavior support plan**
- Seclusion, such as restricting an individual to a specific physical space as a means of controlling behavior or in response to a behavior

Communication

31. Please choose the option that best describes the services and supports for communication:

☐ There are no residential setting/provider limitations to the individual's ability to communicate within the residential setting or with those outside of the setting. If the individual needs a phone or other accommodations or other communication tool, they are provided one and a private space from which to hold conversations. Individuals can access the phone independently at any time and will be supported, if needed. Inside the residential setting, individuals are encouraged and supported to raise and discuss issues or concerns without fear of retaliation.

☐ There are shared modes of communication made available by the residential setting/provider. There may be reasonable waiting periods if others are using the "house" phone or individuals may need the provider's support to access to the phone. They do not need permission to access the phone. Inside the residential setting, individuals may raise and discuss issues or concerns without fear of retaliation.

☐ The ability to communicate privately within and to those on the outside of the residential setting is limited.

32. If you selected "The ability to communicate privately within and to those on the outside of the residential setting is limited" above, are the limits universally applied to everyone living in the residential setting?

☐ Yes ☐ No

33. Are the limits only applied to those who need them? ☐ Yes ☐ No

34. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

35. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

36. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Homelike Accommodations

37. Please choose the option that best describes the services and supports for homelike accommodations:

☐ Individuals have full access to typical homelike accommodations such as a kitchen, dining area, family/living room, laundry, and bathroom.

☐ Individuals have full access to most typical homelike accommodations but may share bathrooms and not have access to the full (commercial) kitchen, in a larger facility. Individuals are offered substitute equipment and a means to cook.

☐ There are residential setting/provider limits to full access to typical homelike accommodations.

38. If you selected “There are residential setting/provider limits to full access to typical homelike accommodations” above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

39. Are the limits only applied to those who need them? ☐Yes ☐No

40. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

41. If limits are used, are the limitations identified in the individual’s person-centered service plan? ☐Yes ☐No

42. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 5: Personal Privacy

43. Please choose the option that best describes the services and supports for personal privacy:

☐ All individuals may lock their bedroom and living unit doors. Door locks are single-action which means when the individual turns the handle or lever the door unlocks. All individuals have bathroom facilities that allow for complete privacy through the ability to lock the door or stall. Bathing areas are private and individuals are shielded or protected from others walking in on them. Only appropriate staff have keys.

☐ All individuals may lock their bedroom or living unit doors for privacy. Door locks are single-action which means when the individual turns the handle or lever the door unlocks. Bathrooms may be used by others and individuals may need additional support to obtain privacy, such as assistance to get from a wheelchair into the bathroom, in order to be able to shut the door for privacy. Only appropriate staff have keys.

☐ Doors are not lockable but privacy is assured through knocking before entering an individual's bedroom, living unit, or bathroom.

☐ There are residential setting/provider limits on an individual's ability to have personal privacy.

44. If you selected "There are residential setting/provider limits on an individual's ability to have personal privacy" above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

45. Are the limits only applied to those who need them? ☐Yes ☐No

46. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

47. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

48. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 6: Choice of Roommates/Sharing Space

49. Please choose the option that best describes the services and supports individuals have in their choice of roommates and sharing space:

☐ This facility only offers private rooms.

☐ There are shared bedrooms or living units. There are methods in place for individuals to seek a new roommate should they desire. Individuals have the opportunity to meet new potential roommates and have input in the selection of their roommate.

☐ There are shared bedroom or living units in the facility. There are residential setting/provider limits regarding the individual's involvement in the selection of roommates or their ability to have input in the choice of roommates.

50. If you selected "There are shared bedroom or living units in the facility. There are residential setting/provider limits regarding the individual's involvement in the selection of roommates or their ability to have input in the choice of roommates" above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

51. Are the limits only applied to those who need them? ☐Yes ☐No

52. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

53. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

54. I If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 7: Freedom to Furnish and Decorate

55. Please choose the option that best describes the services and supports to individuals regarding furnishing and decorating:

☐ Individuals may bring their own furnishings and are supported and encouraged to personalize their space. Individuals may paint or secure pictures to walls or use accessories, as needed. There may be landlord/tenant type agreements regarding approval of painting, nails or holes in walls, but individual experience is that obtaining necessary permissions is reasonable and does not inhibit their personal style or ability to decorate.

☐ Individuals may bring their own furnishings. Decorating is not encouraged or discouraged. There may be landlord/tenant type agreements regarding approval of nails or holes in walls. Substantial changes, such as painting, may not be allowed.

☐ There are residential setting/provider limits on an individual's ability to furnish and decorate.

56. If you selected "There are residential setting/provider limits on an individual's ability to furnish and decorate" above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

57. Are the limits only applied to those who need them? ☐Yes ☐No

58. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

59. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

60. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 8: The individual can have access to food at any time

61. Please choose the option that best describes the services and supports to individuals regarding access to food.

    ☐ Individuals are provided three nutritious meals and two snacks a day. Individuals may assist with menu planning and personal preferences are considered. If an individual misses a meal, alternatives such as a to-go sack meal or heatable meals, are available Individuals have access to personal food storage, including refrigeration, freezer, and dry storage, that they can access at any time.

    ☐ Individuals are provided three nutritious meals and two snacks a day. Individuals may assist with menu planning and personal preferences are considered. If an individual misses a meal it is typically not replaced unless requested. Storing personal food items is not encouraged, but is allowed if requested.

    ☐ There are limits in place regarding access to food at any time.

62. If you selected "There are limits in place regarding access to food at any time" above, are the limits universally applied to everyone living in the residential setting? ☐ Yes ☐ No

63. Are the limits only applied to those who need them? ☐ Yes ☐ No

64. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

65. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

66. If limits are used, they are primarily used to (select the best answer):

    ☐ Protect the individual or others ☐ Efficiently manage operations

Section 9: The individual can have visitors at any time

67. Please choose the option that best describes the services and supports to individuals regarding having visitors.

☐ Individuals may have visitors at any time. Individuals living in the site understand there are no residential setting/provider limits to the time when visitors may be received. Individuals are encouraged and supported to have visitors. .

☐ Individuals may have visitors at any time. The residential setting/provider may have policies in place for after-hours visitors or a check-in process to address safety or privacy concerns.

☐ There are residential setting/provider limits to individuals having visitors at any time.

68. If you selected "There are residential setting/provider limits to individuals having visitors at any time" above, are the limits universally applied to everyone living in the residential setting? ☐ Yes ☐ No

69. Are the limits only applied to those who need them? ☐ Yes ☐ No

70. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

71. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

72. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

73. **Is there any other information that you as a provider of community-based services would like to provide?**

Thank you for completing this Survey.

Survey ID# [Survey_ID]

1. **Date_____**
2. **Name of Child Living in the Setting: [FirstName LastName]**
3. **Age of Child Living in the Setting_____**
4. **Residential Setting Name_____**
5. **Residential Setting Address_____**

   _____

Please choose one of the following to describe how the survey is being completed:

6. **I am the child or youth living in the setting and I am completing the survey with assistance from someone.**
7. **Best description of the role of the person helping me :**

   ☐ Legal Representative ☐ Not Applicable

   ☐ Survey Hotline/Peer Advocate ☐ Family Member/Friend

   ☐ Other; Explain_____

8. **Reason somebody is helping me:**

   ☐ I require assistance ☐ I requested assistance

   ☐ Other; Explain_____

9. **Name of person helping me_____**
10. ☐ **I am the child or youth living in the setting and I am completing the survey on my own without assistance from someone.**
11. ☐ **I am the legal representative for the child living in the setting and I am completing the survey on the child's behalf.**
12. **Type of legal representative:** ☐ Parent with legal custody ☐ Legal guardian
13. **Name of person completing the survey for me_____**

Please complete the survey questions from the perspective of the child who is receiving services in a residential (group home or foster home) setting.

Section 1: Where I live supports access to the broader community

14. Please choose the description that best describes how the location of the home where the child receives services supports access to the community:

Pick the best answer:

☐ Where I live makes it **EASY** for me to be part of the community where I am located.

☐ Where I live makes it **HARD** for me to be part of the community where I am located.

Where I live makes it easy for me to:

15. Participate in community activities

☐ Always ☐ Usually ☐ Sometimes ☐ Never

16. Go places in the community

☐ Always ☐ Usually ☐ Sometimes ☐ Never

17. Obtain work-related experience (such as summer or after school work, volunteer work, etc.) or get a job in the community:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I am working on other things right now and do not wish to work or obtain work experience at this time.

☐ N/A- I am too young to work or gain work-related experience right now.

Section 2: I am supported where I live to be part of the community

18. I have regular opportunities be part of the broader community. The following are some examples that help explain what this means: getting work experience in the community; participating in extracurricular activities; going to the park, the library, or church; shopping for food, clothing or other items; going to the gym or an exercise class; going out for ice cream; going to the movies, fairs, rodeos, or other community events.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 3: Choosing where I live

19. Before I moved to where I live now, I (or my parent or guardian) was told about or able to visit other places to live.

☐ Yes ☐ No

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was told about other options)

20. Before moving to where I live now, I (or my parent or guardian) was offered different choices of where I could live. One of the choices was a service setting where not all people experience disabilities; this choice may have included the option for me to receive services in my family home.

☐ Yes ☐ No

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was told about other options)

21. If I have a shared bedroom, I (or my parent or guardian) was offered a choice of a home for me that offered a private bedroom.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was offered the choice of a home with a private bedroom)

22. My guardian has a say in who I share my bedroom with.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

☐ I don't know (I am a youth completing the survey and I don't know if my guardian has a say in who is share my bedroom with)

23. I got to visit the home where I live now and meet members of the household before I moved in.

☐ Yes ☐ No

Section 4: Where I live supports my independence and making life choices

Work or Work Experience

24. My provider/setting supports me with my daily needs in order for me to work or obtain work-related experience.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I am working on other things right now and do not wish to work or obtain work-related experience at this time.

☐ N/A- I am too young to work or gain work-related experience right now.

Personal Finances (Resources)

25. I have a say in how I spend my personal funds.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

26. I get support to manage my money so I can buy the things I want.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 5: I am supported where I live to participate in creating my own schedule

27. I have an active role in planning my own schedule. I am supported in choosing preferred activities and my provider helps me to plan my day so that I can do things I like while also planning for necessary things like school, physical activity, and sleep.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 6: Where I live ensures my rights of privacy, dignity and respect, and freedom from coercion (strong-arm) and restraint

Coercion

28. Where I live now, my provider/staff has never used physical force or physical punishment, or threats to make me do something I don't want to do.

☐ True – I **HAVE NOT** been forced to make decisions against my will

☐ False – I **HAVE** been forced to make decisions against my will

Restraint

29. Where I live now, I have never been forced to take a medication as a consequence of my behavior.

☐ True – I **HAVE NOT** been forced to take medication as a consequence of my behavior against my will.

☐ False - I **HAVE** been forced to take medication as a consequence of my behavior against my will.

30. Where I live now, I have never been tied down to control my behavior against my will.

☐ True – I **HAVE NOT** been tied down to control my behavior against my will.

☐ False - I **HAVE** been tied down to control my behavior against my will.

31. Where I live now, I have never been held down by a person or object to control my behavior against my will.

☐ True – I **HAVE NOT** been held down to control my behavior against my will.

☐ False - I **HAVE** been held down to control my behavior against my will.

32. Where I live now, I have never been kept away from others in a confined space or locked in a room as punishment against my will.

☐ True – I **HAVE NOT** been kept or locked in a room as punishment against my will

☐ False - I **HAVE** been kept or locked in a room as punishment against my will

Communication

33. I feel free to openly discuss any of my concerns with my provider/staff.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

34. I have access to a phone or to other methods of communicating with others outside of where I live. My provider allows me to talk to my guardian (or my attorney or CASA, if I have one) at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Access in all areas of the home where I live

35. I can be in the following areas of my home: kitchen; dining room; living/family room; bedroom; and bathroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 7: Staff where I live respect my personal privacy

36. I have privacy in my bedroom and opportunity for private time if I desire it. Staff and other household members knock before entering my room.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

37. I have privacy when I use the bathroom. I may have assistance when using the bathroom, but people do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

38. I have privacy when I take a shower or bath. I may have assistance when showering or bathing, but people do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 8: Where I live allows me to decorate and furnish my bedroom or living unit

39. I have a say in how I decorate my bedroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

40. I may furnish my bedroom with my own furniture.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 9: Where I live allows me to have access to food at any time

41. My provider serves some of my favorite foods and I am offered healthy alternatives if I don't like something that is being served.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

42. In addition to the meals and snacks provided to me by my provider, I have access to snacks and have the option of purchasing my favorite foods.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 10: Where I live allows me to have visitors at any time

43. My provider, guardian, and ISP team work together to support me in having visits with friends.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

44. My provider is supportive of visits with my family (except where limited by a court order) and I feel like my family is welcome in the home where I live.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

You have completed the survey questions for where you live.

We would now like to ask some questions about services you might get outside of where you live. Not everyone has these services and that is ok. Please answer the questions that are applicable to you

Section 11: Services outside of where I live

45. I work or use employment services outside of where I live.

☐ Yes ☐ No

☐ N/A- I am too young to work or gain work-related experience right now.

46. If yes: I work or use employment services in a typical community setting where my coworkers come from a variety of different backgrounds and do not necessarily have disabilities (not including paid support staff): ☐ Yes ☐ No

47. I work or use employment services in a setting where most of my coworkers are people who also have some type of disability: ☐ Yes ☐ No

48. If yes: I had an option to work or use services in a place where I could meet and form relationships with people from a variety of different backgrounds, and not only with other people who have disabilities: ☐ Yes ☐ No

49. I am paid for my work: ☐ Yes ☐ No

50. If yes: I am paid minimum wage or better: ☐ Yes ☐ No

51. I would like to work more hours now or in the future: ☐ Yes ☐ No

52. I would like to be able to have a job where I could make more money now or in the future:

☐ Yes ☐ No

53. Is there any other information that you would like to share about where you live or receive services?

Thank you for completing this survey.

Survey ID#: [insert Survey_ID]

Home and Community-Based Services Setting Provider Self-Assessment Survey for Children's Residential Settings (Foster Care and Group Homes)

1. **Date**_____
2. **Provider Name**_____
3. **Person completing Survey and Title/Position**_____

   _____
4. **Medicaid Provider Number**_____
5. **Type of License or Certification**_____
6. **Licensing or Certification Agency (check one):**

   ☐ DD ☐ Child Welfare ☐ Other: _____
7. **Primary Population(s) Served**_____
8. **Physical Address of Service Site**_____

   _____
9. **Number of individuals in the home receiving Medicaid HCBS**_____
10. **Total number of persons residing in the household**_____
11. **Mailing Address (if different from above)**_____

    _____
12. **Phone**_____
13. **Email**_____
14. **Total number of sites you will be completing surveys on**_____

Section 1: The residential setting is integrated and supports full access to the greater community and does not isolate individuals

15. **Part A:** Please choose the option that best describes the group home or foster home.

☐ Individuals are supported in having full access to the community. The home does not specialize in, nor does the provider target, a specific disability or diagnosis type. There may be a mix of people with and without disabilities living in the home. The home may have a mix of residents receiving Medicaid funded services and others who do not. Individuals are supported in obtaining services outside of the home in the broader community in addition to the care they receive in the home. The home encourages opportunities to work or seek work related experience (on the same basis as people who are the same age and do not have a disability). Other off-site services may include school services, community activities, gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ Individuals receive some services in the home and other services in the broader community. Onsite and off-site services may include school services, community activities gym, work or work related experience (on the same basis as people who are the same age and do not have a disability), medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ The home is designed for people with disabilities and often for people with a certain type of disability. The individuals in the home are primarily or exclusively people with disabilities and on-site staff provides many of the services. Individuals have regular opportunities to engage in the broader community. However, the home setting does not encourage opportunities to work or obtain work related experience (on the same basis as people who are the same age and do not have a disability).

☐ The home is designed for individuals with disabilities to receive multiple types of services on-site or in the home, including housing, school services, medical, behavioral and therapeutic services, and/or social and recreational activities and people in the home have limited, if any, interaction with the broader community. The home setting does not encourage opportunities to work or obtain related experience (on the same basis as people who are the same age and do not have a disability).

Part B: Indicate if any of the following apply:

16. The residential setting is a locked facility. ☐ Yes ☐ No

17. The residential setting is one of the following: ☐ Yes ☐ No

- Farmstead or disability specific farm community located in rural residential setting on a large parcel of land with little ability to access the broader community outside of the farm.
- Gated/secured "community" for people with disabilities where services are provided on-site and individuals rarely leave the gated community.
- Residential school where individuals receive both education and residential services in one setting and do not go into the broader community for education.
- Multiple residential settings co-located and operationally related (operated by the same provider) where services are provided on campus with individuals rarely accessing the broader community.

Section 2: Optimizes autonomy and independence in making life choices

Work or Work Experience

18. Please choose the option that best describes the residential service setting provider's role related to services and supports for work or work-related experiences:

☐ The home/provider encourages opportunities for individuals to obtain work or work-related experience. Individuals who would like to work are either working or obtaining some type of work related experience. Individuals who live in this home have supports from the provider to plan for or otherwise meet daily needs required to maintain work or a work experience. Individuals who live in this home, including those who are not working, are regularly encouraged throughout the year to discuss work or career goals.

☐ The home/provider encourages opportunities for individuals to obtain work or work related experience on the same basis as people who are the same age and do not have a disability. Individuals who may be focused on school right now will be encouraged to pursue work and work related experiences in the future. Individual have opportunities to talk about work or career goals.

☐ The home /provider supports individuals in getting ready for school and/or work each day, but does not necessarily encourage individuals to seek work or work-related experience on the same basis as people who are the same age and do not have disabilities. Work or career goals are rarely talked about.

☐ Individuals are not encouraged or emotionally supported by the provider to work or obtain work experience. Work or career goals are rarely or never talked about, and likely will not be discussed in the future.

☐ All individuals in the home are focused on school right now or are not yet of school age. Individuals in the home are encouraged to discuss future plans and career goals that include work in an integrated setting.

Personal Finances (Resources)

19. Please choose the option that best describes the services and supports for personal resources:

☐Individuals may or may not have a Social Security designated Representative Payee. Individual may or may not be beneficiaries of a Special Needs Trust or Discretionary Trust. The existence of one of these is not considered a limitation by the residential setting/provider.

☐The home /provider places no limitations to an individual's, or their designated representatives', ability to access personal financial resources (personal spending monies, personal property, real estate, assets, savings, etc.). Personal resources may be safeguarded but individuals have easy access to, experience no barriers, and are supported in obtaining and using personal resources as desired.

☐There may be some limitations based on the safeguarding of personal resources. The provider assists individuals in budgeting and managing funds, however, the individual self-directs and is engaged in the process as much as possible. The individual's financial plan is addressed in the ISP and the provider supports the individual in meeting identified goals.

☐ Limitations beyond age appropriate structure and guidance are placed on an individual's, or their designated representatives', access to personal resources.

20. If you selected "Limitations beyond age appropriate structure and guidance are placed on an individual's, or their designated representatives', access to personal resources" above, are the limits universally applied to everyone living in the home?

☐Yes ☐No

21. Are the limits only applied to those who need them? ☐Yes ☐No

22. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

23. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

24. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

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Section 3: The individual controls his/her own schedule

25. Please choose the option that best describes the services and supports for controlling one's own schedule:

☐Individuals are supported to control their own schedules in an age appropriate manner as much as possible. The provider engages with the individual to promote self-direction and honor individual preferences related to routine and activities. Routine activities such as bathing and mealtimes are flexible and work around the individual's personal schedule. Requests for engaging in the broader community such as participating in extracurricular school activities, working or participating in work-related experiences, going shopping, to the library, or to the park are routinely supported and accommodated. When individuals work, their schedules are supported. Children in the home are encouraged to participate in extra-curricular activities such as school or community sporting programs or clubs.

☐Individuals are an active part of directing or creating their personal schedules. The preferences of the individual are honored whenever possible. The provider helps the individual identify preferred activities and activity times, while also supporting the individual in addressing necessary components of their daily routine such as school attendance, exercise, and adequate rest. Routine activities in the household and general scheduling is flexible and is adjusted based on who lives in the home and what is important to members of the household.

☐ Most activities are scheduled by the provider, including daily living activities such as mealtimes, bathing, and social and recreation opportunities. The provider seeks little input from the individual in scheduling activities. The household operates by a routine schedule that has little flexibility and little variation, even when the household composition changes.

☐ There are home/provider limits to the amount of control individuals have over their own schedules.

26. If you selected "There are home/provider limits to the amount of control individuals have over their own schedule" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

27. Are the limits only applied to those who need them? ☐Yes ☐No

28. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

29. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

30. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

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Section 4: Setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

Freedom from Coercion

31. Are individuals free from coercion as defined below? ☐Yes ☐No

- Threats of serious harm to or physical restraint against any person;
- Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
- The abuse or threatened abuse of the legal process.

32. Do the provider/staff utilize any of the following restraints on individuals receiving services in this home to address and control behavior? ☐Yes ☐No

- Chemical restraints, such as the forced administration of a medication as a controlling or punitive response to a behavioral episode.
- Mechanical restraints, such as devices that limit an individual's ability to freely move their body, not part of the person's formal behavior support plan
- Physical restraints, such as using a physical maneuver to limit an individual's ability to freely move, where the maneuver is weight-bearing and/or not part of the person's formal behavior support plan
- Seclusion, such as restricting an individual to a specific physical space as a punitive response to a behavior

Communication

33. Please choose the option that best describes the services and supports for communication:

☐ Individuals are encouraged and supported to communicate within the home and with others outside of the home. Individuals are afforded privacy in communication as safe and appropriate to their chronological age. Individuals may have access to the phone or other methods of communication with assistance or oversight from the provider. Individuals have privacy in communication with their parents or legal guardian, except where restricted by a court order. Where applicable, individuals have privacy in communication with their Child Welfare caseworker, attorney, and/or CASA.

☐ Individuals are encouraged and supported to communication with others in the home and in the community. Access to the phone or other modes of communication may be made with the provider's permission, or in accordance with the individual's ISP. There may be legal orders that direct the types of communication and level of supervision or access an individual may have.

☐The ability to communicate privately within the home and with others outside of the home is limited.

34. If you selected "The ability to communicate privately within the home and with others outside of the home is limited" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

35. Are the limits only applied to those who need them? ☐Yes ☐No

36. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

37. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

38. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Homelike Accommodations

39. Please choose the option that best describes the services and supports for homelike accommodations:

☐ Individuals have access to typical homelike accommodations such as a kitchen, dining area, family/living room, laundry, and bathroom appropriate to the chronological age of the individual.

☐ Individuals have full access to most typical homelike accommodations, however, providers may modify access to address safety incidental to the provision of daily living activities.

☐ There are home/provider limits beyond age appropriate structure and guidance to full access to typical homelike accommodations.

40. If you selected "There are home/provider limits beyond age appropriate structure and guidance to full access to typical homelike accommodations" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

41. Are the limits only applied to those who need them? ☐Yes ☐No

42. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

43. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

44. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Section 5: Personal Privacy

45. Please choose the option that best describes the services and supports for personal privacy:

☐ Individuals have the opportunity to have privacy or private time in their bedroom, including the ability to close the door, should they desire it. Individuals have privacy when using the bathroom. Individuals are able to close the bathroom door and are shielded or protected from others walking in on them when using the toilet or bathing. Staff/caregivers are present in the bathroom or during private time only when necessary to provide required assistance or to address safety. Staff and other members of the household knock and wait to receive permission before entering a closed room.

☐ There are home/provider limits beyond age appropriate structure and guidance on an individual's ability to have personal privacy.

46. If you selected "There are home/provider limits on an individual's ability to have personal privacy" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

47. Are the limits only applied to those who need them? ☐Yes ☐No

48. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

49. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

50. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 6: Choice of Roommates

51. Please choose the option that best describes the services and supports individuals and/or their guardians have in the choice of roommates in a shared bedroom situation:

☐ This home only offers private rooms.

☐ There are shared bedrooms in the home. The individual's legal guardian has consented to and supports the individual having a shared bedroom. There are methods in place for guardians to request a change in roommate or shared room situation should this be desired. Individuals and their guardians have the opportunity to meet new potential shared bedroom roommates and have input in the selection of their shared bedroom roommate.

☐ There are shared bedrooms in the home. There are provider limits regarding the individual's and their guardian's involvement in the selection of shared bedroom roommates or their ability to have input in the choice of shared bedroom roommates.

52. If you selected "There are shared bedrooms in the home. There are provider limits regarding the individual's and their guardian's involvement in the selection of shared bedroom roommates or their ability to have input in the choice of shared bedroom roommates" above, are the limits universally applied to everyone living in the home?

☐Yes ☐No

53. Are the limits only applied to those who need them? ☐Yes ☐No

54. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

55. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

56. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 7: Freedom to Furnish and Decorate

57. Please choose the option that best describes the services and supports to individuals regarding furnishing and decorating:

☐ Individuals may bring their own furnishings and are supported and encouraged to personalize their space. Individuals are encouraged to have age appropriate décor that reflects their personal style. The provider may provide guidance to the individual to address safety and family-friendly considerations.

☐ The home provider limits an individual's ability to furnish and decorate.

58. If you selected "The home provider limits an individual's ability to furnish and decorate" above, are the limits universally applied to everyone living in the home?

☐Yes ☐No

59. Are the limits only applied to those who need them? ☐Yes ☐No

60. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

61. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

62. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 8: The individual can have access to food at any time

63. Please choose the option that best describes the services and supports to individuals regarding access to food.

☐ Individuals are provided three nutritious meals and two snacks a day. Individuals are encouraged to participate in menu planning, and cultural and personal preferences of the individual are honored. The individual may participate in grocery shopping, selection of meal options, and routinely have an opportunity to have favorite foods. Mealtimes offer some choice in food options and individuals are not required or expected to eat foods they do not like. If an individual misses a meal, alternatives such as a to-go sack meal or heatable meals, are available upon return.

☐ Individuals are provided three nutritious meals and two snacks a day. The provider seeks little input from the individual related to menu planning. Individual preferences or favorite foods are rarely served and alternative options for meals are not offered.

☐There are limits beyond age appropriate structure and guidance in place regarding access to food at any time.

64. If you selected "There are limits beyond age appropriate structure and guidance in place regarding access to food at any time" above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

65. Are the limits only applied to those who need them? ☐Yes ☐No

66. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

67. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

68. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Section 9: The individual can have visitors at any time

69. Please choose the option that best describes the services and supports to individuals regarding having visitors.

☐ Individuals are encouraged to have visitors in the home. Legal guardians and family members have access to the individual at any time (except where limited by a court order). The provider works with the individual in identifying opportunities to have visitors and planning for social opportunities.

☐Individuals are not necessarily encouraged to have visitors in the home. When an individual desires to have visitors, they are encouraged to meet with friends or family outside of the home, rather than hosting guests at the residence.

☐There are residential setting/provider limits beyond age appropriate structure and guidance to individuals having visitors at any time.

70. If you selected "There are residential setting/provider limits beyond age appropriate structure and guidance to individuals having visitors at any time" above, are the limits universally applied to everyone living in the residential setting?

☐Yes ☐No

71. Are the limits only applied to those who need them? ☐Yes ☐No

72. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

73. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

74. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

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Is there any other information that you as a provider of community-based services would like to provide?

Thank you for completing the Provider Self-Assessment Survey

APPENDIX B. OHA/DHS SCORING GUIDES

Individual Experience Survey - Where I Live and Get Services

Date

Name
Address
City, State, Zip

Dear Name

Please complete this survey if you live in one of the following settings:

- Assisted Living Facility
- Residential Care Facility
- Group Home
- Residential Treatment Home
- Residential Treatment Facility
- Foster Home

You are being asked to complete this survey because we would like to learn more about your experiences living in the settings listed above. The support you receive in these settings are considered Home and Community-Based Services (HCBS). HCBS provides needed supports for individuals to live integrated in the community and have experiences, including employment, just like other members of the community.

In January 2014 the Federal Centers for Medicare and Medicaid Services (CMS) issued new rules regarding settings in which HCBS are provided. These rules provide new protections for individuals using HCBS. We are looking at service settings to see if the new requirements are being met. Your individual answers will not be shared with your provider/staff. We may use the information to help your provider/staff understand changes they may need to make under these rules.

We want to use your answers to better understand if we need to make changes to improve everyone's community experience. Your input is valuable to us.
Completing the survey should only take about 10 minutes. You may:

- Complete your survey online; go to xxxxxxxxxxxxxxxxxx.

- Complete your survey on paper.

If you would like help to complete your survey, you may choose who helps you. Options for assistance may include:

- Call toll free 1-800-XXX-XXXX to have someone complete the survey with you.

- Contact the person who provides your case management services for assistance.
- Work with your legal representative, a peer advocate, friend or family member.
- Contact a local advocacy program (staff where you live may help you find one).
- Ask staff where you live for help.

We really hope you will take the time to complete this survey. Your experiences in your current setting are important us. Thank you for taking the time to participate.

Thank you for your time in completing this survey. If you would like to read more information about these new rules, you may view them online at this website:
http://www.oregon.gov/dhs/dhsnews/pages/hcbs-transitionplan.aspx

Date:

Question 1: Name of Individual Living in the Setting:

Question 2: Age of Individual Living in the Setting:

☐ 18-24 years old

☐ 25-34 years old

☐ 35-44 years old

☐ 45-54 years old

☐ 55-64 years old

☐ 75-85 years old

☐ 85 or older

Question 3: To which race or ethnic group do you (individual living in the setting) *most* identify?

☐ Asian

☐ Black/African American

☐ Hispanic

☐ Native American/Alaskan Native

☐ Pacific Islander

☐ White

☐ Other

Question 4: Residential Setting Name:

Question 5: Residential Setting Address:

Question 6: Person assisting me complete the survey: ☐ Not Applicable

Question 7: Best description of the role of the person helping to complete the survey:

☐ Not Applicable; ☐ Legal Representative; ☐ Case Manager; ☐ Survey Hotline/Peer Advocate; ☐ Family Member/Friend; ☐ Other; Explain:

Question 8: Reason somebody is completing the survey for me:

☐ I require assistance; ☐ I requested assistance ☐ Other; Explain

Question 9: Person completing survey if not me; Name: ☐ Not Applicable

Question 10: My Survey Number:

Section 1: Where I live supports access to the broader community

Question 11: Please choose the description that best describes how the location of your home or residential setting supports your access to the community:

Pick the best answer:

G ☐ Where I live makes it easy for me to be part of the community where I am located.

R ☐ Where I live makes it hard for me to be part of the community where I am located.

Where I live makes it easy for me to:

Question 12: Participate in community activities

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 13: Get around in the community as I desire

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 14: Look for a job in the community where I can make at least minimum wage, if I want to work:

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Y ☐ I do not want to work at this time

Section 2: I am supported where I live to be part of the community

Question 15: I have regular opportunities be part of the broader community. The following are some examples that help explain what this means: working in the community, going to the park, the library, church, shopping for food, clothing or other items, getting my hair cut at a beauty or barber shop, going out for coffee, going to the movies, fairs, rodeos, or other community events.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 3: Choosing where I live

Question 16: Before I moved to where I live now, I was told about or able to visit other places to live.

G ☐ Yes

R ☐ No

Question 17: I was offered the choice to live in a place that is not only for people who have disabilities.

G ☐ Yes

R ☐ No

Question 18: If I live in a shared room, I was offered the choice of a private bedroom or living unit.

G ☐ Yes

R ☐ No

Y ☐ Not applicable - I am in a private room

Question 19: I have a choice in who my roommate is.

G ☐ Yes

R ☐ No

Y ☐ Not applicable – I am in a private room

Section 4: Where I live supports my independence and making life choices

Employment

Question 20: My provider/setting supports me with my daily needs in order for me to work.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Y ☐ I do not want to work at this time

Question 21: Personal Finances (Resources)

The provider/staff where I live support me in managing my money.

G ☐ Yes

G ☐ No, I manage my own money

G ☐ No, my guardian or representative manages my money

G ☐ I have a Social Security Representative Payee, or I am a beneficiary of a Special Needs Trust or Discretionary Trust.

Question 22: I can easily get my money and spend my money as I wish.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 5: I am supported where I live to make my own scheduling decisions

Question 23: I create my own schedule. For example, I decide when to go to bed or when I get up. I can go out alone, with friends or family as I wish. My provider/staff work around my activities. If my activities cause me to miss a scheduled mealtime, laundry time, or bath time, I can get the meal or service when convenient for me.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 6: Where I live ensures my rights of privacy, dignity and respect, and freedom from coercion (strong-arm) and restraint

Coercion

Question 24: Where I live now, my provider/staff has never threatened me with physical harm, or used restraints, or punished me, to force me to make a decision I did not want to make.

G ☐ True – I have not been forced to make decisions against my will

R ☐ False – I have been forced to make decisions against my will

Restraint

Question 25: Where I live now, I have never been given a medication against my will to control my behavior.

G ☐ True – I have not been forced to take medication to control my behavior against my will.

R ☐ False - I have been forced to take medication to control my behavior against my will.

Question 26: Where I live now, I have never been held or tied down by a person or object against my will.

G ☐ True – I have not been held or tied down against my will

R ☐ False - I have been held or tied down against my will

Question 27: Where I live now, I have never been kept or locked in a room against my will.

G ☐ True – I have not been kept or locked in a room against my will

R ☐ False - I have been kept or locked in a room against my will

Communication

Question 28: I feel free to openly discuss any of my concerns with my provider/staff.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 29: I have access to a phone or to other methods of communicating with others outside of where I live. I can talk to anyone I want at any time.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Access in all areas where I live

Question 30: I have full access to the following areas in where I live any time I want or need: kitchen; dining room; living/family room; bedroom; and bathroom.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 7: Staff where I live respect my personal privacy

Question 31: I may lock my bedroom or living unit door for privacy.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 32: I have privacy when I use the bathroom. People do not walk in on me without my permission.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 33: I may take a shower or bath privately. People do not walk in on me without my permission.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 8: Where I live allows me to decorate and furnish my bedroom or living unit

Question 34: I may decorate my bedroom or living unit the way I choose.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 35: I may furnish my bedroom or living unit with my own furniture.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 9: Where I live allows me to have access to food at any time

Question 36: In addition to the meals and snacks provided to me by my provider, I can purchase food and have access to my food at any time.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 10: Where I live allows me to have visitors at any time

Question 37: I may have visitors at any time.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 11: Services outside of where I live

Question 38: I work or use employment services outside of where I live.

G ☐ Yes

G ☐ No

If yes:

Question 38a: I work or use employment services in a typical community setting where my co-workers come from a variety of different backgrounds and do not necessarily have disabilities (not including paid support staff):

G ☐ Yes

R ☐ No

Question 38b: I work or use employment services in a setting where most of my coworkers are people who also have some type of disability:

G ☐ Yes

R ☐ No

If yes:

Question 38b(i): I had an option to work or use services in a place where I could meet and form relationships with people from a variety of different backgrounds, and not only with other people who have disabilities:

G ☐ Yes

R ☐ No

Question 38c: I am paid for my work:

G ☐ Yes

R ☐ No

If yes:

Question 38c(i): I am paid minimum wage or better:

G ☐ Yes

R ☐ No

Question 38d: I would like to work more hours:

G ☐ Yes

R ☐ No

Question 38e: I would like to be able to have a job where I could make more money.

G ☐ Yes

R ☐ No

You have completed the survey questions for where you live.

We would now like to ask some questions about services you might get outside of where you live. Not everyone has these services and that is ok. Please answer the best that you can.

Question 39: DAY SERVICES ONLY: I use other services in a provider setting (such as Outpatient Mental Health Services, Adult Day Care, Day Services, or Community Inclusion/Alternative to Employment) outside of the place where I live:

G ☐ Yes

G ☐ No

If yes:

Question 39a: When I use these services, I feel I am part of my community:

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 39b: I participate in activities with people I chose to spend time with:

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 39c: When I use these services, I have opportunities to interact with people from the community, who come from a variety of different backgrounds, and not only people who have disabilities (this does not include paid support staff):

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 40: Is there any other information that you would like to share about where you live or receive services?

Thank you for completing this Survey.

Home and Community-Based Services Setting Provider Self-Assessment Survey

Date:

Question 1: Survey #

Question 2: Provider Name:

Question 3: Person completing Survey and Title/Position:

Question 4: Medicaid Provider Number:

Question 5: Type of License or certification:

Question 6: Licensing or Certification Agency:

Question 7: Primary Population(s) Served:

Question 8: Physical Address of Service Site:

Question 9: Mailing Address (if different):

Question 10: Phone:

Question 11: Email:

Question 11a: Total number of sites you will be completing surveys on:

Section 1: The residential setting is integrated and supports full access to the greater community and does not isolate individuals

Question 12: SECTION A: Please choose the best option from the choices below.

G ☐ Individuals have full access to the community. The residential setting does not specialize in, or target, a specific disability or diagnosis type and may have a mix of people with and without disabilities. The residential setting may have a mix of private pay and Medicaid. The setting may include room and board, bathing and other personal assistance while Individuals are supported to obtain many other services outside of the residential setting in the broader community. Off- site services may include competitive integrated employment, day services, beautician services, community activities, gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

Y ☐ Individuals receive some services in-house and others in the broader community. The residential setting may include room and board, bathing and other personal assistance services. The additional services on-site are intended to be convenient for individual access, yet, they may have the unintended consequence of isolation from the broader community. Onsite and off-site services may include competitive integrated employment, day services, beautician services, community activities gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

R ☐ The residential setting is designed for people with disabilities and often for people with a certain type of disability. The individuals in the residential setting are primarily or exclusively people with disabilities and on-site staff provides many of the services. The residential setting services include community access and individuals have regular opportunities to engage in the broader community.

R ☐ The residential setting is designed to provide people with disabilities multiple types of services on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities and **people in the residential setting have limited, if any, interaction with the broader community.** SECTION B: Please indicate whether the below statement is true for this setting.

Question 13: The residential setting is a locked facility.

R ☐ Yes

G ☐ No

Question 14: The residential setting is one of the following:

R ☐ Yes

G ☐ No

- Farmstead or disability specific farm community located in rural residential setting on a large parcel of land with little ability to access the broader community outside of the farm.
- Gated/secured "community" for people with disabilities where services are provided on-site and individuals rarely leave the gated community.
- Residential school where individuals receive both education and residential services in one setting and do not go into the broader community for education.
- Multiple residential settings co-located and operationally related (operated by the same provider) where services are provided on campus with individuals rarely accessing the broader community.

Section 2: Optimizes autonomy and independence in making life choices

Employment

Question 15: Please choose the option that best describes the services and supports for employment:

G ☐ For individuals who want to work, the residential setting/provider encourages the individual's opportunities to seek employment and work in integrated settings and for competitive wages (minimum wage or better). Working individuals who live in this residential setting have supports from the provider in planning and meeting their daily needs in order to access and maintain employment. Individuals who live in this residential setting have frequent opportunities throughout the year to discuss career goals, including career advancement,

career changes, increased wages, or increased hours. Individuals who want to work are working or using employment services in an integrated employment setting where there are opportunities to interact with people who do not have disabilities (not including paid staff).

Y ☐ For individuals who want to work, the residential setting/provider encourages opportunities to seek employment and work in integrated employment for competitive wages (minimum wage or better). Individuals might have opportunities to talk about employment goals once a year or so. Those who want to work are working; however, it may not be in an integrated employment setting where individuals interact with people who do not have disabilities (not including paid staff). Individuals who are working in less integrated or segregated settings continue to be supported in career goals relating to obtaining integrated employment at a competitive wage.

R ☐ The residential setting/provider supports individuals in getting ready for work each day, but does not necessarily encourage individuals in seeking employment and working in integrated competitive settings.

R ☐ Individuals who reside in this residential setting and want to work are not encouraged or emotionally supported by the provider to do so.

Personal Finances (Resources)

Question 16: Please choose the option that best describes the services and supports for personal resources:

Individuals may or may not have a Social Security designated Representative Payee. Individual may or may not be beneficiaries of a Special Needs Trust or Discretionary Trust. The existence of one of these is not a considered a limitation by the residential setting/provider.

G ☐ The residential setting/provider places no limitations to an individual's, or their designated representatives, ability to access personal financial resources (personal spending monies, personal property, real estate, assets, savings, etc.). Personal resources may be safeguarded but individuals have easy access to, experience no barriers, and are supported in obtaining and using personal resources as desired.

Y ☐ There may be some limitations based on the safeguarding of personal resources. Individuals, or their designated representatives, can typically access funds in the same day, or within 24 hours for larger sums. Individuals are supported in obtaining and using their personal resources as desired.

R ☐ Limitations are placed on an individual's, or their designated representatives, access to their personal resources.

Question 16a: If you selected "Limitations are placed on an individual's, or their designated representatives, access to their personal resources" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 16b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 16b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 16b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 16b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 3: The individual controls his/her own schedule

Question 17: Please choose the option that best describes the services and supports for controlling one's own schedule:

G ☐ Individuals are supported to control their own schedules. Services such as bathing and mealtimes are flexible and work around the individual's personal schedule. Requests for engaging in the broader community such as going shopping or to the movies are routinely supported and accommodated. When individuals work, their schedules are supported.

Y ☐ Individuals generally control their own schedules. Services such as mealtimes and bathing are scheduled. If individuals miss a scheduled service activity, such as a bath, meal or laundry, because of their personal schedule, it is not automatically rescheduled or replaced unless the individuals request or otherwise indicate they want the missed service activity.

R ☐ Most activities are scheduled by the provider, including services such as mealtimes and bathing and social and recreation opportunities. If individuals miss a scheduled activity, such as a bath, meal or laundry, because of their personal schedule, it is not replaced, or if replaced, with a lesser quality alternative.

R ☐ There are residential setting/provider limits to the amount of control individuals have over their own schedules.

Question 17a: If you selected "There are residential setting/provider limits to the amount of control individuals have over their own schedule" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 17b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 17b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 17b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 17b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 4: Setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

Freedom from Coercion

Question 18: Are individuals free from coercion as defined below?

G ☐ Yes

R ☐ No

i. Threats of serious harm to or physical restraint against any person;
ii. Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
iii. The abuse or threatened abuse of the legal process.

Question 19: Do the provider/staff utilize any of the following restraints on individuals receiving services in this residential setting to address or control behavior?

R ☐ Yes

G ☐ No

- Chemical restraints
- Mechanical restraints, such as devices that limit an individual's ability to freely move their body, **not part of the person's formal behavior support plan**
- Physical restraints, such as using a physical maneuver to limit an individual's ability to freely move, where the maneuver is weight-bearing and/or **not part of the person's formal behavior support plan**
- Seclusion, such as restricting an individual to a specific physical space as a means of controlling behavior or in response to a behavior

Communication

Question 20: Please choose the option that best describes the services and supports for communication:

G ☐ There are no residential setting/provider limitations to the individual's ability to communicate within the residential setting or with those outside of the setting. If the individual needs a phone or other accommodations or other communication tool, they are provided one and a private space from which to hold conversations. Individuals can access the phone independently at any time and will be supported, if needed. Inside the residential setting, individuals are encouraged and supported to raise and discuss issues or concerns without fear of retaliation.

Y ☐ There are shared modes of communication made available by the residential setting/provider. There may be reasonable waiting periods if others are using the "house" phone or individuals may need the provider's support to access to the phone. They do not need permission to access the phone. Inside the residential setting, individuals may raise and discuss issues or concerns without fear of retaliation.

R ☐ The ability to communicate privately within and to those on the outside of the residential setting is limited.

Question 20a: If you selected "The ability to communicate privately within and to those on the outside of the residential setting is limited" above, are **the limits universally applied to everyone living in the residential setting?**

R ☐ Yes

G ☐ No

Question 20b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 20b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 20b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 20b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Homelike Accommodations

Question 21: Please choose the option that best describes the services and supports for homelike accommodations:

G ☐ Individuals have full access to typical homelike accommodations such as a kitchen, dining area, family/living room, laundry, and bathroom.

Y ☐ Individuals have full access to most typical homelike accommodations but may share bathrooms and not have access to the full (commercial) kitchen, in a larger facility. Individuals are offered substitute equipment and a means to cook.

R ☐ There are residential setting/provider limits to full access to typical homelike accommodations.

Question 21a: If you selected "There are residential setting/provider limits to full access to typical homelike accommodations" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 21ba: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 21b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 21b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 21b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 5: Personal Privacy

Question 22: Please choose the option that best describes the services and supports for personal privacy:

G ☐ All individuals may lock their bedroom and living unit doors. Door locks are single-action which means when the individual turns the handle or lever the door unlocks. All individuals have bathroom facilities that allow for complete privacy through the ability to lock the door or stall. Bathing areas are private and individuals are shielded or protected from others walking in on them. Only appropriate staff have keys.

G ☐ All individuals may lock their bedroom or living unit doors for privacy. Door locks are single-action which means when the individual turns the handle or lever the door unlocks. Bathrooms may be used by others and individuals may need additional support to obtain privacy, such as assistance to get from a wheelchair into the bathroom, in order to be able to shut the door for privacy. Only appropriate staff have keys.

R ☐ Doors are not lockable but privacy is assured through knocking before entering an individual's bedroom, living unit, or bathroom.

R ☐ There are residential setting/provider limits on an individual's ability to have personal privacy.

Question 22a: If you selected "There are residential setting/provider limits on an individual's ability to have personal privacy" above, are **the limits universally applied to everyone living in the residential setting?**

R ☐ Yes

G ☐ No

Question 22b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 22b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 22b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 22b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 6: Choice of Roommates/Sharing Space

Question 23: Please choose the option that best describes the services and supports individuals have in their choice of roommates and sharing space:

G ☐ This facility only offers private rooms.

G ☐ There are shared bedrooms or living units. There are methods in place for individuals to seek a new roommate should they desire. Individuals have the opportunity to meet new potential roommates and have input in the selection of their roommate.

R ☐ There are shared bedroom or living units in the facility. There are residential setting/provider limits regarding the individual's involvement in the selection of roommates or their ability to have input in the choice of roommates.

Question 23a: If you selected "There are shared bedroom or living units in the facility. There are residential setting/provider limits regarding the individual's involvement in the selection of roommates or their ability to have input in the choice of roommates" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 23b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 23b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 23b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 23b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 7: Freedom to Furnish and Decorate

Question 24: Please choose the option that best describes the services and supports to individuals regarding furnishing and decorating:

G ☐ Individuals may bring their own furnishings and are supported and encouraged to personalize their space. Individuals may paint or secure pictures to walls or use accessories, as needed. There may be landlord/tenant type agreements regarding approval of painting, nails or holes in walls, but individual experience is that obtaining necessary permissions is reasonable and does not inhibit their personal style or ability to decorate.

Y ☐ Individuals may bring their own furnishings. Decorating is not encouraged or discouraged. There may be landlord/tenant type agreements regarding approval of nails or holes in walls. Substantial changes, such as painting, may not be allowed.

R ☐ There are residential setting/provider limits on an individual's ability to furnish and decorate.

Question 24a: If you selected "There are residential setting/provider limits on an individual's ability to furnish and decorate" above, are **the limits universally applied to everyone living in the residential setting?**

R ☐ Yes

G ☐ No

Question 24b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 24b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 24b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 24b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 8: The individual can have access to food at any time

Question 25: Please choose the option that best describes the services and supports to individuals regarding access to food.

G ☐ Individuals are provided three nutritious meals and two snacks a day. Individuals may assist with menu planning and personal preferences are considered. If an individual misses a meal, alternatives such as a to-go sack meal or heatable meals, are available Individuals have access to personal food storage, including refrigeration, freezer, and dry storage, that they can access at any time.

Y ☐ Individuals are provided three nutritious meals and two snacks a day. Individuals may assist with menu planning and personal preferences are considered. If an individual misses a meal it is typically not replaced unless requested. Storing personal food items is not encouraged, but is allowed if requested.

R ☐ There are limits in place regarding access to food at any time.

Question 25a: If you selected "There are limits in place regarding access to food at any time" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 25b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 25b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 25b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 25b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 9: The individual can have visitors at any time

Question 26: Please choose the option that best describes the services and supports to individuals regarding having visitors.

G ☐ Individuals may have visitors at any time. Individuals living in the site understand there are no residential setting/provider limits to the time when visitors may be received. Individuals are encouraged and supported to have visitors.

G ☐ Individuals may have visitors at any time. The residential setting/provider may have policies in place for after-hours visitors or a check-in process to address safety or privacy concerns.

R ☐ There are residential setting/provider limits to individuals having visitors at any time.

Question 26a: If you selected "There are residential setting/provider limits to individuals having visitors at any time" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 26b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 26b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 26b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 26b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Question 27: Is there any other information that you as a provider of community-based services would like to provide?

Congratulations! You have completed the Provider Self-Assessment Survey.

Survey ID# [Survey_ID]

1. **Date_____**
2. **Name of Child Living in the Setting: [FirstName LastName]**
3. **Age of Child Living in the Setting_____**
4. **Residential Setting Name_____**
5. **Residential Setting Address_____**

   _____

Please choose one of the following to describe how the survey is being completed:

6. **I am the child or youth living in the setting and I am completing the survey with assistance from someone.**
7. **Best description of the role of the person helping me :**

   ☐ Legal Representative ☐ Not Applicable

   ☐ Survey Hotline/Peer Advocate ☐ Family Member/Friend

   ☐ Other; Explain_____

8. **Reason somebody is helping me:**

   ☐ I require assistance ☐ I requested assistance

   ☐ Other; Explain_____

9. **Name of person helping me_____**
10. ☐ **I am the child or youth living in the setting and I am completing the survey on my own without assistance from someone.**
11. ☐ **I am the legal representative for the child living in the setting and I am completing the survey on the child's behalf.**
12. **Type of legal representative:** ☐ Parent with legal custody ☐ Legal guardian
13. **Name of person completing the survey for me_____**

Please complete the survey questions from the perspective of the child who is receiving services in a residential (group home or foster home) setting.

Section 1: Where I live supports access to the broader community

14. Please choose the description that best describes how the location of the home where the child receives services supports access to the community:

Pick the best answer:

☐ Where I live makes it **EASY** for me to be part of the community where I am located.

☐ Where I live makes it **HARD** for me to be part of the community where I am located.

Where I live makes it easy for me to:

15. Participate in community activities

☐ Always ☐ Usually ☐ Sometimes ☐ Never

16. Go places in the community

☐ Always ☐ Usually ☐ Sometimes ☐ Never

17. Obtain work-related experience (such as summer or after school work, volunteer work, etc.) or get a job in the community:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I am working on other things right now and do not wish to work or obtain work experience at this time.

☐ N/A- I am too young to work or gain work-related experience right now.

Section 2: I am supported where I live to be part of the community

18. I have regular opportunities be part of the broader community. The following are some examples that help explain what this means: getting work experience in the community; participating in extracurricular activities; going to the park, the library, or church; shopping for food, clothing or other items; going to the gym or an exercise class; going out for ice cream; going to the movies, fairs, rodeos, or other community events.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 3: Choosing where I live

19. Before I moved to where I live now, I (or my parent or guardian) was told about or able to visit other places to live.

☐ Yes ☐ No

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was told about other options)

20. Before moving to where I live now, I (or my parent or guardian) was offered different choices of where I could live. One of the choices was a service setting where not all people experience disabilities; this choice may have included the option for me to receive services in my family home.

☐ Yes ☐ No

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was told about other options)

21. If I have a shared bedroom, I (or my parent or guardian) was offered a choice of a home for me that offered a private bedroom.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was offered the choice of a home with a private bedroom)

22. My guardian has a say in who I share my bedroom with.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

☐ I don't know (I am a youth completing the survey and I don't know if my guardian has a say in who is share my bedroom with)

23. I got to visit the home where I live now and meet members of the household before I moved in.

☐ Yes ☐ No

Section 4: Where I live supports my independence and making life choices

Work or Work Experience

24. My provider/setting supports me with my daily needs in order for me to work or obtain work-related experience.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I am working on other things right now and do not wish to work or obtain work-related experience at this time.

☐ N/A- I am too young to work or gain work-related experience right now.

Personal Finances (Resources)

25. I have a say in how I spend my personal funds.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

26. I get support to manage my money so I can buy the things I want.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 5: I am supported where I live to participate in creating my own schedule

27. I have an active role in planning my own schedule. I am supported in choosing preferred activities and my provider helps me to plan my day so that I can do things I like while also planning for necessary things like school, physical activity, and sleep.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 6: Where I live ensures my rights of privacy, dignity and respect, and freedom from coercion (strong-arm) and restraint

Coercion

28. Where I live now, my provider/staff has never used physical force or physical punishment, or threats to make me do something I don't want to do.

☐ True – I **HAVE NOT** been forced to make decisions against my will

☐ False – I **HAVE** been forced to make decisions against my will

Restraint

29. Where I live now, I have never been forced to take a medication as a consequence of my behavior.

☐ True – I **HAVE NOT** been forced to take medication as a consequence of my behavior against my will.

☐ False - I **HAVE** been forced to take medication as a consequence of my behavior against my will.

30. Where I live now, I have never been tied down to control my behavior against my will.

☐ True – I **HAVE NOT** been tied down to control my behavior against my will.

☐ False - I **HAVE** been tied down to control my behavior against my will.

31. Where I live now, I have never been held down by a person or object to control my behavior against my will.

☐ True – I **HAVE NOT** been held down to control my behavior against my will.

☐ False - I **HAVE** been held down to control my behavior against my will.

32. Where I live now, I have never been kept away from others in a confined space or locked in a room as punishment against my will.

☐ True – I **HAVE NOT** been kept or locked in a room as punishment against my will

☐ False - I **HAVE** been kept or locked in a room as punishment against my will

Communication

33. I feel free to openly discuss any of my concerns with my provider/staff.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

34. I have access to a phone or to other methods of communicating with others outside of where I live. My provider allows me to talk to my guardian (or my attorney or CASA, if I have one) at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Access in all areas of the home where I live

35. I can be in the following areas of my home: kitchen; dining room; living/family room; bedroom; and bathroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 7: Staff where I live respect my personal privacy

36. I have privacy in my bedroom and opportunity for private time if I desire it. Staff and other household members knock before entering my room.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

37. I have privacy when I use the bathroom. I may have assistance when using the bathroom, but people do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

38. I have privacy when I take a shower or bath. I may have assistance when showering or bathing, but people do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 8: Where I live allows me to decorate and furnish my bedroom or living unit

39. I have a say in how I decorate my bedroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

40. I may furnish my bedroom with my own furniture.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 9: Where I live allows me to have access to food at any time

41. My provider serves some of my favorite foods and I am offered healthy alternatives if I don't like something that is being served.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

42. In addition to the meals and snacks provided to me by my provider, I have access to snacks and have the option of purchasing my favorite foods.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 10: Where I live allows me to have visitors at any time

43. My provider, guardian, and ISP team work together to support me in having visits with friends.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

44. My provider is supportive of visits with my family (except where limited by a court order) and I feel like my family is welcome in the home where I live.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

You have completed the survey questions for where you live.

We would now like to ask some questions about services you might get outside of where you live. Not everyone has these services and that is ok. Please answer the questions that are applicable to you

Section 11: Services outside of where I live

45. I work or use employment services outside of where I live.

☐ Yes ☐ No

☐ N/A- I am too young to work or gain work-related experience right now.

46. If yes: I work or use employment services in a typical community setting where my coworkers come from a variety of different backgrounds and do not necessarily have disabilities (not including paid support staff): ☐ Yes ☐ No

47. I work or use employment services in a setting where most of my coworkers are people who also have some type of disability: ☐ Yes ☐ No

48. If yes: I had an option to work or use services in a place where I could meet and form relationships with people from a variety of different backgrounds, and not only with other people who have disabilities: ☐ Yes ☐ No

49. I am paid for my work: ☐ Yes ☐ No

50. If yes: I am paid minimum wage or better: ☐ Yes ☐ No

51. I would like to work more hours now or in the future: ☐ Yes ☐ No

52. I would like to be able to have a job where I could make more money now or in the future:

☐ Yes ☐ No

53. Is there any other information that you would like to share about where you live or receive services?

Thank you for completing this survey.

Survey ID#: [insert Survey_ID]

Home and Community-Based Services Setting Provider Self-Assessment Survey for Children's Residential Settings (Foster Care and Group Homes)

1. **Date**_____
2. **Provider Name**_____
3. **Person completing Survey and Title/Position**_____

   _____
4. **Medicaid Provider Number**_____
5. **Type of License or Certification**_____
6. **Licensing or Certification Agency (check one):**

   ☐ DD ☐ Child Welfare ☐ Other: _____
7. **Primary Population(s) Served**_____
8. **Physical Address of Service Site**_____

   _____
9. **Number of individuals in the home receiving Medicaid HCBS**_____
10. **Total number of persons residing in the household**_____
11. **Mailing Address (if different from above)**_____

    _____
12. **Phone**_____
13. **Email**_____
14. **Total number of sites you will be completing surveys on**_____

Section 1: The residential setting is integrated and supports full access to the greater community and does not isolate individuals

15. **Part A:** Please choose the option that best describes the group home or foster home.

☐ Individuals are supported in having full access to the community. The home does not specialize in, nor does the provider target, a specific disability or diagnosis type. There may be a mix of people with and without disabilities living in the home. The home may have a mix of residents receiving Medicaid funded services and others who do not. Individuals are supported in obtaining services outside of the home in the broader community in addition to the care they receive in the home. The home encourages opportunities to work or seek work related experience (on the same basis as people who are the same age and do not have a disability). Other off-site services may include school services, community activities, gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ Individuals receive some services in the home and other services in the broader community. Onsite and off-site services may include school services, community activities gym, work or work related experience (on the same basis as people who are the same age and do not have a disability), medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ The home is designed for people with disabilities and often for people with a certain type of disability. The individuals in the home are primarily or exclusively people with disabilities and on-site staff provides many of the services. Individuals have regular opportunities to engage in the broader community. However, the home setting does not encourage opportunities to work or obtain work related experience (on the same basis as people who are the same age and do not have a disability).

☐ The home is designed for individuals with disabilities to receive multiple types of services on-site or in the home, including housing, school services, medical, behavioral and therapeutic services, and/or social and recreational activities and people in the home have limited, if any, interaction with the broader community. The home setting does not encourage opportunities to work or obtain related experience (on the same basis as people who are the same age and do not have a disability).

Part B: Indicate if any of the following apply:

16. The residential setting is a locked facility. ☐ Yes ☐ No

17. The residential setting is one of the following: ☐ Yes ☐ No

- Farmstead or disability specific farm community located in rural residential setting on a large parcel of land with little ability to access the broader community outside of the farm.
- Gated/secured "community" for people with disabilities where services are provided on-site and individuals rarely leave the gated community.
- Residential school where individuals receive both education and residential services in one setting and do not go into the broader community for education.
- Multiple residential settings co-located and operationally related (operated by the same provider) where services are provided on campus with individuals rarely accessing the broader community.

Section 2: Optimizes autonomy and independence in making life choices

Work or Work Experience

18. Please choose the option that best describes the residential service setting provider's role related to services and supports for work or work-related experiences:

☐ The home/provider encourages opportunities for individuals to obtain work or work-related experience. Individuals who would like to work are either working or obtaining some type of work related experience. Individuals who live in this home have supports from the provider to plan for or otherwise meet daily needs required to maintain work or a work experience. Individuals who live in this home, including those who are not working, are regularly encouraged throughout the year to discuss work or career goals.

☐ The home/provider encourages opportunities for individuals to obtain work or work related experience on the same basis as people who are the same age and do not have a disability. Individuals who may be focused on school right now will be encouraged to pursue work and work related experiences in the future. Individual have opportunities to talk about work or career goals.

☐ The home /provider supports individuals in getting ready for school and/or work each day, but does not necessarily encourage individuals to seek work or work-related experience on the same basis as people who are the same age and do not have disabilities. Work or career goals are rarely talked about.

☐ Individuals are not encouraged or emotionally supported by the provider to work or obtain work experience. Work or career goals are rarely or never talked about, and likely will not be discussed in the future.

☐ All individuals in the home are focused on school right now or are not yet of school age. Individuals in the home are encouraged to discuss future plans and career goals that include work in an integrated setting.

Personal Finances (Resources)

19. Please choose the option that best describes the services and supports for personal resources:

☐Individuals may or may not have a Social Security designated Representative Payee. Individual may or may not be beneficiaries of a Special Needs Trust or Discretionary Trust. The existence of one of these is not considered a limitation by the residential setting/provider.

☐The home /provider places no limitations to an individual's, or their designated representatives', ability to access personal financial resources (personal spending monies, personal property, real estate, assets, savings, etc.). Personal resources may be safeguarded but individuals have easy access to, experience no barriers, and are supported in obtaining and using personal resources as desired.

☐There may be some limitations based on the safeguarding of personal resources. The provider assists individuals in budgeting and managing funds, however, the individual self-directs and is engaged in the process as much as possible. The individual's financial plan is addressed in the ISP and the provider supports the individual in meeting identified goals.

☐ Limitations beyond age appropriate structure and guidance are placed on an individual's, or their designated representatives', access to personal resources.

20. If you selected "Limitations beyond age appropriate structure and guidance are placed on an individual's, or their designated representatives', access to personal resources" above, are the limits universally applied to everyone living in the home?

☐Yes ☐No

21. Are the limits only applied to those who need them? ☐Yes ☐No

22. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

23. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

24. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

---

Section 3: The individual controls his/her own schedule

25. Please choose the option that best describes the services and supports for controlling one's own schedule:

☐Individuals are supported to control their own schedules in an age appropriate manner as much as possible. The provider engages with the individual to promote self-direction and honor individual preferences related to routine and activities. Routine activities such as bathing and mealtimes are flexible and work around the individual's personal schedule. Requests for engaging in the broader community such as participating in extracurricular school activities, working or participating in work-related experiences, going shopping, to the library, or to the park are routinely supported and accommodated. When individuals work, their schedules are supported. Children in the home are encouraged to participate in extra-curricular activities such as school or community sporting programs or clubs.

☐Individuals are an active part of directing or creating their personal schedules. The preferences of the individual are honored whenever possible. The provider helps the individual identify preferred activities and activity times, while also supporting the individual in addressing necessary components of their daily routine such as school attendance, exercise, and adequate rest. Routine activities in the household and general scheduling is flexible and is adjusted based on who lives in the home and what is important to members of the household.

☐ Most activities are scheduled by the provider, including daily living activities such as mealtimes, bathing, and social and recreation opportunities. The provider seeks little input from the individual in scheduling activities. The household operates by a routine schedule that has little flexibility and little variation, even when the household composition changes.

☐ There are home/provider limits to the amount of control individuals have over their own schedules.

26. If you selected "There are home/provider limits to the amount of control individuals have over their own schedule" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

27. Are the limits only applied to those who need them? ☐Yes ☐No

28. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

29. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

30. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

---

Section 4: Setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

Freedom from Coercion

31. Are individuals free from coercion as defined below? ☐Yes ☐No

- Threats of serious harm to or physical restraint against any person;
- Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
- The abuse or threatened abuse of the legal process.

32. Do the provider/staff utilize any of the following restraints on individuals receiving services in this home to address and control behavior? ☐Yes ☐No

- Chemical restraints, such as the forced administration of a medication as a controlling or punitive response to a behavioral episode.
- Mechanical restraints, such as devices that limit an individual's ability to freely move their body, not part of the person's formal behavior support plan
- Physical restraints, such as using a physical maneuver to limit an individual's ability to freely move, where the maneuver is weight-bearing and/or not part of the person's formal behavior support plan
- Seclusion, such as restricting an individual to a specific physical space as a punitive response to a behavior

Communication

33. Please choose the option that best describes the services and supports for communication:

☐ Individuals are encouraged and supported to communicate within the home and with others outside of the home. Individuals are afforded privacy in communication as safe and appropriate to their chronological age. Individuals may have access to the phone or other methods of communication with assistance or oversight from the provider. Individuals have privacy in communication with their parents or legal guardian, except where restricted by a court order. Where applicable, individuals have privacy in communication with their Child Welfare caseworker, attorney, and/or CASA.

☐ Individuals are encouraged and supported to communication with others in the home and in the community. Access to the phone or other modes of communication may be made with the provider's permission, or in accordance with the individual's ISP. There may be legal orders that direct the types of communication and level of supervision or access an individual may have.

☐The ability to communicate privately within the home and with others outside of the home is limited.

34. If you selected "The ability to communicate privately within the home and with others outside of the home is limited" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

35. Are the limits only applied to those who need them? ☐Yes ☐No

36. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

37. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

38. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Homelike Accommodations

39. Please choose the option that best describes the services and supports for homelike accommodations:

☐ Individuals have access to typical homelike accommodations such as a kitchen, dining area, family/living room, laundry, and bathroom appropriate to the chronological age of the individual.

☐ Individuals have full access to most typical homelike accommodations, however, providers may modify access to address safety incidental to the provision of daily living activities.

☐ There are home/provider limits beyond age appropriate structure and guidance to full access to typical homelike accommodations.

40. If you selected "There are home/provider limits beyond age appropriate structure and guidance to full access to typical homelike accommodations" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

41. Are the limits only applied to those who need them? ☐Yes ☐No

42. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

43. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

44. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Section 5: Personal Privacy

45. Please choose the option that best describes the services and supports for personal privacy:

☐ Individuals have the opportunity to have privacy or private time in their bedroom, including the ability to close the door, should they desire it. Individuals have privacy when using the bathroom. Individuals are able to close the bathroom door and are shielded or protected from others walking in on them when using the toilet or bathing. Staff/caregivers are present in the bathroom or during private time only when necessary to provide required assistance or to address safety. Staff and other members of the household knock and wait to receive permission before entering a closed room.

☐ There are home/provider limits beyond age appropriate structure and guidance on an individual's ability to have personal privacy.

46. If you selected "There are home/provider limits on an individual's ability to have personal privacy" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

47. Are the limits only applied to those who need them? ☐Yes ☐No

48. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

49. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

50. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 6: Choice of Roommates

51. Please choose the option that best describes the services and supports individuals and/or their guardians have in the choice of roommates in a shared bedroom situation:

☐ This home only offers private rooms.

☐ There are shared bedrooms in the home. The individual's legal guardian has consented to and supports the individual having a shared bedroom. There are methods in place for guardians to request a change in roommate or shared room situation should this be desired. Individuals and their guardians have the opportunity to meet new potential shared bedroom roommates and have input in the selection of their shared bedroom roommate.

☐ There are shared bedrooms in the home. There are provider limits regarding the individual's and their guardian's involvement in the selection of shared bedroom roommates or their ability to have input in the choice of shared bedroom roommates.

52. If you selected "There are shared bedrooms in the home. There are provider limits regarding the individual's and their guardian's involvement in the selection of shared bedroom roommates or their ability to have input in the choice of shared bedroom roommates" above, are the limits universally applied to everyone living in the home?

☐ Yes ☐ No

53. Are the limits only applied to those who need them? ☐ Yes ☐ No

54. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

55. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

56. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 7: Freedom to Furnish and Decorate

57. Please choose the option that best describes the services and supports to individuals regarding furnishing and decorating:

☐ Individuals may bring their own furnishings and are supported and encouraged to personalize their space. Individuals are encouraged to have age appropriate décor that reflects their personal style. The provider may provide guidance to the individual to address safety and family-friendly considerations.

☐ The home provider limits an individual's ability to furnish and decorate.

58. If you selected "The home provider limits an individual's ability to furnish and decorate" above, are the limits universally applied to everyone living in the home?

☐ Yes ☐ No

59. Are the limits only applied to those who need them? ☐ Yes ☐ No

60. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

61. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

62. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 8: The individual can have access to food at any time

63. Please choose the option that best describes the services and supports to individuals regarding access to food.

☐ Individuals are provided three nutritious meals and two snacks a day. Individuals are encouraged to participate in menu planning, and cultural and personal preferences of the individual are honored. The individual may participate in grocery shopping, selection of meal options, and routinely have an opportunity to have favorite foods. Mealtimes offer some choice in food options and individuals are not required or expected to eat foods they do not like. If an individual misses a meal, alternatives such as a to-go sack meal or heatable meals, are available upon return.

☐ Individuals are provided three nutritious meals and two snacks a day. The provider seeks little input from the individual related to menu planning. Individual preferences or favorite foods are rarely served and alternative options for meals are not offered.

☐ There are limits beyond age appropriate structure and guidance in place regarding access to food at any time.

64. If you selected "There are limits beyond age appropriate structure and guidance in place regarding access to food at any time" above, are the limits universally applied to everyone living in the residential setting? ☐ Yes ☐ No

65. Are the limits only applied to those who need them? ☐ Yes ☐ No

66. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

67. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

68. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 9: The individual can have visitors at any time

69. Please choose the option that best describes the services and supports to individuals regarding having visitors.

☐ Individuals are encouraged to have visitors in the home. Legal guardians and family members have access to the individual at any time (except where limited by a court order). The provider works with the individual in identifying opportunities to have visitors and planning for social opportunities.

☐ Individuals are not necessarily encouraged to have visitors in the home. When an individual desires to have visitors, they are encouraged to meet with friends or family outside of the home, rather than hosting guests at the residence.

☐ There are residential setting/provider limits beyond age appropriate structure and guidance to individuals having visitors at any time.

70. If you selected "There are residential setting/provider limits beyond age appropriate structure and guidance to individuals having visitors at any time" above, are the limits universally applied to everyone living in the residential setting?

☐ Yes ☐ No

71. Are the limits only applied to those who need them? ☐ Yes ☐ No

72. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

73. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

74. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Is there any other information that you as a provider of community-based services would like to provide?

Thank you for completing the Provider Self-Assessment Survey

APPENDIX C. RED FLAG / HIGH SCRUTINY QUESTIONS

Adult Consumer questions indicated as "Red Flag" / "High Scrutiny"

QuestionID	Question
Q21	21. Support in managing money
Q22	22. Easy to access/spend money
Q24	24. Forced to make decisions against my will
Q25	25. Given medication against my will
Q26	26. Held or tied down by person or object
Q27	27. Kept or locked in a room against my will
Q28	28. Free to discuss concerns with provider/staff
Q29	29. Access to communicate with others outside anytime I want.

Adult Provider questions indicated as "Red Flag" / "High Scrutiny"

QuestionID	Question
Q14	14. Locked Facility
Q15	15. Self-contained campus
Q18	18. Personal Finances: Limits applied universally
Q19	19. Personal Finances: Limits only as needed
Q20	20. Personal Finances: Documentation of alternatives
Q21	21. Personal Finances: Identified in ISP
Q22	22. Personal Finances: Purpose of limits
Q24	24. Control of Schedule: Limits applied universally
Q25	25. Control of Schedule: Limits only as needed
Q26	26. Control of Schedule: Documentation of alternatives
Q27	27. Control of Schedule: Identified in ISP
Q28	28. Control of Schedule: Purpose of limits
Q29	29. Freedom from coercion
Q30	30. Use of restraints/seclusion
Q31	31. Communication: Services/Support
Q32	32. Communication: Limits applied universally
Q33	33. Communication: Limits only as needed
Q34	34. Communication: Documentation of alternatives
Q35	35. Communication: Identified in ISP
Q36	36. Communication: Purpose of limits
Q38	38. Homelike Accomodations: Limits applied universally
Q39	39. Homelike Accomodations: Limits only as needed
Q40	40. Homelike Accomodations: Documentation of alternatives
Q41	41. Homelike Accomodations: Identified in ISP
Q42	42. Homelike Accomodations: Purpose of limits
Q44	44. Personal Privacy: Limits applied universally
Q45	45. Personal Privacy: Limits only as needed
Q46	46. Personal Privacy: Documentation of alternatives
Q47	47. Personal Privacy: Identified in ISP
Q48	48. Personal Privacy: Purpose of limits
Q50	50. Roommates/Sharing Space: Limits applied universally

Q51	51. Roommates/Sharing Space: Limits only as needed
Q52	52. Roommates/Sharing Space: Documentation of alternatives
Q53	53. Roommates/Sharing Space: Identified in ISP
Q54	54. Roommates/Sharing Space: Purpose of limits
Q56	56. Freedom to Furnish/Decorate: Limits applied universally
Q57	57. Freedom to Furnish/Decorate: Limits only as needed
Q58	58. Freedom to Furnish/Decorate: Documentation of alternatives
Q59	59. Freedom to Furnish/Decorate: Identified in ISP
Q60	60. Freedom to Furnish/Decorate: Purpose of limits
Q62	62. Access to Food: Limits applied universally
Q63	63. Access to Food: Limits only as needed
Q64	64. Access to Food: Documentation of alternatives
Q65	65. Access to Food: Identified in ISP
Q66	66. Access to Food: Purpose of limits
Q68	68. Visitors: Limits applied universally
Q69	69. Visitors: Limits only as needed
Q70	70. Visitors: Documentation of alternatives
Q71	71. Visitors: Identified in ISP
Q72	72. Visitors: Purpose of limits

Youth Consumer questions indicated as "Red Flag" / "High Scrutiny"

QuestionID	Question
Q25	25. I have say in how I spend my personal funds.
Q26	26. Receive support to manages/spend my money
Q28	28. Forced to make decisions against my will
Q29	29. Given medication against my will
Q30	30. Tied down against my will
Q31	31. Held down by person or object against my will
Q32	32. Isolated from others or locked in a room against my will
Q33	33. Free to discuss concerns with provider/staff
Q34	34. Access to communicate with others outside anytime I want.

Youth Provider questions indicated as "Red Flag" / "High Scrutiny"

QuestionID	Question
Q16	16. Locked Facility
Q17	17. Self-contained campus
Q20	20. Personal Finances: Limits applied universally
Q21	21. Personal Finances: Limits only as needed
Q22	22. Personal Finances: Documentation of alternatives
Q23	23. Personal Finances: Identified in ISP
Q24	24. Personal Finances: Purpose of limits
Q26	26. Control of Schedule: Limits applied universally
Q27	27. Control of Schedule: Limits only as needed
Q28	28. Control of Schedule: Documentation of alternatives
Q29	29. Control of Schedule: Identified in ISP
Q30	30. Control of Schedule: Purpose of limits
Q31	31. Freedom from coercion
Q32	32. Use of restraints/seclusion
Q33	33. Communication: Services/Support
Q34	34. Communication: Limits applied universally
Q35	35. Communication: Limits only as needed
Q36	36. Communication: Documentation of alternatives
Q37	37. Communication: Identified in ISP
Q38	38. Communication: Purpose of limits
Q40	40. Homelike Accomodations: Limits applied universally
Q41	41. Homelike Accomodations: Limits only as needed
Q42	42. Homelike Accomodations: Documentation of alternatives
Q43	43. Homelike Accomodations: Identified in ISP
Q44	44. Homelike Accomodations: Purpose of limits
Q46	46. Personal Privacy: Limits applied universally
Q47	47. Personal Privacy: Limits only as needed
Q48	48. Personal Privacy: Documentation of alternatives
Q49	49. Personal Privacy: Identified in ISP
Q50	50. Personal Privacy: Purpose of limits

Q52	52. Roommates/Sharing Space: Limits applied universally
Q53	53. Roommates/Sharing Space: Limits only as needed
Q54	54. Roommates/Sharing Space: Documentation of alternatives
Q55	55. Roommates/Sharing Space: Identified in ISP
Q56	56. Roommates/Sharing Space: Purpose of limits
Q58	58. Freedom to Furnish/Decorate: Limits applied universally
Q59	59. Freedom to Furnish/Decorate: Limits only as needed
Q60	60. Freedom to Furnish/Decorate: Documentation of alternatives
Q61	61. Freedom to Furnish/Decorate: Identified in ISP
Q62	62. Freedom to Furnish/Decorate: Purpose of limits
Q64	64. Access to Food: Limits applied universally
Q65	65. Access to Food: Limits only as needed
Q66	66. Access to Food: Documentation of alternatives
Q67	67. Access to Food: Identified in ISP
Q68	68. Access to Food: Purpose of limits
Q70	70. Visitors: Limits applied universally
Q71	71. Visitors: Limits only as needed
Q72	72. Visitors: Documentation of alternatives
Q73	73. Visitors: Identified in ISP
Q74	74. Visitors: Purpose of limits

Individual Experience Survey - Where I Live and Get Services

Survey ID#: [Survey_ID]

1. **Date:** _____

2. **Name of Individual Living in the Setting:** [FirstName LastName]

3. **Age of Individual Living in the Setting:**

☐ 18-24 years old
☐ 25-34 years old
☐ 35-44 years old
☐ 45-54 years old
☐ 55-64 years old
☐ 65-74 years old
☐ 75-84 years old
☐ 85 or older

4. **With which race or ethnic group do you (individual living in the setting) *most* identify?**

☐ Asian
☐ Black/African American
☐ Hispanic
☐ Native American/Alaskan Native
☐ Pacific Islander
☐ White
☐ Other

5. **Residential Setting Name**: _____

6. **Residential Setting Address**: _____

7. **Person helping me to complete the survey (Name)**: _____

7a. Best description of the role of the person helping me to complete the survey:

☐ Legal Representative
☐ Survey Hotline/Peer Advocate
☐ Family Member/Friend
☐ Not Applicable
☐ Other; Explain: _____

8. **Reason somebody is helping me to complete the survey:**

☐ I require assistance ☐ I requested assistance ☐ Not Applicable

☐ Other; Explain _____

9. **Is someone other than [FIRST_NAME] completing this survey?** ☐ Yes ☐ No

10. **If yes, please provide your name:**_____

Section 1: Where I live supports access to the broader community

11. **Please choose the description that best describes how the location of your home or residential setting supports your access to the community (Pick the best answer):**

☐ Where I live makes it **EASY** for me to be part of the community where I am located.

☐ Where I live makes it **HARD** for me to be part of the community where I am located.

Where I live makes it easy for me to:

12. **Participate in community activities**

☐ Always ☐ Usually ☐ Sometimes ☐ Never

13. **Get around in the community as I desire**

☐ Always ☐ Usually ☐ Sometimes ☐ Never

14. **Look for a job in the community where I can make at least minimum wage, if I want to work:**

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I do not want to work at this time

Section 2: I am supported where I live to be part of the community

15. I have regular opportunities be part of the broader community. The following are some examples that help explain what this means: working in the community, going to the park, the library, church, shopping for food, clothing or other items, getting my hair cut at a beauty or barber shop, going out for coffee, going to the movies, fairs, rodeos, or other community events.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 3: Choosing where I live

16. Before I moved to where I live now, I was told about or able to visit other places to live.

☐ Yes ☐ No

17. I was offered the choice to live in a place that is not only for people who have disabilities.

☐ Yes ☐ No

18. If I live in a shared room, I was offered the choice of a private bedroom or living unit.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

19. I have a choice in who my roommate is.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

Section 4: Where I live supports my independence and making life choices

Employment

20. My provider/setting supports me with my daily needs in order for me to work.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I do not want to work at this time

Personal Finances (Resources)

21. The provider/staff where I live support me in managing my money.

☐ Yes ☐ No, I manage my own money

☐ No, my guardian or representative manages my money

☐ I have a Social Security Representative Payee, or I am a beneficiary of a Special Needs Trust or Discretionary Trust.

22. I can easily get my money and spend my money as I wish.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 5: I am supported where I live to make my own scheduling decisions

23. I create my own schedule. For example, I decide when to go to bed or when I get up. I can go out alone, with friends or family as I wish. My provider/staff work around my activities. If my activities cause me to miss a scheduled mealtime, laundry time, or bath time, I can get the meal or service when convenient for me.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 6: Where I live ensures my rights of privacy, dignity and respect, and freedom from coercion (strong-arm) and restraint

Coercion

24. **Where I live now, my provider/staff has never threatened me with physical harm, or used restraints, or punished me, to force me to make a decision I did not want to make.**

    ☐ True – I **HAVE NOT** been forced to make decisions against my will

    ☐ False – I **HAVE** been forced to make decisions against my will

Restraint

25. **Where I live now, I have never been given a medication against my will to control my behavior.**

    ☐ True – I **HAVE NOT** been forced to take medication to control my behavior against my will.

    ☐ False - I **HAVE** been forced to take medication to control my behavior against my will.

26. **Where I live now, I have never been held or tied down by a person or object against my will.**

    ☐ True – I **HAVE NOT** been held or tied down against my will

    ☐ False - I **HAVE** been held or tied down against my will

27. **Where I live now, I have never been kept or locked in a room against my will.**

    ☐ True – I **HAVE NOT** been kept or locked in a room against my will

    ☐ False - I **HAVE** been kept or locked in a room against my will

Communication

28. I feel free to openly discuss any of my concerns with my provider/staff.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

29. I have access to a phone or to other methods of communicating with others outside of where I live. I can talk to anyone I want at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Access in all areas where I live

30. I have full access to the following areas where I live any time I want or need: kitchen; dining room; living/family room; bedroom; and bathroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 7: Staff where I live respect my personal privacy

31. I may lock my bedroom or living unit door for privacy.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

32. I have privacy when I use the bathroom. People do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

33. I may take a shower or bath privately. People do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 8: Where I live allows me to decorate and furnish my bedroom or living unit

34. I may decorate my bedroom or living unit the way I choose.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

35. I may furnish my bedroom or living unit with my own furniture.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 9: Where I live allows me to have access to food at any time

36. In addition to the meals and snacks provided to me by my provider, I can purchase food and have access to my food at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 10: Where I live allows me to have visitors at any time

37. I may have visitors at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 11: Services outside of where I live

38. I work or use employment services outside of where I live.

☐ Yes ☐ No

39. **If yes: I work or use employment services in a typical community setting where my co-workers come from a variety of different backgrounds and do not necessarily have disabilities (not including paid support staff):** ☐ Yes ☐ No

40. **I work or use employment services in a setting where most of my coworkers are people who also have some type of disability:**

    ☐ Yes ☐ No

41. **If yes: I had an option to work or use services in a place where I could meet and form relationships with people from a variety of different backgrounds, and not only with other people who have disabilities:** ☐ Yes ☐ No

42. **I am paid for my work:**

    ☐ Yes ☐ No

43. **If yes: I am paid minimum wage or better:** ☐ Yes ☐ No

44. **I would like to work more hours:**

    ☐ Yes ☐ No

45. **I would like to be able to have a job where I could make more money.**

    ☐ Yes ☐ No

You have completed the survey questions for where you live.

We would now like to ask some questions about services you might get outside of where you live. Not everyone has these services and that is ok. Please answer the best that you can.

46. DAY SERVICES ONLY: I use other services in a provider setting (such as Outpatient Mental Health Services, Adult Day Care, Day Services, or Community Inclusion/Alternative to Employment) outside of the place where I live: ☐ Yes ☐ No

47. If yes: When I use these services, I feel I am part of my community:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

48. I participate in activities with people I chose to spend time with:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

49. When I use these services, I have opportunities to interact with people from the community, who come from a variety of different backgrounds, and not only people who have disabilities (this does not include paid support staff):

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Is there any other information that you would like to share about where you live or receive services?

Thank you for completing this Survey.

Survey ID# [Survey_ID]

1. Date_____

2. Provider Name: [SiteName]

3. Person completing Survey and Title/Position _____

   _____

4. Medicaid Provider Number_____

5. Type of License or certification _____

6. Licensing or Certification Agency_____

7. Primary Population(s) Served_____

8. Physical Address of Service Site _____

9. Mailing Address (if different)_____

   _____

10. Phone_____

11. Email_____

12. Total number of sites you will be completing surveys on_____

Section 1: The residential setting is integrated and supports full access to the greater community and does not isolate individuals

SECTION A:

13. **Please choose the best option from the choices below.**

☐ Individuals have full access to the community. The residential setting does not specialize in, or target, a specific disability or diagnosis type and may have a mix of people with and without disabilities. The residential setting may have a mix of private pay and Medicaid. The setting may include room and board, bathing and other personal assistance while Individuals are supported to obtain many other services outside of the residential setting in the broader community. Off-site services may include competitive integrated employment, day services, beautician services, community activities, gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ Individuals receive some services in-house and others in the broader community. The residential setting may include room and board, bathing and other personal assistance services. The additional services on-site are intended to be convenient for individual access, yet, they may have the unintended consequence of isolation from the broader community. On-site and off-site services may include competitive integrated employment, day services, beautician services, community activities gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ The residential setting is designed for people with disabilities and often for people with a certain type of disability. The individuals in the residential setting are primarily or exclusively people with disabilities and on-site staff provides many of the services. The residential setting services include community access and individuals have regular opportunities to engage in the broader community.

☐ The residential setting is designed to provide people with disabilities multiple types of services on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities and people in the residential setting have limited, if any, interaction with the broader community.

Survey ID# [Survey_ID]

SECTION B: Please indicate whether the below statement is true for this setting.

14. The residential setting is a locked facility. ☐ Yes ☐ No

15. The residential setting is one of the following: ☐ Yes ☐ No

- Farmstead or disability specific farm community located in rural residential setting on a large parcel of land with little ability to access the broader community outside of the farm.
- Gated/secured "community" for people with disabilities where services are provided on-site and individuals rarely leave the gated community.
- Residential school where individuals receive both education and residential services in one setting and do not go into the broader community for education.
- Multiple residential settings co-located and operationally related (operated by the same provider) where services are provided on campus with individuals rarely accessing the broader community.

Section 2: Optimizes autonomy and independence in making life choices

Employment

16. Please choose the option that best describes the services and supports for employment:

☐ For individuals who want to work, the residential setting/provider encourages the individual's opportunities to seek employment and work in integrated settings and for competitive wages (minimum wage or better). Working individuals who live in this residential setting have supports from the provider in planning and meeting their daily needs in order to access and maintain employment. Individuals who live in this residential setting have frequent opportunities throughout the year to discuss career goals, including career advancement, career changes, increased wages, or increased hours. Individuals who want to work are working or using employment services in an integrated employment setting where there are opportunities to interact with people who do not have disabilities (not including paid staff).

☐ For individuals who want to work, the residential setting/provider encourages opportunities to seek employment and work in integrated employment for competitive wages (minimum wage or better). Individuals might have opportunities to talk about employment goals once a year or so. Those who want to work are working; however, it may not be in an integrated employment setting where individuals interact with people who do not have disabilities (not including paid staff). Individuals who are working in less integrated or segregated settings continue to be supported in career goals relating to obtaining integrated employment at a competitive wage.

☐ The residential setting/provider supports individuals in getting ready for work each day, but does not necessarily encourage individuals in seeking employment and working in integrated competitive settings.

☐ Individuals who reside in this residential setting and want to work are not encouraged or emotionally supported by the provider to do so.

Survey ID# [Survey_ID]

Personal Finances (Resources)

17. Please choose the option that best describes the services and supports for personal resources:

☐ Individuals may or may not have a Social Security designated Representative Payee. Individual may or may not be beneficiaries of a Special Needs Trust or Discretionary Trust. The existence of one of these is not a considered a limitation by the residential setting/provider.

☐ The residential setting/provider places no limitations to an individual's, or their designated representatives, ability to access personal financial resources (personal spending monies, personal property, real estate, assets, savings, etc.). Personal resources may be safeguarded but individuals have easy access to, experience no barriers, and are supported in obtaining and using personal resources as desired.

☐ There may be some limitations based on the safeguarding of personal resources. Individuals, or their designated representatives, can typically access funds in the same day, or within 24 hours for larger sums. Individuals are supported in obtaining and using their personal resources as desired.

☐ Limitations are placed on an individual's, or their designated representatives, access to their personal resources.

18. If you selected "Limitations are placed on an individual's, or their designated representatives, access to their personal resources" above, are the limits universally applied to everyone living in the residential setting? ☐ Yes ☐ No

19. Are the limits only applied to those who need them? ☐ Yes ☐ No

20. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

21. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

22. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 3: The individual controls his/her own schedule

23. Please choose the option that best describes the services and supports for controlling one's own schedule:

☐Individuals are supported to control their own schedules. Services such as bathing and mealtimes are flexible and work around the individual's personal schedule. Requests for engaging in the broader community such as going shopping or to the movies are routinely supported and accommodated. When individuals work, their schedules are supported.

☐Individuals generally control their own schedules. Services such as mealtimes and bathing are scheduled. If individuals miss a scheduled service activity, such as a bath, meal or laundry, because of their personal schedule, it is not automatically rescheduled or replaced unless the individuals request or otherwise indicate they want the missed service activity.

☐ Most activities are scheduled by the provider, including services such as mealtimes and bathing and social and recreation opportunities. If individuals miss a scheduled activity, such as a bath, meal or laundry, because of their personal schedule, it is not replaced, or if replaced, with a lesser quality alternative.

☐ There are residential setting/provider limits to the amount of control individuals have over their own schedules.

24. If you selected "There are residential setting/provider limits to the amount of control individuals have over their own schedule" above, are the limits universally applied to everyone living in the residential setting?
    ☐Yes ☐No
25. Are the limits only applied to those who need them? ☐Yes ☐No
26. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No
27. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No
28. If limits are used, they are primarily used to (select the best answer):

    ☐Protect the individual or others ☐Efficiently manage operation

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Section 4: Setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

Freedom from Coercion

29. Are individuals free from coercion as defined below? ☐Yes ☐No

    i. Threats of serious harm to or physical restraint against any person;
    ii. Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
    iii. The abuse or threatened abuse of the legal process.

30. Do the provider/staff utilize any of the following restraints on individuals receiving services in this residential setting to address or control behavior?

☐ Yes ☐ No

- Chemical restraints
- Mechanical restraints, such as devices that limit an individual's ability to freely move their body, **not part of the person's formal behavior support plan**
- Physical restraints, such as using a physical maneuver to limit an individual's ability to freely move, where the maneuver is weight-bearing and/or **not part of the person's formal behavior support plan**
- Seclusion, such as restricting an individual to a specific physical space as a means of controlling behavior or in response to a behavior

Communication

31. Please choose the option that best describes the services and supports for communication:

☐ There are no residential setting/provider limitations to the individual's ability to communicate within the residential setting or with those outside of the setting. If the individual needs a phone or other accommodations or other communication tool, they are provided one and a private space from which to hold conversations. Individuals can access the phone independently at any time and will be supported, if needed. Inside the residential setting, individuals are encouraged and supported to raise and discuss issues or concerns without fear of retaliation.

☐ There are shared modes of communication made available by the residential setting/provider. There may be reasonable waiting periods if others are using the "house" phone or individuals may need the provider's support to access to the phone. They do not need permission to access the phone. Inside the residential setting, individuals may raise and discuss issues or concerns without fear of retaliation.

☐ The ability to communicate privately within and to those on the outside of the residential setting is limited.

32. If you selected "The ability to communicate privately within and to those on the outside of the residential setting is limited" above, are the limits universally applied to everyone living in the residential setting?
☐Yes ☐No

33. Are the limits only applied to those who need them? ☐Yes ☐No

34. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

35. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

36. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Homelike Accommodations

37. Please choose the option that best describes the services and supports for homelike accommodations:

☐ Individuals have full access to typical homelike accommodations such as a kitchen, dining area, family/living room, laundry, and bathroom.

☐ Individuals have full access to most typical homelike accommodations but may share bathrooms and not have access to the full (commercial) kitchen, in a larger facility. Individuals are offered substitute equipment and a means to cook.

☐ There are residential setting/provider limits to full access to typical homelike accommodations.

38. If you selected “There are residential setting/provider limits to full access to typical homelike accommodations” above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

39. Are the limits only applied to those who need them? ☐Yes ☐No

40. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

41. If limits are used, are the limitations identified in the individual’s person-centered service plan? ☐Yes ☐No

42. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 5: Personal Privacy

43. Please choose the option that best describes the services and supports for personal privacy:

☐ All individuals may lock their bedroom and living unit doors. Door locks are single-action which means when the individual turns the handle or lever the door unlocks. All individuals have bathroom facilities that allow for complete privacy through the ability to lock the door or stall. Bathing areas are private and individuals are shielded or protected from others walking in on them. Only appropriate staff have keys.

☐ All individuals may lock their bedroom or living unit doors for privacy. Door locks are single-action which means when the individual turns the handle or lever the door unlocks. Bathrooms may be used by others and individuals may need additional support to obtain privacy, such as assistance to get from a wheelchair into the bathroom, in order to be able to shut the door for privacy. Only appropriate staff have keys.

☐ Doors are not lockable but privacy is assured through knocking before entering an individual's bedroom, living unit, or bathroom.

☐ There are residential setting/provider limits on an individual's ability to have personal privacy.

44. If you selected "There are residential setting/provider limits on an individual's ability to have personal privacy" above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

45. Are the limits only applied to those who need them? ☐Yes ☐No

46. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

47. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

48. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 6: Choice of Roommates/Sharing Space

49. Please choose the option that best describes the services and supports individuals have in their choice of roommates and sharing space:

☐ This facility only offers private rooms.

☐ There are shared bedrooms or living units. There are methods in place for individuals to seek a new roommate should they desire. Individuals have the opportunity to meet new potential roommates and have input in the selection of their roommate.

☐ There are shared bedroom or living units in the facility. There are residential setting/provider limits regarding the individual's involvement in the selection of roommates or their ability to have input in the choice of roommates.

50. If you selected "There are shared bedroom or living units in the facility. There are residential setting/provider limits regarding the individual's involvement in the selection of roommates or their ability to have input in the choice of roommates" above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

51. Are the limits only applied to those who need them? ☐Yes ☐No

52. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

53. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

54. I If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 7: Freedom to Furnish and Decorate

55. Please choose the option that best describes the services and supports to individuals regarding furnishing and decorating:

☐ Individuals may bring their own furnishings and are supported and encouraged to personalize their space. Individuals may paint or secure pictures to walls or use accessories, as needed. There may be landlord/tenant type agreements regarding approval of painting, nails or holes in walls, but individual experience is that obtaining necessary permissions is reasonable and does not inhibit their personal style or ability to decorate.

☐ Individuals may bring their own furnishings. Decorating is not encouraged or discouraged. There may be landlord/tenant type agreements regarding approval of nails or holes in walls. Substantial changes, such as painting, may not be allowed.

☐ There are residential setting/provider limits on an individual's ability to furnish and decorate.

56. If you selected "There are residential setting/provider limits on an individual's ability to furnish and decorate" above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

57. Are the limits only applied to those who need them? ☐Yes ☐No

58. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

59. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

60. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 8: The individual can have access to food at any time

61. Please choose the option that best describes the services and supports to individuals regarding access to food.

    ☐ Individuals are provided three nutritious meals and two snacks a day. Individuals may assist with menu planning and personal preferences are considered. If an individual misses a meal, alternatives such as a to-go sack meal or heatable meals, are available Individuals have access to personal food storage, including refrigeration, freezer, and dry storage, that they can access at any time.

    ☐ Individuals are provided three nutritious meals and two snacks a day. Individuals may assist with menu planning and personal preferences are considered. If an individual misses a meal it is typically not replaced unless requested. Storing personal food items is not encouraged, but is allowed if requested.

    ☐ There are limits in place regarding access to food at any time.

62. If you selected "There are limits in place regarding access to food at any time" above, are the limits universally applied to everyone living in the residential setting? ☐ Yes ☐ No

63. Are the limits only applied to those who need them? ☐ Yes ☐ No

64. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

65. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

66. If limits are used, they are primarily used to (select the best answer):

    ☐ Protect the individual or others ☐ Efficiently manage operations

Section 9: The individual can have visitors at any time

67. Please choose the option that best describes the services and supports to individuals regarding having visitors.

☐ Individuals may have visitors at any time. Individuals living in the site understand there are no residential setting/provider limits to the time when visitors may be received. Individuals are encouraged and supported to have visitors. .

☐ Individuals may have visitors at any time. The residential setting/provider may have policies in place for after-hours visitors or a check-in process to address safety or privacy concerns.

☐ There are residential setting/provider limits to individuals having visitors at any time.

68. If you selected "There are residential setting/provider limits to individuals having visitors at any time" above, are the limits universally applied to everyone living in the residential setting? ☐ Yes ☐ No

69. Are the limits only applied to those who need them? ☐ Yes ☐ No

70. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

71. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

72. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

73. **Is there any other information that you as a provider of community-based services would like to provide?**

Thank you for completing this Survey.

Survey ID# [Survey_ID]

1. **Date_____**
2. **Name of Child Living in the Setting: [FirstName LastName]**
3. **Age of Child Living in the Setting_____**
4. **Residential Setting Name_____**
5. **Residential Setting Address_____**

   _____

Please choose one of the following to describe how the survey is being completed:

6. **I am the child or youth living in the setting and I am completing the survey with assistance from someone.**
7. **Best description of the role of the person helping me :**

   ☐ Legal Representative ☐ Not Applicable

   ☐ Survey Hotline/Peer Advocate ☐ Family Member/Friend

   ☐ Other; Explain_____

8. **Reason somebody is helping me:**

   ☐ I require assistance ☐ I requested assistance

   ☐ Other; Explain_____

9. **Name of person helping me_____**
10. ☐ **I am the child or youth living in the setting and I am completing the survey on my own without assistance from someone.**
11. ☐ **I am the legal representative for the child living in the setting and I am completing the survey on the child's behalf.**
12. **Type of legal representative:** ☐ Parent with legal custody ☐ Legal guardian
13. **Name of person completing the survey for me_____**

Please complete the survey questions from the perspective of the child who is receiving services in a residential (group home or foster home) setting.

Section 1: Where I live supports access to the broader community

14. Please choose the description that best describes how the location of the home where the child receives services supports access to the community:

Pick the best answer:

☐ Where I live makes it **EASY** for me to be part of the community where I am located.

☐ Where I live makes it **HARD** for me to be part of the community where I am located.

Where I live makes it easy for me to:

15. Participate in community activities

☐ Always ☐ Usually ☐ Sometimes ☐ Never

16. Go places in the community

☐ Always ☐ Usually ☐ Sometimes ☐ Never

17. Obtain work-related experience (such as summer or after school work, volunteer work, etc.) or get a job in the community:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I am working on other things right now and do not wish to work or obtain work experience at this time.

☐ N/A- I am too young to work or gain work-related experience right now.

Section 2: I am supported where I live to be part of the community

18. I have regular opportunities be part of the broader community. The following are some examples that help explain what this means: getting work experience in the community; participating in extracurricular activities; going to the park, the library, or church; shopping for food, clothing or other items; going to the gym or an exercise class; going out for ice cream; going to the movies, fairs, rodeos, or other community events.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 3: Choosing where I live

19. Before I moved to where I live now, I (or my parent or guardian) was told about or able to visit other places to live.

☐ Yes ☐ No

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was told about other options)

20. Before moving to where I live now, I (or my parent or guardian) was offered different choices of where I could live. One of the choices was a service setting where not all people experience disabilities; this choice may have included the option for me to receive services in my family home.

☐ Yes ☐ No

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was told about other options)

21. If I have a shared bedroom, I (or my parent or guardian) was offered a choice of a home for me that offered a private bedroom.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was offered the choice of a home with a private bedroom)

22. My guardian has a say in who I share my bedroom with.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

☐ I don't know (I am a youth completing the survey and I don't know if my guardian has a say in who is share my bedroom with)

23. I got to visit the home where I live now and meet members of the household before I moved in.

☐ Yes ☐ No

Section 4: Where I live supports my independence and making life choices

Work or Work Experience

24. My provider/setting supports me with my daily needs in order for me to work or obtain work-related experience.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I am working on other things right now and do not wish to work or obtain work-related experience at this time.

☐ N/A- I am too young to work or gain work-related experience right now.

Personal Finances (Resources)

25. I have a say in how I spend my personal funds.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

26. I get support to manage my money so I can buy the things I want.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 5: I am supported where I live to participate in creating my own schedule

27. I have an active role in planning my own schedule. I am supported in choosing preferred activities and my provider helps me to plan my day so that I can do things I like while also planning for necessary things like school, physical activity, and sleep.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 6: Where I live ensures my rights of privacy, dignity and respect, and freedom from coercion (strong-arm) and restraint

Coercion

28. Where I live now, my provider/staff has never used physical force or physical punishment, or threats to make me do something I don't want to do.

☐ True – I **HAVE NOT** been forced to make decisions against my will

☐ False – I **HAVE** been forced to make decisions against my will

Restraint

29. Where I live now, I have never been forced to take a medication as a consequence of my behavior.

☐ True – I **HAVE NOT** been forced to take medication as a consequence of my behavior against my will.

☐ False - I **HAVE** been forced to take medication as a consequence of my behavior against my will.

30. Where I live now, I have never been tied down to control my behavior against my will.

☐ True – I **HAVE NOT** been tied down to control my behavior against my will.

☐ False - I **HAVE** been tied down to control my behavior against my will.

31. Where I live now, I have never been held down by a person or object to control my behavior against my will.

☐ True – I **HAVE NOT** been held down to control my behavior against my will.

☐ False - I **HAVE** been held down to control my behavior against my will.

32. Where I live now, I have never been kept away from others in a confined space or locked in a room as punishment against my will.

☐ True – I **HAVE NOT** been kept or locked in a room as punishment against my will

☐ False - I **HAVE** been kept or locked in a room as punishment against my will

Communication

33. I feel free to openly discuss any of my concerns with my provider/staff.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

34. I have access to a phone or to other methods of communicating with others outside of where I live. My provider allows me to talk to my guardian (or my attorney or CASA, if I have one) at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Access in all areas of the home where I live

35. I can be in the following areas of my home: kitchen; dining room; living/family room; bedroom; and bathroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 7: Staff where I live respect my personal privacy

36. I have privacy in my bedroom and opportunity for private time if I desire it. Staff and other household members knock before entering my room.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

37. I have privacy when I use the bathroom. I may have assistance when using the bathroom, but people do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

38. I have privacy when I take a shower or bath. I may have assistance when showering or bathing, but people do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 8: Where I live allows me to decorate and furnish my bedroom or living unit

39. I have a say in how I decorate my bedroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

40. I may furnish my bedroom with my own furniture.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 9: Where I live allows me to have access to food at any time

41. My provider serves some of my favorite foods and I am offered healthy alternatives if I don't like something that is being served.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

42. In addition to the meals and snacks provided to me by my provider, I have access to snacks and have the option of purchasing my favorite foods.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 10: Where I live allows me to have visitors at any time

43. My provider, guardian, and ISP team work together to support me in having visits with friends.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

44. My provider is supportive of visits with my family (except where limited by a court order) and I feel like my family is welcome in the home where I live.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

You have completed the survey questions for where you live.

We would now like to ask some questions about services you might get outside of where you live. Not everyone has these services and that is ok. Please answer the questions that are applicable to you

Section 11: Services outside of where I live

45. I work or use employment services outside of where I live.

☐ Yes ☐ No

☐ N/A- I am too young to work or gain work-related experience right now.

46. If yes: I work or use employment services in a typical community setting where my coworkers come from a variety of different backgrounds and do not necessarily have disabilities (not including paid support staff): ☐ Yes ☐ No

47. I work or use employment services in a setting where most of my coworkers are people who also have some type of disability: ☐ Yes ☐ No

48. If yes: I had an option to work or use services in a place where I could meet and form relationships with people from a variety of different backgrounds, and not only with other people who have disabilities: ☐ Yes ☐ No

49. I am paid for my work: ☐ Yes ☐ No

50. If yes: I am paid minimum wage or better: ☐ Yes ☐ No

51. I would like to work more hours now or in the future: ☐ Yes ☐ No

52. I would like to be able to have a job where I could make more money now or in the future:

☐ Yes ☐ No

53. Is there any other information that you would like to share about where you live or receive services?

Thank you for completing this survey.

Survey ID#: [insert Survey_ID]

Home and Community-Based Services Setting Provider Self-Assessment Survey for Children's Residential Settings (Foster Care and Group Homes)

1. **Date**_____
2. **Provider Name**_____
3. **Person completing Survey and Title/Position**_____

   _____
4. **Medicaid Provider Number**_____
5. **Type of License or Certification**_____
6. **Licensing or Certification Agency (check one):**

   ☐ DD ☐ Child Welfare ☐ Other: _____
7. **Primary Population(s) Served**_____
8. **Physical Address of Service Site**_____

   _____
9. **Number of individuals in the home receiving Medicaid HCBS**_____
10. **Total number of persons residing in the household**_____
11. **Mailing Address (if different from above)**_____

    _____
12. **Phone**_____
13. **Email**_____
14. **Total number of sites you will be completing surveys on**_____

Section 1: The residential setting is integrated and supports full access to the greater community and does not isolate individuals

15. **Part A:** Please choose the option that best describes the group home or foster home.

☐ Individuals are supported in having full access to the community. The home does not specialize in, nor does the provider target, a specific disability or diagnosis type. There may be a mix of people with and without disabilities living in the home. The home may have a mix of residents receiving Medicaid funded services and others who do not. Individuals are supported in obtaining services outside of the home in the broader community in addition to the care they receive in the home. The home encourages opportunities to work or seek work related experience (on the same basis as people who are the same age and do not have a disability). Other off-site services may include school services, community activities, gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ Individuals receive some services in the home and other services in the broader community. Onsite and off-site services may include school services, community activities gym, work or work related experience (on the same basis as people who are the same age and do not have a disability), medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ The home is designed for people with disabilities and often for people with a certain type of disability. The individuals in the home are primarily or exclusively people with disabilities and on-site staff provides many of the services. Individuals have regular opportunities to engage in the broader community. However, the home setting does not encourage opportunities to work or obtain work related experience (on the same basis as people who are the same age and do not have a disability).

☐ The home is designed for individuals with disabilities to receive multiple types of services on-site or in the home, including housing, school services, medical, behavioral and therapeutic services, and/or social and recreational activities and people in the home have limited, if any, interaction with the broader community. The home setting does not encourage opportunities to work or obtain related experience (on the same basis as people who are the same age and do not have a disability).

Part B: Indicate if any of the following apply:

16. The residential setting is a locked facility. ☐ Yes ☐ No

17. The residential setting is one of the following: ☐ Yes ☐ No

- Farmstead or disability specific farm community located in rural residential setting on a large parcel of land with little ability to access the broader community outside of the farm.
- Gated/secured "community" for people with disabilities where services are provided on-site and individuals rarely leave the gated community.
- Residential school where individuals receive both education and residential services in one setting and do not go into the broader community for education.
- Multiple residential settings co-located and operationally related (operated by the same provider) where services are provided on campus with individuals rarely accessing the broader community.

Section 2: Optimizes autonomy and independence in making life choices

Work or Work Experience

18. Please choose the option that best describes the residential service setting provider's role related to services and supports for work or work-related experiences:

☐ The home/provider encourages opportunities for individuals to obtain work or work-related experience. Individuals who would like to work are either working or obtaining some type of work related experience. Individuals who live in this home have supports from the provider to plan for or otherwise meet daily needs required to maintain work or a work experience. Individuals who live in this home, including those who are not working, are regularly encouraged throughout the year to discuss work or career goals.

☐ The home/provider encourages opportunities for individuals to obtain work or work related experience on the same basis as people who are the same age and do not have a disability. Individuals who may be focused on school right now will be encouraged to pursue work and work related experiences in the future. Individual have opportunities to talk about work or career goals.

☐ The home /provider supports individuals in getting ready for school and/or work each day, but does not necessarily encourage individuals to seek work or work-related experience on the same basis as people who are the same age and do not have disabilities. Work or career goals are rarely talked about.

☐ Individuals are not encouraged or emotionally supported by the provider to work or obtain work experience. Work or career goals are rarely or never talked about, and likely will not be discussed in the future.

☐ All individuals in the home are focused on school right now or are not yet of school age. Individuals in the home are encouraged to discuss future plans and career goals that include work in an integrated setting.

Personal Finances (Resources)

19. Please choose the option that best describes the services and supports for personal resources:

☐Individuals may or may not have a Social Security designated Representative Payee. Individual may or may not be beneficiaries of a Special Needs Trust or Discretionary Trust. The existence of one of these is not considered a limitation by the residential setting/provider.

☐The home /provider places no limitations to an individual's, or their designated representatives', ability to access personal financial resources (personal spending monies, personal property, real estate, assets, savings, etc.). Personal resources may be safeguarded but individuals have easy access to, experience no barriers, and are supported in obtaining and using personal resources as desired.

☐There may be some limitations based on the safeguarding of personal resources. The provider assists individuals in budgeting and managing funds, however, the individual self-directs and is engaged in the process as much as possible. The individual's financial plan is addressed in the ISP and the provider supports the individual in meeting identified goals.

☐ Limitations beyond age appropriate structure and guidance are placed on an individual's, or their designated representatives', access to personal resources.

20. If you selected "Limitations beyond age appropriate structure and guidance are placed on an individual's, or their designated representatives', access to personal resources" above, are the limits universally applied to everyone living in the home?

☐Yes ☐No

21. Are the limits only applied to those who need them? ☐Yes ☐No

22. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

23. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

24. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

---

Section 3: The individual controls his/her own schedule

25. Please choose the option that best describes the services and supports for controlling one's own schedule:

☐Individuals are supported to control their own schedules in an age appropriate manner as much as possible. The provider engages with the individual to promote self-direction and honor individual preferences related to routine and activities. Routine activities such as bathing and mealtimes are flexible and work around the individual's personal schedule. Requests for engaging in the broader community such as participating in extracurricular school activities, working or participating in work-related experiences, going shopping, to the library, or to the park are routinely supported and accommodated. When individuals work, their schedules are supported. Children in the home are encouraged to participate in extra-curricular activities such as school or community sporting programs or clubs.

☐Individuals are an active part of directing or creating their personal schedules. The preferences of the individual are honored whenever possible. The provider helps the individual identify preferred activities and activity times, while also supporting the individual in addressing necessary components of their daily routine such as school attendance, exercise, and adequate rest. Routine activities in the household and general scheduling is flexible and is adjusted based on who lives in the home and what is important to members of the household.

☐ Most activities are scheduled by the provider, including daily living activities such as mealtimes, bathing, and social and recreation opportunities. The provider seeks little input from the individual in scheduling activities. The household operates by a routine schedule that has little flexibility and little variation, even when the household composition changes.

☐ There are home/provider limits to the amount of control individuals have over their own schedules.

26. If you selected "There are home/provider limits to the amount of control individuals have over their own schedule" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

27. Are the limits only applied to those who need them? ☐Yes ☐No

28. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

29. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

30. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

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Section 4: Setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

Freedom from Coercion

31. Are individuals free from coercion as defined below? ☐Yes ☐No

- Threats of serious harm to or physical restraint against any person;
- Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
- The abuse or threatened abuse of the legal process.

32. Do the provider/staff utilize any of the following restraints on individuals receiving services in this home to address and control behavior? ☐Yes ☐No

- Chemical restraints, such as the forced administration of a medication as a controlling or punitive response to a behavioral episode.
- Mechanical restraints, such as devices that limit an individual's ability to freely move their body, not part of the person's formal behavior support plan
- Physical restraints, such as using a physical maneuver to limit an individual's ability to freely move, where the maneuver is weight-bearing and/or not part of the person's formal behavior support plan
- Seclusion, such as restricting an individual to a specific physical space as a punitive response to a behavior

Communication

33. Please choose the option that best describes the services and supports for communication:

☐ Individuals are encouraged and supported to communicate within the home and with others outside of the home. Individuals are afforded privacy in communication as safe and appropriate to their chronological age. Individuals may have access to the phone or other methods of communication with assistance or oversight from the provider. Individuals have privacy in communication with their parents or legal guardian, except where restricted by a court order. Where applicable, individuals have privacy in communication with their Child Welfare caseworker, attorney, and/or CASA.

☐ Individuals are encouraged and supported to communication with others in the home and in the community. Access to the phone or other modes of communication may be made with the provider's permission, or in accordance with the individual's ISP. There may be legal orders that direct the types of communication and level of supervision or access an individual may have.

☐The ability to communicate privately within the home and with others outside of the home is limited.

34. If you selected "The ability to communicate privately within the home and with others outside of the home is limited" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

35. Are the limits only applied to those who need them? ☐Yes ☐No

36. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

37. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

38. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Homelike Accommodations

39. Please choose the option that best describes the services and supports for homelike accommodations:

☐ Individuals have access to typical homelike accommodations such as a kitchen, dining area, family/living room, laundry, and bathroom appropriate to the chronological age of the individual.

☐ Individuals have full access to most typical homelike accommodations, however, providers may modify access to address safety incidental to the provision of daily living activities.

☐ There are home/provider limits beyond age appropriate structure and guidance to full access to typical homelike accommodations.

40. If you selected "There are home/provider limits beyond age appropriate structure and guidance to full access to typical homelike accommodations" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

41. Are the limits only applied to those who need them? ☐Yes ☐No

42. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

43. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

44. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Section 5: Personal Privacy

45. Please choose the option that best describes the services and supports for personal privacy:

☐ Individuals have the opportunity to have privacy or private time in their bedroom, including the ability to close the door, should they desire it. Individuals have privacy when using the bathroom. Individuals are able to close the bathroom door and are shielded or protected from others walking in on them when using the toilet or bathing. Staff/caregivers are present in the bathroom or during private time only when necessary to provide required assistance or to address safety. Staff and other members of the household knock and wait to receive permission before entering a closed room.

☐ There are home/provider limits beyond age appropriate structure and guidance on an individual's ability to have personal privacy.

46. If you selected "There are home/provider limits on an individual's ability to have personal privacy" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

47. Are the limits only applied to those who need them? ☐Yes ☐No

48. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

49. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

50. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 6: Choice of Roommates

51. Please choose the option that best describes the services and supports individuals and/or their guardians have in the choice of roommates in a shared bedroom situation:

☐ This home only offers private rooms.

☐ There are shared bedrooms in the home. The individual's legal guardian has consented to and supports the individual having a shared bedroom. There are methods in place for guardians to request a change in roommate or shared room situation should this be desired. Individuals and their guardians have the opportunity to meet new potential shared bedroom roommates and have input in the selection of their shared bedroom roommate.

☐ There are shared bedrooms in the home. There are provider limits regarding the individual's and their guardian's involvement in the selection of shared bedroom roommates or their ability to have input in the choice of shared bedroom roommates.

52. If you selected "There are shared bedrooms in the home. There are provider limits regarding the individual's and their guardian's involvement in the selection of shared bedroom roommates or their ability to have input in the choice of shared bedroom roommates" above, are the limits universally applied to everyone living in the home?

☐Yes ☐No

53. Are the limits only applied to those who need them? ☐Yes ☐No

54. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

55. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

56. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 7: Freedom to Furnish and Decorate

57. Please choose the option that best describes the services and supports to individuals regarding furnishing and decorating:

☐ Individuals may bring their own furnishings and are supported and encouraged to personalize their space. Individuals are encouraged to have age appropriate décor that reflects their personal style. The provider may provide guidance to the individual to address safety and family-friendly considerations.

☐ The home provider limits an individual's ability to furnish and decorate.

58. If you selected "The home provider limits an individual's ability to furnish and decorate" above, are the limits universally applied to everyone living in the home?

☐Yes ☐No

59. Are the limits only applied to those who need them? ☐Yes ☐No

60. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

61. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

62. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 8: The individual can have access to food at any time

63. Please choose the option that best describes the services and supports to individuals regarding access to food.

☐ Individuals are provided three nutritious meals and two snacks a day. Individuals are encouraged to participate in menu planning, and cultural and personal preferences of the individual are honored. The individual may participate in grocery shopping, selection of meal options, and routinely have an opportunity to have favorite foods. Mealtimes offer some choice in food options and individuals are not required or expected to eat foods they do not like. If an individual misses a meal, alternatives such as a to-go sack meal or heatable meals, are available upon return.

☐ Individuals are provided three nutritious meals and two snacks a day. The provider seeks little input from the individual related to menu planning. Individual preferences or favorite foods are rarely served and alternative options for meals are not offered.

☐There are limits beyond age appropriate structure and guidance in place regarding access to food at any time.

64. If you selected "There are limits beyond age appropriate structure and guidance in place regarding access to food at any time" above, are the limits universally applied to everyone living in the residential setting? ☐Yes ☐No

65. Are the limits only applied to those who need them? ☐Yes ☐No

66. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

67. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

68. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Section 9: The individual can have visitors at any time

69. Please choose the option that best describes the services and supports to individuals regarding having visitors.

☐ Individuals are encouraged to have visitors in the home. Legal guardians and family members have access to the individual at any time (except where limited by a court order). The provider works with the individual in identifying opportunities to have visitors and planning for social opportunities.

☐Individuals are not necessarily encouraged to have visitors in the home. When an individual desires to have visitors, they are encouraged to meet with friends or family outside of the home, rather than hosting guests at the residence.

☐There are residential setting/provider limits beyond age appropriate structure and guidance to individuals having visitors at any time.

70. If you selected "There are residential setting/provider limits beyond age appropriate structure and guidance to individuals having visitors at any time" above, are the limits universally applied to everyone living in the residential setting?

☐Yes ☐No

71. Are the limits only applied to those who need them? ☐Yes ☐No

72. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

73. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

74. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

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Is there any other information that you as a provider of community-based services would like to provide?

Thank you for completing the Provider Self-Assessment Survey

APPENDIX B. OHA/DHS SCORING GUIDES

Individual Experience Survey - Where I Live and Get Services

Date

Name
Address
City, State, Zip

Dear Name

Please complete this survey if you live in one of the following settings:

- Assisted Living Facility
- Residential Care Facility
- Group Home
- Residential Treatment Home
- Residential Treatment Facility
- Foster Home

You are being asked to complete this survey because we would like to learn more about your experiences living in the settings listed above. The support you receive in these settings are considered Home and Community-Based Services (HCBS). HCBS provides needed supports for individuals to live integrated in the community and have experiences, including employment, just like other members of the community.

In January 2014 the Federal Centers for Medicare and Medicaid Services (CMS) issued new rules regarding settings in which HCBS are provided. These rules provide new protections for individuals using HCBS. We are looking at service settings to see if the new requirements are being met. Your individual answers will not be shared with your provider/staff. We may use the information to help your provider/staff understand changes they may need to make under these rules.

We want to use your answers to better understand if we need to make changes to improve everyone's community experience. Your input is valuable to us.
Completing the survey should only take about 10 minutes. You may:

- Complete your survey online; go to xxxxxxxxxxxxxxxxxx.

- Complete your survey on paper.

If you would like help to complete your survey, you may choose who helps you. Options for assistance may include:

- Call toll free 1-800-XXX-XXXX to have someone complete the survey with you.

- Contact the person who provides your case management services for assistance.
- Work with your legal representative, a peer advocate, friend or family member.
- Contact a local advocacy program (staff where you live may help you find one).
- Ask staff where you live for help.

We really hope you will take the time to complete this survey. Your experiences in your current setting are important us. Thank you for taking the time to participate.

Thank you for your time in completing this survey. If you would like to read more information about these new rules, you may view them online at this website:
http://www.oregon.gov/dhs/dhsnews/pages/hcbs-transitionplan.aspx

Date:

Question 1: Name of Individual Living in the Setting:

Question 2: Age of Individual Living in the Setting:

☐ 18-24 years old

☐ 25-34 years old

☐ 35-44 years old

☐ 45-54 years old

☐ 55-64 years old

☐ 75-85 years old

☐ 85 or older

Question 3: To which race or ethnic group do you (individual living in the setting) *most* identify?

☐ Asian

☐ Black/African American

☐ Hispanic

☐ Native American/Alaskan Native

☐ Pacific Islander

☐ White

☐ Other

Question 4: Residential Setting Name:

Question 5: Residential Setting Address:

Question 6: Person assisting me complete the survey: ☐ Not Applicable

Question 7: Best description of the role of the person helping to complete the survey:

☐ Not Applicable; ☐ Legal Representative; ☐ Case Manager; ☐ Survey Hotline/Peer Advocate; ☐ Family Member/Friend; ☐ Other; Explain:

Question 8: Reason somebody is completing the survey for me:

☐ I require assistance; ☐ I requested assistance ☐ Other; Explain

Question 9: Person completing survey if not me; Name: ☐ Not Applicable

Question 10: My Survey Number:

Section 1: Where I live supports access to the broader community

Question 11: Please choose the description that best describes how the location of your home or residential setting supports your access to the community:

Pick the best answer:

G ☐ Where I live makes it easy for me to be part of the community where I am located.

R ☐ Where I live makes it hard for me to be part of the community where I am located.

Where I live makes it easy for me to:

Question 12: Participate in community activities

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 13: Get around in the community as I desire

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 14: Look for a job in the community where I can make at least minimum wage, if I want to work:

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Y ☐ I do not want to work at this time

Section 2: I am supported where I live to be part of the community

Question 15: I have regular opportunities be part of the broader community. The following are some examples that help explain what this means: working in the community, going to the park, the library, church, shopping for food, clothing or other items, getting my hair cut at a beauty or barber shop, going out for coffee, going to the movies, fairs, rodeos, or other community events.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 3: Choosing where I live

Question 16: Before I moved to where I live now, I was told about or able to visit other places to live.

G ☐ Yes

R ☐ No

Question 17: I was offered the choice to live in a place that is not only for people who have disabilities.

G ☐ Yes

R ☐ No

Question 18: If I live in a shared room, I was offered the choice of a private bedroom or living unit.

G ☐ Yes

R ☐ No

Y ☐ Not applicable - I am in a private room

Question 19: I have a choice in who my roommate is.

G ☐ Yes

R ☐ No

Y ☐ Not applicable – I am in a private room

Section 4: Where I live supports my independence and making life choices

Employment

Question 20: My provider/setting supports me with my daily needs in order for me to work.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Y ☐ I do not want to work at this time

Question 21: Personal Finances (Resources)

The provider/staff where I live support me in managing my money.

G ☐ Yes

G ☐ No, I manage my own money

G ☐ No, my guardian or representative manages my money

G ☐ I have a Social Security Representative Payee, or I am a beneficiary of a Special Needs Trust or Discretionary Trust.

Question 22: I can easily get my money and spend my money as I wish.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 5: I am supported where I live to make my own scheduling decisions

Question 23: I create my own schedule. For example, I decide when to go to bed or when I get up. I can go out alone, with friends or family as I wish. My provider/staff work around my activities. If my activities cause me to miss a scheduled mealtime, laundry time, or bath time, I can get the meal or service when convenient for me.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 6: Where I live ensures my rights of privacy, dignity and respect, and freedom from coercion (strong-arm) and restraint

Coercion

Question 24: Where I live now, my provider/staff has never threatened me with physical harm, or used restraints, or punished me, to force me to make a decision I did not want to make.

G ☐ True – I have not been forced to make decisions against my will

R ☐ False – I have been forced to make decisions against my will

Restraint

Question 25: Where I live now, I have never been given a medication against my will to control my behavior.

G ☐ True – I have not been forced to take medication to control my behavior against my will.

R ☐ False - I have been forced to take medication to control my behavior against my will.

Question 26: Where I live now, I have never been held or tied down by a person or object against my will.

G ☐ True – I have not been held or tied down against my will

R ☐ False - I have been held or tied down against my will

Question 27: Where I live now, I have never been kept or locked in a room against my will.

G ☐ True – I have not been kept or locked in a room against my will

R ☐ False - I have been kept or locked in a room against my will

Communication

Question 28: I feel free to openly discuss any of my concerns with my provider/staff.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 29: I have access to a phone or to other methods of communicating with others outside of where I live. I can talk to anyone I want at any time.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Access in all areas where I live

Question 30: I have full access to the following areas in where I live any time I want or need: kitchen; dining room; living/family room; bedroom; and bathroom.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 7: Staff where I live respect my personal privacy

Question 31: I may lock my bedroom or living unit door for privacy.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 32: I have privacy when I use the bathroom. People do not walk in on me without my permission.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 33: I may take a shower or bath privately. People do not walk in on me without my permission.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 8: Where I live allows me to decorate and furnish my bedroom or living unit

Question 34: I may decorate my bedroom or living unit the way I choose.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 35: I may furnish my bedroom or living unit with my own furniture.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 9: Where I live allows me to have access to food at any time

Question 36: In addition to the meals and snacks provided to me by my provider, I can purchase food and have access to my food at any time.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 10: Where I live allows me to have visitors at any time

Question 37: I may have visitors at any time.

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Section 11: Services outside of where I live

Question 38: I work or use employment services outside of where I live.

G ☐ Yes

G ☐ No

If yes:

Question 38a: I work or use employment services in a typical community setting where my co-workers come from a variety of different backgrounds and do not necessarily have disabilities (not including paid support staff):

G ☐ Yes

R ☐ No

Question 38b: I work or use employment services in a setting where most of my coworkers are people who also have some type of disability:

G ☐ Yes

R ☐ No

If yes:

Question 38b(i): I had an option to work or use services in a place where I could meet and form relationships with people from a variety of different backgrounds, and not only with other people who have disabilities:

G ☐ Yes

R ☐ No

Question 38c: I am paid for my work:

G ☐ Yes

R ☐ No

If yes:

Question 38c(i): I am paid minimum wage or better:

G ☐ Yes

R ☐ No

Question 38d: I would like to work more hours:

G ☐ Yes

R ☐ No

Question 38e: I would like to be able to have a job where I could make more money.

G ☐ Yes

R ☐ No

You have completed the survey questions for where you live.

We would now like to ask some questions about services you might get outside of where you live. Not everyone has these services and that is ok. Please answer the best that you can.

Question 39: DAY SERVICES ONLY: I use other services in a provider setting (such as Outpatient Mental Health Services, Adult Day Care, Day Services, or Community Inclusion/Alternative to Employment) outside of the place where I live:

G ☐ Yes

G ☐ No

If yes:

Question 39a: When I use these services, I feel I am part of my community:

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 39b: I participate in activities with people I chose to spend time with:

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 39c: When I use these services, I have opportunities to interact with people from the community, who come from a variety of different backgrounds, and not only people who have disabilities (this does not include paid support staff):

G ☐ Always

Y ☐ Usually

R ☐ Sometimes

R ☐ Never

Question 40: Is there any other information that you would like to share about where you live or receive services?

Thank you for completing this Survey.

Home and Community-Based Services Setting Provider Self-Assessment Survey

Date:

Question 1: Survey #

Question 2: Provider Name:

Question 3: Person completing Survey and Title/Position:

Question 4: Medicaid Provider Number:

Question 5: Type of License or certification:

Question 6: Licensing or Certification Agency:

Question 7: Primary Population(s) Served:

Question 8: Physical Address of Service Site:

Question 9: Mailing Address (if different):

Question 10: Phone:

Question 11: Email:

Question 11a: Total number of sites you will be completing surveys on:

Section 1: The residential setting is integrated and supports full access to the greater community and does not isolate individuals

Question 12: SECTION A: Please choose the best option from the choices below.

G ☐ Individuals have full access to the community. The residential setting does not specialize in, or target, a specific disability or diagnosis type and may have a mix of people with and without disabilities. The residential setting may have a mix of private pay and Medicaid. The setting may include room and board, bathing and other personal assistance while Individuals are supported to obtain many other services outside of the residential setting in the broader community. Off- site services may include competitive integrated employment, day services, beautician services, community activities, gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

Y ☐ Individuals receive some services in-house and others in the broader community. The residential setting may include room and board, bathing and other personal assistance services. The additional services on-site are intended to be convenient for individual access, yet, they may have the unintended consequence of isolation from the broader community. Onsite and off-site services may include competitive integrated employment, day services, beautician services, community activities gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

R ☐ The residential setting is designed for people with disabilities and often for people with a certain type of disability. The individuals in the residential setting are primarily or exclusively people with disabilities and on-site staff provides many of the services. The residential setting services include community access and individuals have regular opportunities to engage in the broader community.

R ☐ The residential setting is designed to provide people with disabilities multiple types of services on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities and **people in the residential setting have limited, if any, interaction with the broader community.** SECTION B: Please indicate whether the below statement is true for this setting.

Question 13: The residential setting is a locked facility.

R ☐ Yes

G ☐ No

Question 14: The residential setting is one of the following:

R ☐ Yes

G ☐ No

- Farmstead or disability specific farm community located in rural residential setting on a large parcel of land with little ability to access the broader community outside of the farm.
- Gated/secured "community" for people with disabilities where services are provided on-site and individuals rarely leave the gated community.
- Residential school where individuals receive both education and residential services in one setting and do not go into the broader community for education.
- Multiple residential settings co-located and operationally related (operated by the same provider) where services are provided on campus with individuals rarely accessing the broader community.

Section 2: Optimizes autonomy and independence in making life choices

Employment

Question 15: Please choose the option that best describes the services and supports for employment:

G ☐ For individuals who want to work, the residential setting/provider encourages the individual's opportunities to seek employment and work in integrated settings and for competitive wages (minimum wage or better). Working individuals who live in this residential setting have supports from the provider in planning and meeting their daily needs in order to access and maintain employment. Individuals who live in this residential setting have frequent opportunities throughout the year to discuss career goals, including career advancement,

career changes, increased wages, or increased hours. Individuals who want to work are working or using employment services in an integrated employment setting where there are opportunities to interact with people who do not have disabilities (not including paid staff).

Y ☐ For individuals who want to work, the residential setting/provider encourages opportunities to seek employment and work in integrated employment for competitive wages (minimum wage or better). Individuals might have opportunities to talk about employment goals once a year or so. Those who want to work are working; however, it may not be in an integrated employment setting where individuals interact with people who do not have disabilities (not including paid staff). Individuals who are working in less integrated or segregated settings continue to be supported in career goals relating to obtaining integrated employment at a competitive wage.

R ☐ The residential setting/provider supports individuals in getting ready for work each day, but does not necessarily encourage individuals in seeking employment and working in integrated competitive settings.

R ☐ Individuals who reside in this residential setting and want to work are not encouraged or emotionally supported by the provider to do so.

Personal Finances (Resources)

Question 16: Please choose the option that best describes the services and supports for personal resources:

Individuals may or may not have a Social Security designated Representative Payee. Individual may or may not be beneficiaries of a Special Needs Trust or Discretionary Trust. The existence of one of these is not a considered a limitation by the residential setting/provider.

G ☐ The residential setting/provider places no limitations to an individual's, or their designated representatives, ability to access personal financial resources (personal spending monies, personal property, real estate, assets, savings, etc.). Personal resources may be safeguarded but individuals have easy access to, experience no barriers, and are supported in obtaining and using personal resources as desired.

Y ☐ There may be some limitations based on the safeguarding of personal resources. Individuals, or their designated representatives, can typically access funds in the same day, or within 24 hours for larger sums. Individuals are supported in obtaining and using their personal resources as desired.

R ☐ Limitations are placed on an individual's, or their designated representatives, access to their personal resources.

Question 16a: If you selected "Limitations are placed on an individual's, or their designated representatives, access to their personal resources" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 16b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 16b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 16b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 16b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 3: The individual controls his/her own schedule

Question 17: Please choose the option that best describes the services and supports for controlling one's own schedule:

G ☐ Individuals are supported to control their own schedules. Services such as bathing and mealtimes are flexible and work around the individual's personal schedule. Requests for engaging in the broader community such as going shopping or to the movies are routinely supported and accommodated. When individuals work, their schedules are supported.

Y ☐ Individuals generally control their own schedules. Services such as mealtimes and bathing are scheduled. If individuals miss a scheduled service activity, such as a bath, meal or laundry, because of their personal schedule, it is not automatically rescheduled or replaced unless the individuals request or otherwise indicate they want the missed service activity.

R ☐ Most activities are scheduled by the provider, including services such as mealtimes and bathing and social and recreation opportunities. If individuals miss a scheduled activity, such as a bath, meal or laundry, because of their personal schedule, it is not replaced, or if replaced, with a lesser quality alternative.

R ☐ There are residential setting/provider limits to the amount of control individuals have over their own schedules.

Question 17a: If you selected "There are residential setting/provider limits to the amount of control individuals have over their own schedule" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 17b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 17b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 17b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 17b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 4: Setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

Freedom from Coercion

Question 18: Are individuals free from coercion as defined below?

G ☐ Yes

R ☐ No

i. Threats of serious harm to or physical restraint against any person;
ii. Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
iii. The abuse or threatened abuse of the legal process.

Question 19: Do the provider/staff utilize any of the following restraints on individuals receiving services in this residential setting to address or control behavior?

R ☐ Yes

G ☐ No

- Chemical restraints
- Mechanical restraints, such as devices that limit an individual's ability to freely move their body, **not part of the person's formal behavior support plan**
- Physical restraints, such as using a physical maneuver to limit an individual's ability to freely move, where the maneuver is weight-bearing and/or **not part of the person's formal behavior support plan**
- Seclusion, such as restricting an individual to a specific physical space as a means of controlling behavior or in response to a behavior

Communication

Question 20: Please choose the option that best describes the services and supports for communication:

G ☐ There are no residential setting/provider limitations to the individual's ability to communicate within the residential setting or with those outside of the setting. If the individual needs a phone or other accommodations or other communication tool, they are provided one and a private space from which to hold conversations. Individuals can access the phone independently at any time and will be supported, if needed. Inside the residential setting, individuals are encouraged and supported to raise and discuss issues or concerns without fear of retaliation.

Y ☐ There are shared modes of communication made available by the residential setting/provider. There may be reasonable waiting periods if others are using the "house" phone or individuals may need the provider's support to access to the phone. They do not need permission to access the phone. Inside the residential setting, individuals may raise and discuss issues or concerns without fear of retaliation.

R ☐ The ability to communicate privately within and to those on the outside of the residential setting is limited.

Question 20a: If you selected "The ability to communicate privately within and to those on the outside of the residential setting is limited" above, are **the limits universally applied to everyone living in the residential setting?**

R ☐ Yes

G ☐ No

Question 20b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 20b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 20b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 20b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Homelike Accommodations

Question 21: Please choose the option that best describes the services and supports for homelike accommodations:

G ☐ Individuals have full access to typical homelike accommodations such as a kitchen, dining area, family/living room, laundry, and bathroom.

Y ☐ Individuals have full access to most typical homelike accommodations but may share bathrooms and not have access to the full (commercial) kitchen, in a larger facility. Individuals are offered substitute equipment and a means to cook.

R ☐ There are residential setting/provider limits to full access to typical homelike accommodations.

Question 21a: If you selected "There are residential setting/provider limits to full access to typical homelike accommodations" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 21ba: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 21b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 21b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 21b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 5: Personal Privacy

Question 22: Please choose the option that best describes the services and supports for personal privacy:

G ☐ All individuals may lock their bedroom and living unit doors. Door locks are single-action which means when the individual turns the handle or lever the door unlocks. All individuals have bathroom facilities that allow for complete privacy through the ability to lock the door or stall. Bathing areas are private and individuals are shielded or protected from others walking in on them. Only appropriate staff have keys.

G ☐ All individuals may lock their bedroom or living unit doors for privacy. Door locks are single-action which means when the individual turns the handle or lever the door unlocks. Bathrooms may be used by others and individuals may need additional support to obtain privacy, such as assistance to get from a wheelchair into the bathroom, in order to be able to shut the door for privacy. Only appropriate staff have keys.

R ☐ Doors are not lockable but privacy is assured through knocking before entering an individual's bedroom, living unit, or bathroom.

R ☐ There are residential setting/provider limits on an individual's ability to have personal privacy.

Question 22a: If you selected "There are residential setting/provider limits on an individual's ability to have personal privacy" above, are **the limits universally applied to everyone living in the residential setting?**

R ☐ Yes

G ☐ No

Question 22b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 22b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 22b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 22b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 6: Choice of Roommates/Sharing Space

Question 23: Please choose the option that best describes the services and supports individuals have in their choice of roommates and sharing space:

G ☐ This facility only offers private rooms.

G ☐ There are shared bedrooms or living units. There are methods in place for individuals to seek a new roommate should they desire. Individuals have the opportunity to meet new potential roommates and have input in the selection of their roommate.

R ☐ There are shared bedroom or living units in the facility. There are residential setting/provider limits regarding the individual's involvement in the selection of roommates or their ability to have input in the choice of roommates.

Question 23a: If you selected "There are shared bedroom or living units in the facility. There are residential setting/provider limits regarding the individual's involvement in the selection of roommates or their ability to have input in the choice of roommates" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 23b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 23b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 23b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 23b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 7: Freedom to Furnish and Decorate

Question 24: Please choose the option that best describes the services and supports to individuals regarding furnishing and decorating:

G ☐ Individuals may bring their own furnishings and are supported and encouraged to personalize their space. Individuals may paint or secure pictures to walls or use accessories, as needed. There may be landlord/tenant type agreements regarding approval of painting, nails or holes in walls, but individual experience is that obtaining necessary permissions is reasonable and does not inhibit their personal style or ability to decorate.

Y ☐ Individuals may bring their own furnishings. Decorating is not encouraged or discouraged. There may be landlord/tenant type agreements regarding approval of nails or holes in walls. Substantial changes, such as painting, may not be allowed.

R ☐ There are residential setting/provider limits on an individual's ability to furnish and decorate.

Question 24a: If you selected "There are residential setting/provider limits on an individual's ability to furnish and decorate" above, are **the limits universally applied to everyone living in the residential setting?**

R ☐ Yes

G ☐ No

Question 24b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 24b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 24b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 24b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 8: The individual can have access to food at any time

Question 25: Please choose the option that best describes the services and supports to individuals regarding access to food.

G ☐ Individuals are provided three nutritious meals and two snacks a day. Individuals may assist with menu planning and personal preferences are considered. If an individual misses a meal, alternatives such as a to-go sack meal or heatable meals, are available Individuals have access to personal food storage, including refrigeration, freezer, and dry storage, that they can access at any time.

Y ☐ Individuals are provided three nutritious meals and two snacks a day. Individuals may assist with menu planning and personal preferences are considered. If an individual misses a meal it is typically not replaced unless requested. Storing personal food items is not encouraged, but is allowed if requested.

R ☐ There are limits in place regarding access to food at any time.

Question 25a: If you selected "There are limits in place regarding access to food at any time" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 25b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 25b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 25b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 25b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Section 9: The individual can have visitors at any time

Question 26: Please choose the option that best describes the services and supports to individuals regarding having visitors.

G ☐ Individuals may have visitors at any time. Individuals living in the site understand there are no residential setting/provider limits to the time when visitors may be received. Individuals are encouraged and supported to have visitors.

G ☐ Individuals may have visitors at any time. The residential setting/provider may have policies in place for after-hours visitors or a check-in process to address safety or privacy concerns.

R ☐ There are residential setting/provider limits to individuals having visitors at any time.

Question 26a: If you selected "There are residential setting/provider limits to individuals having visitors at any time" above, are the limits universally applied to everyone living in the residential setting?

R ☐ Yes

G ☐ No

Question 26b: Are the limits only applied to those who need them?

G ☐ Yes

R ☐ No

Question 26b(i): If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits?

G ☐ Yes

R ☐ No

Question 26b(ii): If limits are used, are the limitations identified in the individual's person-centered service plan?

G ☐ Yes

R ☐ No

Question 26b(iii): If limits are used, they are primarily used to (select the best answer):

G ☐ Protect the individual or others

R ☐ Efficiently manage operations

Question 27: Is there any other information that you as a provider of community-based services would like to provide?

Congratulations! You have completed the Provider Self-Assessment Survey.

Survey ID# [Survey_ID]

1. **Date_____**
2. **Name of Child Living in the Setting: [FirstName LastName]**
3. **Age of Child Living in the Setting_____**
4. **Residential Setting Name_____**
5. **Residential Setting Address_____**

   _____

Please choose one of the following to describe how the survey is being completed:

6. **I am the child or youth living in the setting and I am completing the survey with assistance from someone.**
7. **Best description of the role of the person helping me :**

   ☐ Legal Representative ☐ Not Applicable

   ☐ Survey Hotline/Peer Advocate ☐ Family Member/Friend

   ☐ Other; Explain_____

8. **Reason somebody is helping me:**

   ☐ I require assistance ☐ I requested assistance

   ☐ Other; Explain_____

9. **Name of person helping me_____**
10. ☐ **I am the child or youth living in the setting and I am completing the survey on my own without assistance from someone.**
11. ☐ **I am the legal representative for the child living in the setting and I am completing the survey on the child's behalf.**
12. **Type of legal representative:** ☐ Parent with legal custody ☐ Legal guardian
13. **Name of person completing the survey for me_____**

Please complete the survey questions from the perspective of the child who is receiving services in a residential (group home or foster home) setting.

Section 1: Where I live supports access to the broader community

14. Please choose the description that best describes how the location of the home where the child receives services supports access to the community:

Pick the best answer:

☐ Where I live makes it **EASY** for me to be part of the community where I am located.

☐ Where I live makes it **HARD** for me to be part of the community where I am located.

Where I live makes it easy for me to:

15. Participate in community activities

☐ Always ☐ Usually ☐ Sometimes ☐ Never

16. Go places in the community

☐ Always ☐ Usually ☐ Sometimes ☐ Never

17. Obtain work-related experience (such as summer or after school work, volunteer work, etc.) or get a job in the community:

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I am working on other things right now and do not wish to work or obtain work experience at this time.

☐ N/A- I am too young to work or gain work-related experience right now.

Section 2: I am supported where I live to be part of the community

18. I have regular opportunities be part of the broader community. The following are some examples that help explain what this means: getting work experience in the community; participating in extracurricular activities; going to the park, the library, or church; shopping for food, clothing or other items; going to the gym or an exercise class; going out for ice cream; going to the movies, fairs, rodeos, or other community events.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 3: Choosing where I live

19. Before I moved to where I live now, I (or my parent or guardian) was told about or able to visit other places to live.

☐ Yes ☐ No

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was told about other options)

20. Before moving to where I live now, I (or my parent or guardian) was offered different choices of where I could live. One of the choices was a service setting where not all people experience disabilities; this choice may have included the option for me to receive services in my family home.

☐ Yes ☐ No

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was told about other options)

21. If I have a shared bedroom, I (or my parent or guardian) was offered a choice of a home for me that offered a private bedroom.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

☐ I don't know (I am a youth completing the survey and I don't know if my guardian was offered the choice of a home with a private bedroom)

22. My guardian has a say in who I share my bedroom with.

☐ Yes ☐ No ☐ Not applicable - I am in a private room

☐ I don't know (I am a youth completing the survey and I don't know if my guardian has a say in who is share my bedroom with)

23. I got to visit the home where I live now and meet members of the household before I moved in.

☐ Yes ☐ No

Section 4: Where I live supports my independence and making life choices

Work or Work Experience

24. My provider/setting supports me with my daily needs in order for me to work or obtain work-related experience.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

☐ I am working on other things right now and do not wish to work or obtain work-related experience at this time.

☐ N/A- I am too young to work or gain work-related experience right now.

Personal Finances (Resources)

25. I have a say in how I spend my personal funds.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

26. I get support to manage my money so I can buy the things I want.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 5: I am supported where I live to participate in creating my own schedule

27. I have an active role in planning my own schedule. I am supported in choosing preferred activities and my provider helps me to plan my day so that I can do things I like while also planning for necessary things like school, physical activity, and sleep.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 6: Where I live ensures my rights of privacy, dignity and respect, and freedom from coercion (strong-arm) and restraint

Coercion

28. Where I live now, my provider/staff has never used physical force or physical punishment, or threats to make me do something I don't want to do.

☐ True – I **HAVE NOT** been forced to make decisions against my will

☐ False – I **HAVE** been forced to make decisions against my will

Restraint

29. Where I live now, I have never been forced to take a medication as a consequence of my behavior.

☐ True – I **HAVE NOT** been forced to take medication as a consequence of my behavior against my will.

☐ False - I **HAVE** been forced to take medication as a consequence of my behavior against my will.

30. Where I live now, I have never been tied down to control my behavior against my will.

☐ True – I **HAVE NOT** been tied down to control my behavior against my will.

☐ False - I **HAVE** been tied down to control my behavior against my will.

31. Where I live now, I have never been held down by a person or object to control my behavior against my will.

☐ True – I **HAVE NOT** been held down to control my behavior against my will.

☐ False - I **HAVE** been held down to control my behavior against my will.

32. Where I live now, I have never been kept away from others in a confined space or locked in a room as punishment against my will.

☐ True – I **HAVE NOT** been kept or locked in a room as punishment against my will

☐ False - I **HAVE** been kept or locked in a room as punishment against my will

Communication

33. I feel free to openly discuss any of my concerns with my provider/staff.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

34. I have access to a phone or to other methods of communicating with others outside of where I live. My provider allows me to talk to my guardian (or my attorney or CASA, if I have one) at any time.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Access in all areas of the home where I live

35. I can be in the following areas of my home: kitchen; dining room; living/family room; bedroom; and bathroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 7: Staff where I live respect my personal privacy

36. I have privacy in my bedroom and opportunity for private time if I desire it. Staff and other household members knock before entering my room.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

37. I have privacy when I use the bathroom. I may have assistance when using the bathroom, but people do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

38. I have privacy when I take a shower or bath. I may have assistance when showering or bathing, but people do not walk in on me without my permission.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 8: Where I live allows me to decorate and furnish my bedroom or living unit

39. I have a say in how I decorate my bedroom.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

40. I may furnish my bedroom with my own furniture.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 9: Where I live allows me to have access to food at any time

41. My provider serves some of my favorite foods and I am offered healthy alternatives if I don't like something that is being served.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

42. In addition to the meals and snacks provided to me by my provider, I have access to snacks and have the option of purchasing my favorite foods.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Section 10: Where I live allows me to have visitors at any time

43. My provider, guardian, and ISP team work together to support me in having visits with friends.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

44. My provider is supportive of visits with my family (except where limited by a court order) and I feel like my family is welcome in the home where I live.

☐ Always ☐ Usually ☐ Sometimes ☐ Never

You have completed the survey questions for where you live.

We would now like to ask some questions about services you might get outside of where you live. Not everyone has these services and that is ok. Please answer the questions that are applicable to you

Section 11: Services outside of where I live

45. I work or use employment services outside of where I live.

☐ Yes ☐ No

☐ N/A- I am too young to work or gain work-related experience right now.

46. If yes: I work or use employment services in a typical community setting where my coworkers come from a variety of different backgrounds and do not necessarily have disabilities (not including paid support staff): ☐ Yes ☐ No

47. I work or use employment services in a setting where most of my coworkers are people who also have some type of disability: ☐ Yes ☐ No

48. If yes: I had an option to work or use services in a place where I could meet and form relationships with people from a variety of different backgrounds, and not only with other people who have disabilities: ☐ Yes ☐ No

49. I am paid for my work: ☐ Yes ☐ No

50. If yes: I am paid minimum wage or better: ☐ Yes ☐ No

51. I would like to work more hours now or in the future: ☐ Yes ☐ No

52. I would like to be able to have a job where I could make more money now or in the future:

☐ Yes ☐ No

53. Is there any other information that you would like to share about where you live or receive services?

Thank you for completing this survey.

Survey ID#: [insert Survey_ID]

Home and Community-Based Services Setting Provider Self-Assessment Survey for Children's Residential Settings (Foster Care and Group Homes)

1. **Date**_____
2. **Provider Name**_____
3. **Person completing Survey and Title/Position**_____

   _____
4. **Medicaid Provider Number**_____
5. **Type of License or Certification**_____
6. **Licensing or Certification Agency (check one):**

   ☐ DD ☐ Child Welfare ☐ Other: _____
7. **Primary Population(s) Served**_____
8. **Physical Address of Service Site**_____

   _____
9. **Number of individuals in the home receiving Medicaid HCBS**_____
10. **Total number of persons residing in the household**_____
11. **Mailing Address (if different from above)**_____

    _____
12. **Phone**_____
13. **Email**_____
14. **Total number of sites you will be completing surveys on**_____

Section 1: The residential setting is integrated and supports full access to the greater community and does not isolate individuals

15. **Part A:** Please choose the option that best describes the group home or foster home.

☐ Individuals are supported in having full access to the community. The home does not specialize in, nor does the provider target, a specific disability or diagnosis type. There may be a mix of people with and without disabilities living in the home. The home may have a mix of residents receiving Medicaid funded services and others who do not. Individuals are supported in obtaining services outside of the home in the broader community in addition to the care they receive in the home. The home encourages opportunities to work or seek work related experience (on the same basis as people who are the same age and do not have a disability). Other off-site services may include school services, community activities, gym, medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ Individuals receive some services in the home and other services in the broader community. Onsite and off-site services may include school services, community activities gym, work or work related experience (on the same basis as people who are the same age and do not have a disability), medical care, behavioral and therapeutic services, and/or social recreational activities.

☐ The home is designed for people with disabilities and often for people with a certain type of disability. The individuals in the home are primarily or exclusively people with disabilities and on-site staff provides many of the services. Individuals have regular opportunities to engage in the broader community. However, the home setting does not encourage opportunities to work or obtain work related experience (on the same basis as people who are the same age and do not have a disability).

☐ The home is designed for individuals with disabilities to receive multiple types of services on-site or in the home, including housing, school services, medical, behavioral and therapeutic services, and/or social and recreational activities and people in the home have limited, if any, interaction with the broader community. The home setting does not encourage opportunities to work or obtain related experience (on the same basis as people who are the same age and do not have a disability).

Part B: Indicate if any of the following apply:

16. The residential setting is a locked facility. ☐ Yes ☐ No

17. The residential setting is one of the following: ☐ Yes ☐ No

- Farmstead or disability specific farm community located in rural residential setting on a large parcel of land with little ability to access the broader community outside of the farm.
- Gated/secured "community" for people with disabilities where services are provided on-site and individuals rarely leave the gated community.
- Residential school where individuals receive both education and residential services in one setting and do not go into the broader community for education.
- Multiple residential settings co-located and operationally related (operated by the same provider) where services are provided on campus with individuals rarely accessing the broader community.

Section 2: Optimizes autonomy and independence in making life choices

Work or Work Experience

18. Please choose the option that best describes the residential service setting provider's role related to services and supports for work or work-related experiences:

☐ The home/provider encourages opportunities for individuals to obtain work or work-related experience. Individuals who would like to work are either working or obtaining some type of work related experience. Individuals who live in this home have supports from the provider to plan for or otherwise meet daily needs required to maintain work or a work experience. Individuals who live in this home, including those who are not working, are regularly encouraged throughout the year to discuss work or career goals.

☐ The home/provider encourages opportunities for individuals to obtain work or work related experience on the same basis as people who are the same age and do not have a disability. Individuals who may be focused on school right now will be encouraged to pursue work and work related experiences in the future. Individual have opportunities to talk about work or career goals.

☐ The home /provider supports individuals in getting ready for school and/or work each day, but does not necessarily encourage individuals to seek work or work-related experience on the same basis as people who are the same age and do not have disabilities. Work or career goals are rarely talked about.

☐ Individuals are not encouraged or emotionally supported by the provider to work or obtain work experience. Work or career goals are rarely or never talked about, and likely will not be discussed in the future.

☐ All individuals in the home are focused on school right now or are not yet of school age. Individuals in the home are encouraged to discuss future plans and career goals that include work in an integrated setting.

Personal Finances (Resources)

19. Please choose the option that best describes the services and supports for personal resources:

☐Individuals may or may not have a Social Security designated Representative Payee. Individual may or may not be beneficiaries of a Special Needs Trust or Discretionary Trust. The existence of one of these is not considered a limitation by the residential setting/provider.

☐The home /provider places no limitations to an individual's, or their designated representatives', ability to access personal financial resources (personal spending monies, personal property, real estate, assets, savings, etc.). Personal resources may be safeguarded but individuals have easy access to, experience no barriers, and are supported in obtaining and using personal resources as desired.

☐There may be some limitations based on the safeguarding of personal resources. The provider assists individuals in budgeting and managing funds, however, the individual self-directs and is engaged in the process as much as possible. The individual's financial plan is addressed in the ISP and the provider supports the individual in meeting identified goals.

☐ Limitations beyond age appropriate structure and guidance are placed on an individual's, or their designated representatives', access to personal resources.

20. If you selected "Limitations beyond age appropriate structure and guidance are placed on an individual's, or their designated representatives', access to personal resources" above, are the limits universally applied to everyone living in the home?

☐Yes ☐No

21. Are the limits only applied to those who need them? ☐Yes ☐No

22. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

23. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

24. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

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Section 3: The individual controls his/her own schedule

25. Please choose the option that best describes the services and supports for controlling one's own schedule:

☐Individuals are supported to control their own schedules in an age appropriate manner as much as possible. The provider engages with the individual to promote self-direction and honor individual preferences related to routine and activities. Routine activities such as bathing and mealtimes are flexible and work around the individual's personal schedule. Requests for engaging in the broader community such as participating in extracurricular school activities, working or participating in work-related experiences, going shopping, to the library, or to the park are routinely supported and accommodated. When individuals work, their schedules are supported. Children in the home are encouraged to participate in extra-curricular activities such as school or community sporting programs or clubs.

☐Individuals are an active part of directing or creating their personal schedules. The preferences of the individual are honored whenever possible. The provider helps the individual identify preferred activities and activity times, while also supporting the individual in addressing necessary components of their daily routine such as school attendance, exercise, and adequate rest. Routine activities in the household and general scheduling is flexible and is adjusted based on who lives in the home and what is important to members of the household.

☐ Most activities are scheduled by the provider, including daily living activities such as mealtimes, bathing, and social and recreation opportunities. The provider seeks little input from the individual in scheduling activities. The household operates by a routine schedule that has little flexibility and little variation, even when the household composition changes.

☐ There are home/provider limits to the amount of control individuals have over their own schedules.

26. If you selected "There are home/provider limits to the amount of control individuals have over their own schedule" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

27. Are the limits only applied to those who need them? ☐Yes ☐No

28. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

29. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

30. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

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Section 4: Setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint

Freedom from Coercion

31. Are individuals free from coercion as defined below? ☐Yes ☐No

- Threats of serious harm to or physical restraint against any person;
- Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
- The abuse or threatened abuse of the legal process.

32. Do the provider/staff utilize any of the following restraints on individuals receiving services in this home to address and control behavior? ☐Yes ☐No

- Chemical restraints, such as the forced administration of a medication as a controlling or punitive response to a behavioral episode.
- Mechanical restraints, such as devices that limit an individual's ability to freely move their body, not part of the person's formal behavior support plan
- Physical restraints, such as using a physical maneuver to limit an individual's ability to freely move, where the maneuver is weight-bearing and/or not part of the person's formal behavior support plan
- Seclusion, such as restricting an individual to a specific physical space as a punitive response to a behavior

Communication

33. Please choose the option that best describes the services and supports for communication:

☐ Individuals are encouraged and supported to communicate within the home and with others outside of the home. Individuals are afforded privacy in communication as safe and appropriate to their chronological age. Individuals may have access to the phone or other methods of communication with assistance or oversight from the provider. Individuals have privacy in communication with their parents or legal guardian, except where restricted by a court order. Where applicable, individuals have privacy in communication with their Child Welfare caseworker, attorney, and/or CASA.

☐ Individuals are encouraged and supported to communication with others in the home and in the community. Access to the phone or other modes of communication may be made with the provider's permission, or in accordance with the individual's ISP. There may be legal orders that direct the types of communication and level of supervision or access an individual may have.

☐The ability to communicate privately within the home and with others outside of the home is limited.

34. If you selected "The ability to communicate privately within the home and with others outside of the home is limited" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

35. Are the limits only applied to those who need them? ☐Yes ☐No

36. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

37. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

38. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Homelike Accommodations

39. Please choose the option that best describes the services and supports for homelike accommodations:

☐ Individuals have access to typical homelike accommodations such as a kitchen, dining area, family/living room, laundry, and bathroom appropriate to the chronological age of the individual.

☐ Individuals have full access to most typical homelike accommodations, however, providers may modify access to address safety incidental to the provision of daily living activities.

☐ There are home/provider limits beyond age appropriate structure and guidance to full access to typical homelike accommodations.

40. If you selected "There are home/provider limits beyond age appropriate structure and guidance to full access to typical homelike accommodations" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

41. Are the limits only applied to those who need them? ☐Yes ☐No

42. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

43. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

44. If limits are used, they are primarily used to (select the best answer):

☐Protect the individual or others ☐Efficiently manage operations

Section 5: Personal Privacy

45. Please choose the option that best describes the services and supports for personal privacy:

☐ Individuals have the opportunity to have privacy or private time in their bedroom, including the ability to close the door, should they desire it. Individuals have privacy when using the bathroom. Individuals are able to close the bathroom door and are shielded or protected from others walking in on them when using the toilet or bathing. Staff/caregivers are present in the bathroom or during private time only when necessary to provide required assistance or to address safety. Staff and other members of the household knock and wait to receive permission before entering a closed room.

☐ There are home/provider limits beyond age appropriate structure and guidance on an individual's ability to have personal privacy.

46. If you selected "There are home/provider limits on an individual's ability to have personal privacy" above, are the limits universally applied to everyone living in the home? ☐Yes ☐No

47. Are the limits only applied to those who need them? ☐Yes ☐No

48. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐Yes ☐No

49. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐Yes ☐No

50. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 6: Choice of Roommates

51. Please choose the option that best describes the services and supports individuals and/or their guardians have in the choice of roommates in a shared bedroom situation:

☐ This home only offers private rooms.

☐ There are shared bedrooms in the home. The individual's legal guardian has consented to and supports the individual having a shared bedroom. There are methods in place for guardians to request a change in roommate or shared room situation should this be desired. Individuals and their guardians have the opportunity to meet new potential shared bedroom roommates and have input in the selection of their shared bedroom roommate.

☐ There are shared bedrooms in the home. There are provider limits regarding the individual's and their guardian's involvement in the selection of shared bedroom roommates or their ability to have input in the choice of shared bedroom roommates.

52. If you selected "There are shared bedrooms in the home. There are provider limits regarding the individual's and their guardian's involvement in the selection of shared bedroom roommates or their ability to have input in the choice of shared bedroom roommates" above, are the limits universally applied to everyone living in the home?

☐ Yes ☐ No

53. Are the limits only applied to those who need them? ☐ Yes ☐ No

54. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

55. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

56. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 7: Freedom to Furnish and Decorate

57. Please choose the option that best describes the services and supports to individuals regarding furnishing and decorating:

☐ Individuals may bring their own furnishings and are supported and encouraged to personalize their space. Individuals are encouraged to have age appropriate décor that reflects their personal style. The provider may provide guidance to the individual to address safety and family-friendly considerations.

☐ The home provider limits an individual's ability to furnish and decorate.

58. If you selected "The home provider limits an individual's ability to furnish and decorate" above, are the limits universally applied to everyone living in the home?

☐ Yes ☐ No

59. Are the limits only applied to those who need them? ☐ Yes ☐ No

60. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

61. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

62. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

Section 8: The individual can have access to food at any time

63. Please choose the option that best describes the services and supports to individuals regarding access to food.

☐ Individuals are provided three nutritious meals and two snacks a day. Individuals are encouraged to participate in menu planning, and cultural and personal preferences of the individual are honored. The individual may participate in grocery shopping, selection of meal options, and routinely have an opportunity to have favorite foods. Mealtimes offer some choice in food options and individuals are not required or expected to eat foods they do not like. If an individual misses a meal, alternatives such as a to-go sack meal or heatable meals, are available upon return.

☐ Individuals are provided three nutritious meals and two snacks a day. The provider seeks little input from the individual related to menu planning. Individual preferences or favorite foods are rarely served and alternative options for meals are not offered.

☐ There are limits beyond age appropriate structure and guidance in place regarding access to food at any time.

64. If you selected "There are limits beyond age appropriate structure and guidance in place regarding access to food at any time" above, are the limits universally applied to everyone living in the residential setting? ☐ Yes ☐ No

65. Are the limits only applied to those who need them? ☐ Yes ☐ No

66. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

67. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

68. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

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Section 9: The individual can have visitors at any time

69. Please choose the option that best describes the services and supports to individuals regarding having visitors.

☐ Individuals are encouraged to have visitors in the home. Legal guardians and family members have access to the individual at any time (except where limited by a court order). The provider works with the individual in identifying opportunities to have visitors and planning for social opportunities.

☐ Individuals are not necessarily encouraged to have visitors in the home. When an individual desires to have visitors, they are encouraged to meet with friends or family outside of the home, rather than hosting guests at the residence.

☐ There are residential setting/provider limits beyond age appropriate structure and guidance to individuals having visitors at any time.

70. If you selected "There are residential setting/provider limits beyond age appropriate structure and guidance to individuals having visitors at any time" above, are the limits universally applied to everyone living in the residential setting?

☐ Yes ☐ No

71. Are the limits only applied to those who need them? ☐ Yes ☐ No

72. If you answered yes to the above, is there documentation of less restrictive alternatives tried before applying limits? ☐ Yes ☐ No

73. If limits are used, are the limitations identified in the individual's person-centered service plan? ☐ Yes ☐ No

74. If limits are used, they are primarily used to (select the best answer):

☐ Protect the individual or others ☐ Efficiently manage operations

---

Is there any other information that you as a provider of community-based services would like to provide?

Thank you for completing the Provider Self-Assessment Survey

APPENDIX C. RED FLAG / HIGH SCRUTINY QUESTIONS

Adult Consumer questions indicated as "Red Flag" / "High Scrutiny"

QuestionID	Question
Q21	21. Support in managing money
Q22	22. Easy to access/spend money
Q24	24. Forced to make decisions against my will
Q25	25. Given medication against my will
Q26	26. Held or tied down by person or object
Q27	27. Kept or locked in a room against my will
Q28	28. Free to discuss concerns with provider/staff
Q29	29. Access to communicate with others outside anytime I want.

Adult Provider questions indicated as "Red Flag" / "High Scrutiny"

QuestionID	Question
Q14	14. Locked Facility
Q15	15. Self-contained campus
Q18	18. Personal Finances: Limits applied universally
Q19	19. Personal Finances: Limits only as needed
Q20	20. Personal Finances: Documentation of alternatives
Q21	21. Personal Finances: Identified in ISP
Q22	22. Personal Finances: Purpose of limits
Q24	24. Control of Schedule: Limits applied universally
Q25	25. Control of Schedule: Limits only as needed
Q26	26. Control of Schedule: Documentation of alternatives
Q27	27. Control of Schedule: Identified in ISP
Q28	28. Control of Schedule: Purpose of limits
Q29	29. Freedom from coercion
Q30	30. Use of restraints/seclusion
Q31	31. Communication: Services/Support
Q32	32. Communication: Limits applied universally
Q33	33. Communication: Limits only as needed
Q34	34. Communication: Documentation of alternatives
Q35	35. Communication: Identified in ISP
Q36	36. Communication: Purpose of limits
Q38	38. Homelike Accomodations: Limits applied universally
Q39	39. Homelike Accomodations: Limits only as needed
Q40	40. Homelike Accomodations: Documentation of alternatives
Q41	41. Homelike Accomodations: Identified in ISP
Q42	42. Homelike Accomodations: Purpose of limits
Q44	44. Personal Privacy: Limits applied universally
Q45	45. Personal Privacy: Limits only as needed
Q46	46. Personal Privacy: Documentation of alternatives
Q47	47. Personal Privacy: Identified in ISP
Q48	48. Personal Privacy: Purpose of limits
Q50	50. Roommates/Sharing Space: Limits applied universally

Q51	51. Roommates/Sharing Space: Limits only as needed
Q52	52. Roommates/Sharing Space: Documentation of alternatives
Q53	53. Roommates/Sharing Space: Identified in ISP
Q54	54. Roommates/Sharing Space: Purpose of limits
Q56	56. Freedom to Furnish/Decorate: Limits applied universally
Q57	57. Freedom to Furnish/Decorate: Limits only as needed
Q58	58. Freedom to Furnish/Decorate: Documentation of alternatives
Q59	59. Freedom to Furnish/Decorate: Identified in ISP
Q60	60. Freedom to Furnish/Decorate: Purpose of limits
Q62	62. Access to Food: Limits applied universally
Q63	63. Access to Food: Limits only as needed
Q64	64. Access to Food: Documentation of alternatives
Q65	65. Access to Food: Identified in ISP
Q66	66. Access to Food: Purpose of limits
Q68	68. Visitors: Limits applied universally
Q69	69. Visitors: Limits only as needed
Q70	70. Visitors: Documentation of alternatives
Q71	71. Visitors: Identified in ISP
Q72	72. Visitors: Purpose of limits

Youth Consumer questions indicated as "Red Flag" / "High Scrutiny"

QuestionID	Question
Q25	25. I have say in how I spend my personal funds.
Q26	26. Receive support to manages/spend my money
Q28	28. Forced to make decisions against my will
Q29	29. Given medication against my will
Q30	30. Tied down against my will
Q31	31. Held down by person or object against my will
Q32	32. Isolated from others or locked in a room against my will
Q33	33. Free to discuss concerns with provider/staff
Q34	34. Access to communicate with others outside anytime I want.

Youth Provider questions indicated as "Red Flag" / "High Scrutiny"

QuestionID	Question
Q16	16. Locked Facility
Q17	17. Self-contained campus
Q20	20. Personal Finances: Limits applied universally
Q21	21. Personal Finances: Limits only as needed
Q22	22. Personal Finances: Documentation of alternatives
Q23	23. Personal Finances: Identified in ISP
Q24	24. Personal Finances: Purpose of limits
Q26	26. Control of Schedule: Limits applied universally
Q27	27. Control of Schedule: Limits only as needed
Q28	28. Control of Schedule: Documentation of alternatives
Q29	29. Control of Schedule: Identified in ISP
Q30	30. Control of Schedule: Purpose of limits
Q31	31. Freedom from coercion
Q32	32. Use of restraints/seclusion
Q33	33. Communication: Services/Support
Q34	34. Communication: Limits applied universally
Q35	35. Communication: Limits only as needed
Q36	36. Communication: Documentation of alternatives
Q37	37. Communication: Identified in ISP
Q38	38. Communication: Purpose of limits
Q40	40. Homelike Accomodations: Limits applied universally
Q41	41. Homelike Accomodations: Limits only as needed
Q42	42. Homelike Accomodations: Documentation of alternatives
Q43	43. Homelike Accomodations: Identified in ISP
Q44	44. Homelike Accomodations: Purpose of limits
Q46	46. Personal Privacy: Limits applied universally
Q47	47. Personal Privacy: Limits only as needed
Q48	48. Personal Privacy: Documentation of alternatives
Q49	49. Personal Privacy: Identified in ISP
Q50	50. Personal Privacy: Purpose of limits

Q52	52. Roommates/Sharing Space: Limits applied universally
Q53	53. Roommates/Sharing Space: Limits only as needed
Q54	54. Roommates/Sharing Space: Documentation of alternatives
Q55	55. Roommates/Sharing Space: Identified in ISP
Q56	56. Roommates/Sharing Space: Purpose of limits
Q58	58. Freedom to Furnish/Decorate: Limits applied universally
Q59	59. Freedom to Furnish/Decorate: Limits only as needed
Q60	60. Freedom to Furnish/Decorate: Documentation of alternatives
Q61	61. Freedom to Furnish/Decorate: Identified in ISP
Q62	62. Freedom to Furnish/Decorate: Purpose of limits
Q64	64. Access to Food: Limits applied universally
Q65	65. Access to Food: Limits only as needed
Q66	66. Access to Food: Documentation of alternatives
Q67	67. Access to Food: Identified in ISP
Q68	68. Access to Food: Purpose of limits
Q70	70. Visitors: Limits applied universally
Q71	71. Visitors: Limits only as needed
Q72	72. Visitors: Documentation of alternatives
Q73	73. Visitors: Identified in ISP
Q74	74. Visitors: Purpose of limits

2016 Oregon Mental Health Statistics Improvement Program Survey for Adults – Outpatient and Residential Report

Oregon Health Authority

March 2017

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2016 Oregon Mental Health Statistics Improvement Program Survey for Adults – Outpatient and Residential

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Table of Contents

EXECUTIVE SUMMARY 1
INTRODUCTION 9
METHODOLOGY 10
Survey Respondent Population 10
Survey Mailings 11
Survey Questionnaire 12
Domain Scoring Analysis 13
SURVEY RESPONSES 15
OVERALL SURVEY RESULTS 16
Overall Domain Satisfaction 16
Domain Scores by Treatment Setting 18
OUTPATIENT SURVEY RESULTS 20
Respondent Race and Ethnicity 22
Domain Satisfaction 24
Domain Satisfaction by Response Method 25
Domain Satisfaction by CCO 25
Demographic Comparisons 27
Analysis of State-Added Questions 40
Mental health treatment status 40
Service coordination 42
Service expectations and results 44
Primary care and overall health 46
Assistance by mental health provider 48
Arrest history 55
Alcohol and drug use 56
Trauma 58
Residence 59
RESIDENTIAL SURVEY RESULTS 61
Domain Satisfaction 62
Analysis of State-Added Questions 63
Service coordination 63
Treatment expectations and results 65

Primary care and overall health 67
Housing 70
Employment 71
Assistance with mental health crisis 72
Current employment status and income source 72
Arrest history 74
Alcohol and drug use 75
Trauma 77
Residence 78
Living in residential care 79
Independent living 84
DISCUSSION AND RECOMMENDATIONS 85
Overall Survey Results 85
Survey Limitations 85
Recommendations 86
APPENDIX A A-1
Survey Data Security and Quality Assurance Procedures A-1
Data Analysis Decisions A-1
APPENDIX B - MHSIP SURVEY FORMS B-2

Index of Tables and Figures

Table 1. Survey Response Rate by Treatment Setting 15
Table 2. Outpatient Survey Response Rate by Gender, Age, Race, and Rural/Urban Residence 20
Table 3. Survey Response Rate by CCO (Outpatient Respondents) 21
Table 4. Outpatient Domain Satisfaction by CCO, with 95% Confidence Intervals 26
Table 5. Domain Satisfaction by Race, 2016 33
Table 6. Domain Satisfaction by Survey Language, 2016 39
Table 7. Residential Survey Response Rate by Gender, Age, Race, and Rural/Urban Residence. 61
Table 8. Respondents' Residences in the Last 12 Months, 2013–2016: Percentage of Responses.78
Table 9. "Why are you living in a residential facility?" 79
Table 10. Types of Services Received in Residential Care, 2012–2016: Percentage of Responses.83
Table 11. Reasons responders do not feel ready for independent living 84

Figure 1. 2012–2016 Comparison of Domain Satisfaction. 17
Figure 2. Domain Satisfaction by Treatment Setting, with 95% Confidence Intervals 19
Figure 3. Comparison of State-Recorded and Self-Reported Race and Ethnicity Data, by Respondent. 23
Figure 4. Outpatient Survey Domain Scores, 2012–2015 24
Figure 5. 2012–2016 Domain Satisfaction by Gender: Female. 28
Figure 6. 2012–2016 Domain Satisfaction by Gender: Male. 29
Figure 7. 2012–2016 Domain Satisfaction by Residence: Rural. 30
Figure 8. 2012–2016 Domain Satisfaction by Residence: Urban 31
Figure 9. 2012–2016 Domain Satisfaction by Ethnicity: General Satisfaction. 34
Figure 10. 2012–2016 Domain Satisfaction by Ethnicity: Access. 35
Figure 11. 2012–2016 Domain Satisfaction by Ethnicity: Quality/Appropriateness. 35
Figure 12. 2012–2016 Domain Satisfaction by Ethnicity: Treatment Outcomes. 36
Figure 13. 2012–2016 Domain Satisfaction by Ethnicity: Daily Functioning. 36
Figure 14. 2012–2016 Domain Satisfaction by Ethnicity: Social Connectedness. 37
Figure 15. 2012–2016 Domain Satisfaction by Ethnicity: Participation. 37
Figure 16. Mental Health Treatment Status. 41
Figure 17. Satisfaction with Service Coordination. 43

Figure 18. Expectations for Mental Health Services 45
Figure 19. "My physical health provider (checkups, routine medical care and advice) or mental health service provider has talked to me about..." 47
Figure 20. Health Status by Physical Health Care Provider. 48
Figure 21. Provider Assistance with Housing. 49
Figure 22. Provider Assistance with Employment. 50
Figure 23. Respondents' Employment Status 51
Figure 24. Current Source of Income 52
Figure 25. Provider Assistance During Mental Health Crisis. 54
Figure 26. Encounters with Police. 55
Figure 27. Questions Related to Alcohol Use: 2014–2016 Comparison. 56
Figure 28. Questions Related to Drug Use: 2014–2016 Comparison. 57
Figure 29. Trauma Screening, 2013–2016. 58
Figure 30. Respondent's Current Residence, 2012–2016. 59
Figure 31. Respondents' Residences in the Last 12 Months, 2012-2016. 60
Figure 32. Residential Domain Satisfaction, 2012–2016. 62
Figure 33. Satisfaction with Service Coordination. 64
Figure 34. Treatment Expectations and Results. 66
Figure 35. Health Status by Physical Health Care Provider. 67
Figure 36. "My doctor or mental health service provider has talked to me about…" 69
Figure 37. Provider Assistance with Housing, 2013–2016. 70
Figure 38. Provider Assistance with Employment, 2013–2016. 71
Figure 39. Provider Assistance with Mental Health Crisis, 2013–2016. 72
Figure 40. Employment Status 73
Figure 41. Arrest History. 74
Figure 42. Alcohol Use: 2014–2016 Comparison. 75
Figure 43. Drug Use 2014–2016 Comparison. 76
Figure 44. Trauma Screening, 2013–2016. 77
Figure 45. Services Received by Respondents who Have Made Progress in Mental Health. 81
Figure 46. Services received by respondents who have made progress in Activities of Daily Living. (N=173). 82

EXECUTIVE SUMMARY

The Health Systems Division (HSD) of the Oregon Health Authority (OHA) annually surveys adults who have received mental health services through the Oregon Health Plan (OHP). HealthInsight Oregon (formerly Acumentra Health) contracted with OHA to distribute, process, and analyze two surveys: one for adults who had received outpatient services through OHP managed care, and the other for adults in residential treatment or foster care with Medicaid fee-for-service (FFS).

The surveys, based on the national Mental Health Statistics Improvement Program (MHSIP) survey instrument, measure perception of services in seven domains:

- **General Satisfaction**: whether the client would get services at the provider agency again or recommend the agency to a friend or family member
- **Access to Services**: service location, frequency and availability of appointments, and responsiveness of staff
- **Service Quality**: staff sensitivity to client culture, empowerment, consumer-run programs, belief in client's recovery, and client education about rights and medications
- **Daily Functioning**: ability to take care of needs, reduction in symptoms, and participation in meaningful activities
- **Social Connectedness**: friendships, belonging, and social supports
- **Treatment Participation**: client's participation in determining treatment goals and comfort in asking questions
- **Treatment Outcomes**: client's ability to deal with problems and crises, control life, relationships with family, functioning in social situations and school or work, housing, and reduction in symptoms

Both surveys also contained questions added by the state about employment status and income sources, primary care and overall health, problems with alcohol and drugs, trauma history, and respondents' expectations for treatment and the actual results of treatment. The outpatient survey also included items about current residence; arrest history; provider coordination efforts; and provider assistance with housing, job search, and mental health crises. The

residential survey contained questions about services received and progress made while in residential treatment, and about respondents' perception of their readiness for more independent living.

Oregon's 16 coordinated care organizations CCOs manage physical, behavioral, and dental health services for OHP members. Per Oregon's Medicaid demonstration waiver, Oregon must conduct statewide standardized surveys of patients' experience of care (satisfaction) and allow for plan-to-plan comparisons.

The survey results provide OHA-HSD with data to assess enrollees' perceptions of mental health services delivered in outpatient, residential, and adult foster care settings and the impact of those services on their lives. OHA-HSD will use the outpatient and residential survey findings to help guide its ongoing efforts to improve the quality of state-funded mental health services and supports for members. CCOs should use information from all satisfaction surveys (these surveys, as well as Consumer Assessment of Healthcare Providers and Systems [CAHPS], etc.) when assessing the quality and appropriateness of care provided, and incorporate this information into their ongoing care integration efforts.

Survey Results

HealthInsight Oregon mailed the surveys to 10,787 adults who had received mental health services during July–December 2015, including 9,280 adults receiving outpatient services and 1,507 adults in either residential or foster care.

A total of 1,946 adults returned surveys for a response rate of 18%, which is lower than the 2015 response rate (19%). The response rate was highest for the foster care group (22%) and lowest for the residential group (17%).

Highlights of Combined Survey Results

- Percentages of respondent satisfaction in most domains were relatively consistent from 2012 to 2016. The percentage of respondents satisfied in the daily functioning domain has trended significantly upward from 2012 to 2016.
- Outpatient respondents were less satisfied in all domains compared to respondents in foster care, and less satisfied in most domains compared to respondents in psychiatric residential care. The differences were

statistically significant in treatment outcomes, daily functioning, and social connectedness.

Outpatient Survey Results

Response rates

- A total of 1,649 enrollees returned their surveys for a response rate of 18%. This is a decrease from the 2015 rate of 19% and 23% in 2014.
- Most respondents, 1,232 (74.71%), completed the survey by mail, while 417 (25.29%) completed it online, which was notable increase from the 249 (14.5%) in 2015.
- Individuals age 65 and over had the highest response rate at 25%, compared with 19% for the 26–64 age group and 9% for the 18–25 group.

Overall satisfaction

- The percentage of outpatient respondents satisfied with their daily functioning has trended significantly upward from 2012 to 2016.

Satisfaction by demographic groups

- **Age**: Satisfaction among respondents age 65+ has trended significantly downward in treatment outcomes, daily functioning and participation over the last 5 years. For the 26–64 age group, satisfaction with daily functioning trended upward. Satisfaction with treatment outcomes trended downward for the 18–25 age group.
- **Gender**: Over the last five years, satisfaction among male respondents has trended significantly downward in the general satisfaction, access, and quality/appropriateness domains, while satisfaction among female respondents has trended significantly upward in daily functioning.
- **Rural or urban residence**: Satisfaction among both urban and rural residents trended significantly upward in the daily functioning domain over the last five years, while all other domains showed no significant upward or downward trend.

Coordination between mental health provider and other service providers

- Satisfaction was lowest with collaboration between primary mental health providers and employment services (64%); the same category in which the most respondents (21%) said they needed but did not receive this service.
- Over the last four years, the percentage of respondents who needed but did not receive services has shown a statistically significant downward trend in the following areas:
    - Corrections
    - Developmental disabilities
    - Drug and alcohol treatment provider
    - Employment services
    - Physical health provide

Housing

- In 2016, 38% of respondents wanted or needed housing or better housing; of those, 37% found housing or better housing.
- The percentage of respondents who wanted or needed housing or better housing has trended significantly upward in the last five years. At the same time, the percentage of respondents who found housing or better housing has trended significantly downward.
- Of respondents whose provider offered them housing choices, 53% found housing or better housing, compared to 19% whose provider did not offer them choices.

Employment and income sources

- Over the past 5 years, the percentage of respondents who wanted or needed a job or better job has trended significantly upward, from 29% to 48% in 2016. There are corresponding statistically significant upward trends in the percentage of respondents whose service providers tried to help them find a job or a better job (from 26% to 40%), and in the percentage of respondents who found a job or a better job (from 22% to 29%).

- The most common income sources, Supplemental Security Income (26% in 2016) and Social Security Disability Income (21% in 2016), have trended significantly downward over the past five years, while earned employment has trended significantly upward (24% in 2016).

Police encounters

- Most respondents (87%) did not have an encounter with police since starting services. Of those who reported encounters, 55% said they had decreased since starting services.

Alcohol and drug use

- In 2016, 1 in 10 respondents reported that they had a problem with alcohol.
  - Of these, 84% had received the help they wanted or needed.
  - Of those who got help, 84% quit drinking after starting treatment, and 90% quit drinking for at least 3 months.
- In 2016, 8% of respondents though they had a problem with drugs.
  - Of these, 78% got the help they wanted/needed.
  - Of those who received help, 88% quit using drugs after starting treatment, while 94% quit using for at least 3 months.

These results are similar to 2014 and 2015 for both alcohol and drug use.

Trauma-informed care

- When asked if the mental health service provider had asked about any history of trauma when starting treatment, 68% of respondents said "yes," a statistically significant upward trend in the last four years.
- Of those who have experienced trauma, 52% reported that it was adequately addressed during treatment, also a statistically significant upward trend since 2013, when the question was first included in the survey.

Residence in the past 12 months

- A majority (60%) of respondents owned or rented a home or apartment, while 27% lived in someone else's home or apartment.
- There was a statistically significant upward trend in the percentage of respondents who lived in someone else's home or apartment over the last five years, while there was a statistically significant downward trend in the percentage of respondents who resided in a medical hospital, psychiatric hospital, or residential substance abuse treatment program.
- The percentage of respondents who were homeless in the last year has remained stable at 5%.

Residential and Foster Care Survey Results

The adult residential and foster care survey maintains the basic MHSIP questions presented on the adult outpatient survey and includes additional questions related to both the services received in residential treatment and the individuals' readiness to transition to more independent settings.

Response rate

- HealthInsight Oregon mailed 1,507 residential surveys to valid addresses and received 297 responses for an overall response rate of 20%. This is similar to the response rate of 19% in 2015, but lower than the response rate of 29% in 2014.

Domain satisfaction since 2012

- The percentage of respondents satisfied with the quality and appropriateness of their services has shown a statistically significant upward trend in the last five years, despite some variation between years.

Care coordination

- Respondents were most satisfied with coordination between their current mental health provider and other mental health providers (94%) and their

physical health provider (91%). Dissatisfaction was highest with employment services (15%) and hospitals (11%).

- The survey asked respondents to identify health topics that their doctor or mental health care provider had talked to them about.
    - Sixty percent of respondents indicated their physical health provider had talked to them about losing weight, while only 22% said their mental health provider had discussed the same.
    - Sixty-three percent said their mental health provider had discussed benefits and side effects of psychiatric medications, while only 29% said their physical health provider had discussed the same.
- An analysis of responses over the past four years (when these questions were added to the survey) found that:
    - The percentages of respondents whose physical health providers asked about or discussed the following has trended significantly upward: tobacco use, heart disease risk, gambling behavior, or alcohol or drug use.
    - The percentage of respondents whose mental health provider discussed weight loss has trended significantly downward.

Arrest history

- Ten percent of respondents reported an arrest in the 12 months prior to starting services, while 2% reported an arrest after starting services.

Alcohol and drug use

- Over the past three years, the percentage of respondents who have a problem with alcohol has remained around 8% or 9%, while the percentage of those reporting a problem with drugs has stayed at 10%.
- In 2016, 88% received the help they wanted/needed for alcohol, compared to 92% in 2014 and 83% in 2015.
- In 2016, 79% received the help they wanted/needed for drug use, compared to 63% in 2014 and 85% in 2015.

Areas of progress in residential treatment

The survey asked respondents about progress made in their mental health as well as areas of daily living.

- Among respondents who reported progress in their mental health, the most commonly cited services received in residential care included:
  - medication management (79%)
  - psychiatric visits (70%)
  - support with activities of daily living (65%)
  - social and recreational activities (63%)
- Similarly, respondents who reported progress with their activities of daily living most often identified the same four service areas:
  - medication management (77%)
  - support with activities of daily living (71%)
  - psychiatric visits (71%)
  - social and recreational activities (65%)

  These four services were the most commonly cited services among respondents who reported progress in all areas identified in the survey.

INTRODUCTION

The outpatient survey has been administered annually since 2006, and the residential survey since 2012 to measure OHP members' perception of services in seven domains.

- General satisfaction
- Access to services
- Service quality
- Daily functioning
- Social connectedness
- Treatment participation
- Treatment outcomes

The surveys are based on the national MHSIP survey instrument. While both surveys preserved basic MHSIP questions about enrollee satisfaction, HSD added questions to ascertain the living circumstances of each group. The surveys gather important information about consumer satisfaction and the provision of services, and compared those across different settings in the community.

This year, as in previous years, the survey sample was determined by HSD, and included a representative sample by CCO and an oversample of racial minorities.

METHODOLOGY

The surveys are designed to assess responses from individuals who received state-funded mental health services from July 1, 2015, through December 31, 2015, as identified by claims and encounter data from OHA's Medicaid Management Information System (MMIS) operated by HSD.

The survey instruments present questions designed to measure respondent perception of the performance and services of mental health service providers in seven domains. Both the 2016 outpatient and residential surveys were fielded in English and Spanish, according to the individual's primary language identified in Oregon's MMIS.

Survey Respondent Population

HSD classified adults in the survey population according to the setting in which the respondent received mental health services.

- The **Outpatient Treatment** group includes respondents who received mental health services only in an outpatient setting, including primary care settings.
- The **Residential Treatment** group consisted of respondents who received at least one day of treatment services in a residential setting.
- The **Adult Foster Care Treatment** group consisted of respondents who received at least one day of mental health services in an adult foster care facility, but who received no residential treatment services. This population received the same survey as the residential treatment group, purposes.

HSD provided HealthInsight Oregon with a random sample of 10,787 adult Medicaid enrollees who had received mental health services during the July–December 2015 time period and was combined with the residential treatment group for analysis.

The outpatient group included a random sample of 9,280 enrollees receiving outpatient care, including care provided in a primary care setting, plus a supplemental group of enrollees whose race was indicated as non-white, and enrollees whose ethnicity was indicated as Hispanic. The residential survey

population included 1,507 FFS adults receiving services in foster care (n=708) or residential treatment facilities (n=799).

HSD identified all enrollees in the survey population using claims and encounter data from MMIS. Enrollees who were 18 years of age or older when they received a mental health service were eligible for inclusion in the survey sample.

Importantly, results presented here reflect the survey sample rather than the whole population. Changes or differences in survey scores can merely represent changes or differences in the sample, rather than in the population of interest. To detect changes in population results or differences in different populations' results, HealthInsight Oregon performed statistical tests, usually chi-square tests of proportions. If significant results were found, they are noted in each table.

Survey Mailings

On May 16, 2016, HealthInsight Oregon mailed introductory letters to the potential participants in outpatient treatment, informing them of the upcoming survey. These letters also contained instructions for members to complete the survey online, including the web address and individual password. On April 26, 2016, HealthInsight Oregon mailed similar introductory letters to the potential participants in residential treatment and foster care; subsequent letters also included instructions for completing the survey online.

Each enrollee received a letter and the subsequent survey in English or Spanish, depending on the language preference identified in the Medicaid enrollment file. Some enrollees opted out of the survey or did not have identifiable addresses, and some opted to complete the survey online. HealthInsight Oregon removed enrollees from the subsequent mailing lists who opted out of the survey, had incorrect or outdated addresses, or completed the survey online.

The first outpatient survey was mailed on June 27, 2016. After HealthInsight Oregon filtered out incorrect addresses and respondents who had returned the survey, a second mailing went out to non-respondents on August 12, 2016. The first residential survey was mailed on June 6, 2016; a second survey was sent to non-respondents on July 14, 2016.

All survey responses are confidential. See Appendix A for a description of HealthInsight Oregon's data security and quality assurance procedures.

Survey Questionnaire

HealthInsight Oregon used the MHSIP Consumer Survey with supplemental questions added by the HSD for the outpatient and residential surveys.[1] The National Association of State Mental Health Program Directors has endorsed Version 1.2 of the survey (the version HSD adapted). The survey presents 37 questions with possible responses arrayed on a five-point Likert scale that ranges from "Strongly Agree" (5) to "Strongly Disagree" (1).

This survey is one of the performance measurement tools comprising the MHSIP Quality Report, used to assess and report on the quality and efficiency of mental health services.[2] The main purpose of the survey is to understand enrollees' perception of their experiences with mental health services. The information is used to improve the quality of that care. HSD surveyed OHP enrollees on topics in seven performance domains.

Each domain has corresponding survey items that collectively gauge respondents' perceptions in that domain.

HSD expanded both the outpatient and residential surveys by adding questions on:

- treatment expectations and actual results
- arrest histories before and after treatment
- current employment status
- current income source
- whether the respondents had primary care providers
- whether their doctors or mental health care providers discussed certain health topics with them, including weight loss and smoking
- general health
- alcohol and recreational drug use
- trauma screening

[1] MHSIP is supported by the Center for Mental Health Services, an agency within the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services.

[2] Ganju V, Smith ME, Adams N, et al. *The MHSIP Quality Report: The Next Generation of Mental Health Performance Measures.* Rockville, MD: Center for Mental Health Services, Mental Health Statistics Improvement Program, 2005.

- service coordination (communication between different service providers who have a shared client)

The outpatient survey was expanded with additional questions on:

- treatment status
- assistance by mental health providers with obtaining housing and employment
- assistance by mental health providers during mental health crises
- current and recent residence

The residential survey was expanded with additional questions on:

- reasons for living in a residential facility
- types of services received
- progress made while living there
- readiness for more independent living

Appendix B presents English and Spanish versions of the surveys.

Domain Scoring Analysis

Computation of domain scores followed a methodology established for the MHSIP Consumer Survey, with higher scores representing more positive perceptions (e.g., 4 = "Agree" and 5 = "Strongly Agree"). There were no reverse-scored items in the survey.

In this report, the term "domain score" is used in two different ways. First, the domain score represents the average score on a set of questions. Second, the domain score represents the percentage of respondents who reported an average positive value for that domain.

A domain score greater than 3.5 indicated that the respondent positively perceived the services offered in that domain. For example, the General Satisfaction domain contains three items:

- "I like the services that I received here."
- "If I had other choices, I would still get services from this agency."
- "I would recommend this agency to a friend or family member."

A respondent's score for this domain was calculated if the respondent reported a score for at least two of the three items in the domain. If a respondent answered all three and reported the scores 3, 4, and 5, respectively, the average of those scores would be (3+4+5)/3 = 4. Since 4 is greater than 3.5, this respondent would be considered satisfied within the participation domain.[3] **Throughout this report, we reference the percentage of respondents satisfied in various domains. This refers to the percentage of respondents whose domain score was >3.5.**

The domain score calculation sets a relatively high threshold for characterizing positivity of enrollee responses. A respondent scoring just one domain item with a "1" (Strongly Disagree") or a "2" ("Disagree") can reduce the domain score to 3.5 or less. For example, in the Access domain, which contains two questions, a response of 4 (positive) to one question and of 2 (negative) to the other question results in a domain score of 6/2, or 3. A domain score of 3 is less than 3.5, so would be considered negatively perceiving the services in this domain.

[3] The number of responses reported in each data table may be lower than the total number of survey respondents, as some respondents may not have answered all items needed to calculate a particular domain score.

SURVEY RESPONSES

HealthInsight Oregon mailed the surveys to a total of 10,787 adults who had received mental health services during July–December 2015, including 9,280 adults receiving outpatient services and 1,507 adults in either residential or foster care. In all, 1,946 adults returned surveys, for a response rate of 18% which is lower than the 2015 response rate (19%). HealthInsight Oregon excluded data from surveys received after the deadline of September 15, 2016, from the survey analysis. The denominator of 10,787 excludes bad addresses and opt-outs.

Table 1 shows the response rates for the outpatient survey and for the residential survey, which included the adult foster care group. The response rate was highest for the foster care group (22%) and lowest for the residential group (17%).

Table 1. Survey Response Rate by Treatment Setting.

Setting	Number of responses	Number of surveys sent	Response rate (%)
Outpatient	1,649	9,280	18
Residential Total	297	1,507	20
Residential	139	799	17
Adult Foster Care	158	708	22
Total	**1,946**	**10,787**	**18**

Note: Surveys sent exclude opt-outs and bad addresses.

OVERALL SURVEY RESULTS

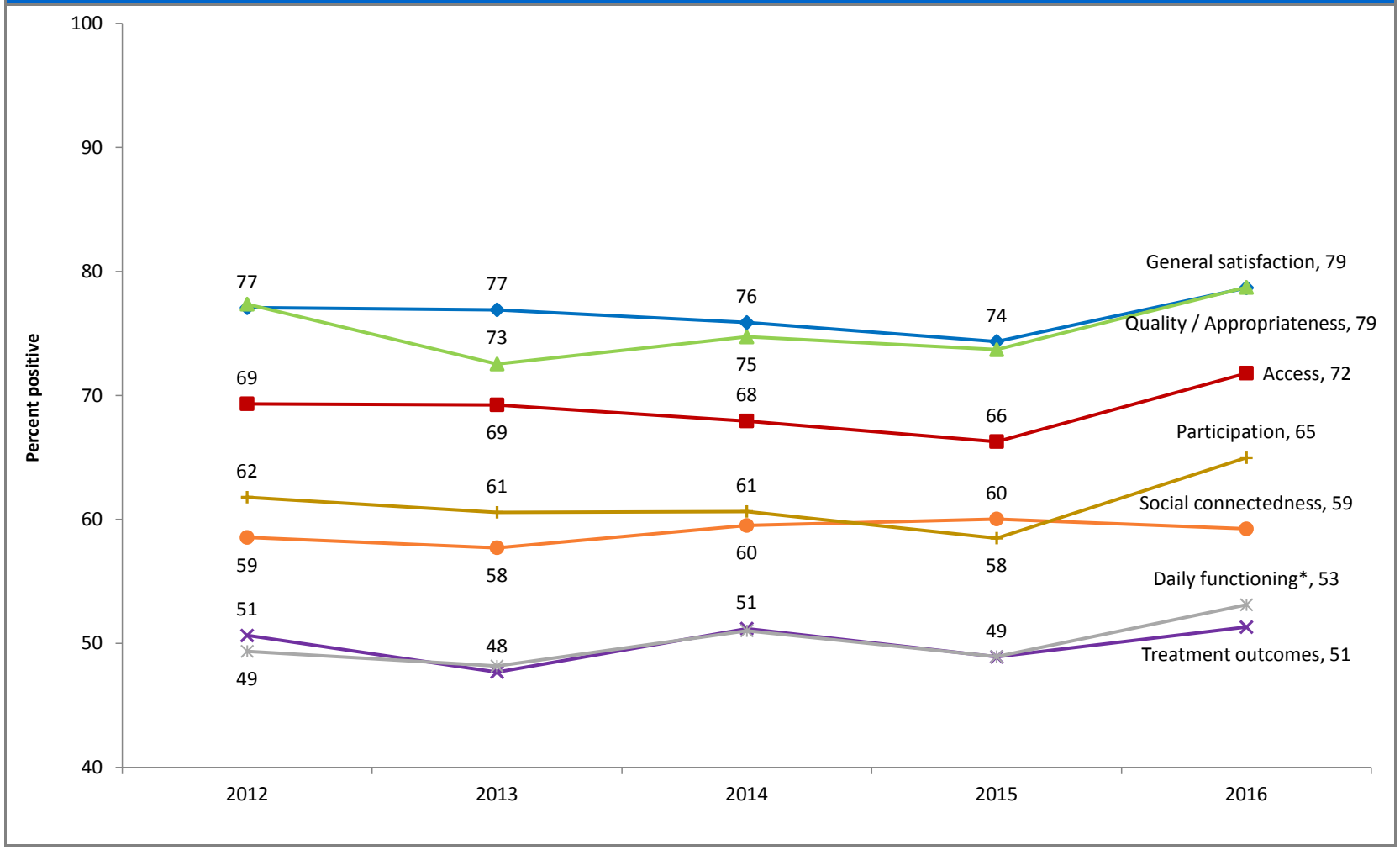
This section conveys the results of the 2016 outpatient and residential surveys combined. Detailed results for each survey follow in separate sections.

Overall Domain Satisfaction

The satisfaction according to domain represents the percentage of respondents who were satisfied in that domain (see Methodology, page 10, for further explanation).

Figure 1 shows overall domain scores (combining outpatient and residential scores) in the adult survey over the past five years. Percentages of respondent satisfaction in most domains were relatively consistent from 2012 to 2016. The percentage of respondents satisfied in the daily functioning domain has trended significantly upward from 2012 to 2016.

Figure 1. 2012–2016 Comparison of Domain Satisfaction.



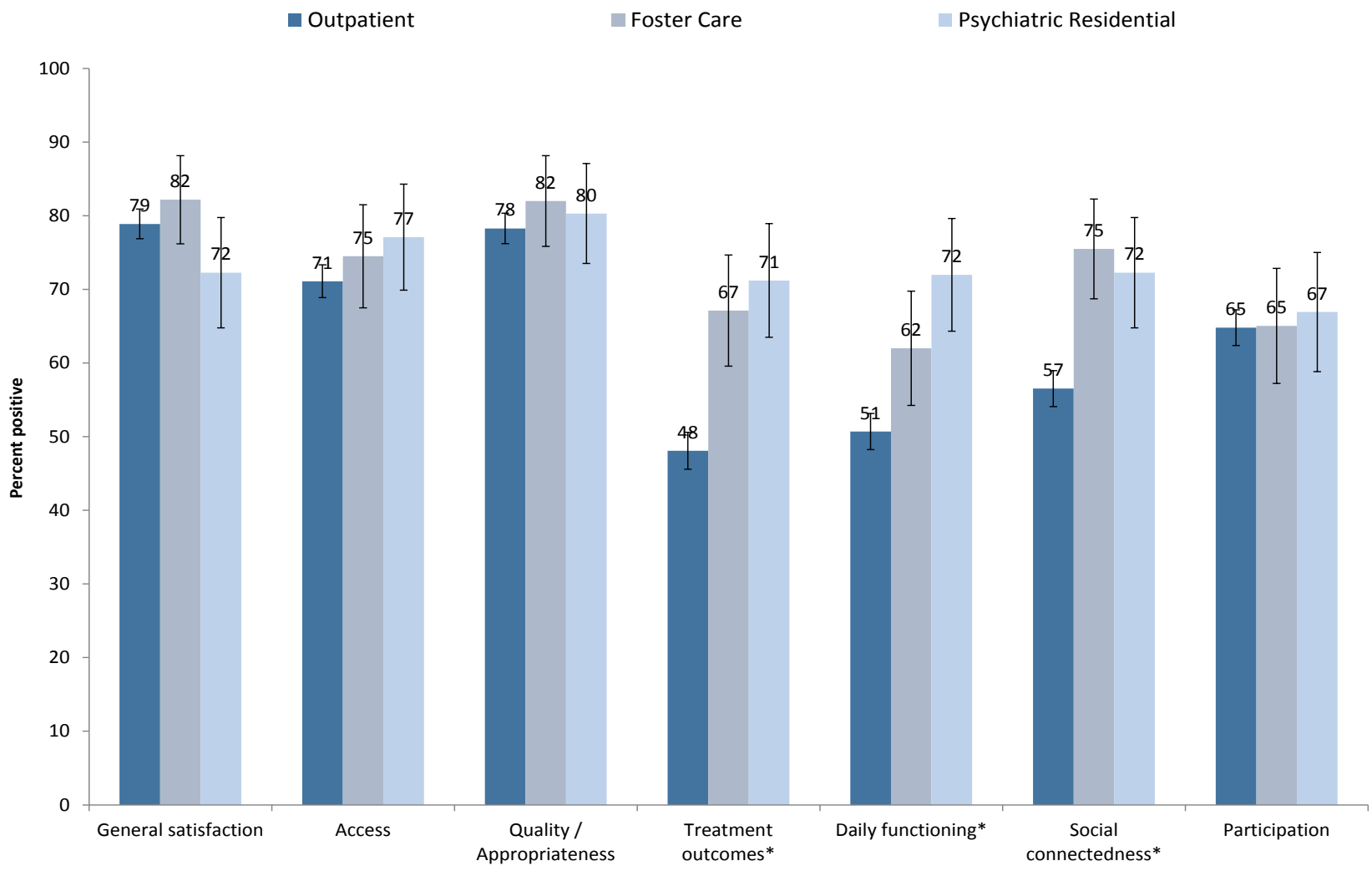
*Indicates statistically significant upward or downward trend (p<.05) over time for that domain.

Domain Satisfaction by Treatment Setting

Figure 2 displays the 2016 domain scores according to the treatment setting in which the enrollee received services. Figure 2 also presents the 95% confidence interval (CI) for each score. The CI indicates the upper and lower limits within which the score would be expected to fall 95 times if HealthInsight Oregon conducted 100 identical surveys. The more the CI's overlap, the more similar the results between groups are.

Compared to respondents in residential and foster care settings, fewer respondents in outpatient settings reported satisfaction in all domains.

Figure 2. Domain Satisfaction by Treatment Setting, with 95% Confidence Intervals.



*Indicates a statistically significant difference (p<.05) in scores for outpatient setting compared to other settings as a group.

OUTPATIENT SURVEY RESULTS

HealthInsight Oregon mailed 9,280 outpatient surveys to valid addresses (excluding bad addresses and opt-outs)—this is the denominator for the response rate calculation. A total of 1,649 enrollees returned their surveys by the deadline for an overall response rate of 18%, which is lower than the 2014 rate of 23% and 2015 rate of 19%.

A majority of respondents, 1,232 (74.71%), completed the survey by mail, while 417 (25.29%) completed it online, which was notable increase from the 249 (14.5%) in 2015.

Table 2 shows response rates by demographic characteristics of those served in outpatient settings. The 65-and-over age group had the highest response rate (25%), compared with the other two age groups.

Table 2. Outpatient Survey Response Rate by Gender, Age, Race, and Rural/Urban Residence.

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
Gender	Female	1,102	5,923	19
	Male	547	3,357	16
Age group	18-25	135	1,523	9
	26-64	1,410	7,348	19
	65+	104	409	25
Race	Non-White	519	3,020	17
	White (Caucasian)	928	4,928	19
	Unknown	202	1,332	15
Rural/Urban	Rural	574	3,332	17
	Urban	1,063	5,865	18
	Unknown	12	83	14
Language	English	1,248	6,848	18
	Spanish	43	287	15
	Other	358	2,145	17

Note: Surveys sent exclude opt-outs and bad addresses.

At the time of the survey, OHA contracted with 16 CCOs to manage OHP mental health services. Table 3 displays the survey responses from individuals who received services from each CCO and those who receive services fee-for-service (FFS). Response rates ranged from 10% to 26% by CCO.

Table 3. Survey Response Rate by CCO (Outpatient Respondents).

CCO	Number of responses	Number of surveys sent	Response rate (%)
AllCare Health Plan	61	326	19
Cascade Health Alliance (CHA)	30	209	14
Columbia Pacific CCO (CPCCO)	37	184	20
Eastern Oregon CCO (EOCCO)	54	313	17
FamilyCare Health	200	1,065	19
Health Share of Oregon	445	2,477	18
InterCommunity Health Network (IHN)	102	571	18
Jackson Care Connect (JCC)	38	190	20
PacificSource Community Solutions–Central Oregon (PCS-CO)	43	430	10
PacificSource Community Solutions–Columbia Gorge (PCS-CG)	34	189	18
Primary Health of Josephine County (PHJC)	34	180	19
Trillium Community Health Plan (TCHP)	201	1,021	20
Umpqua Health Alliance (UHA)	45	187	24
Western Oregon Advanced Health (WOAH)	34	173	20
Willamette Valley Community Health (WVCH)	163	831	20
Yamhill Community Care Organization (YCCO)	27	202	13
GOBHI MHO*	10	38	26
Fee-for-service	91	694	13

CCO	Number of responses	Number of surveys sent	Response rate (%)
Total	**1,649**	**9,280**	**18**

Note: Surveys sent exclude opt-outs and bad addresses.

*GOBHI is not a CCO, but a Medicaid managed mental health care organization (MHO). GOBHI members were not explicitly sampled, and the number of responses (n=10) was too small to perform any MHO-specific analyses.

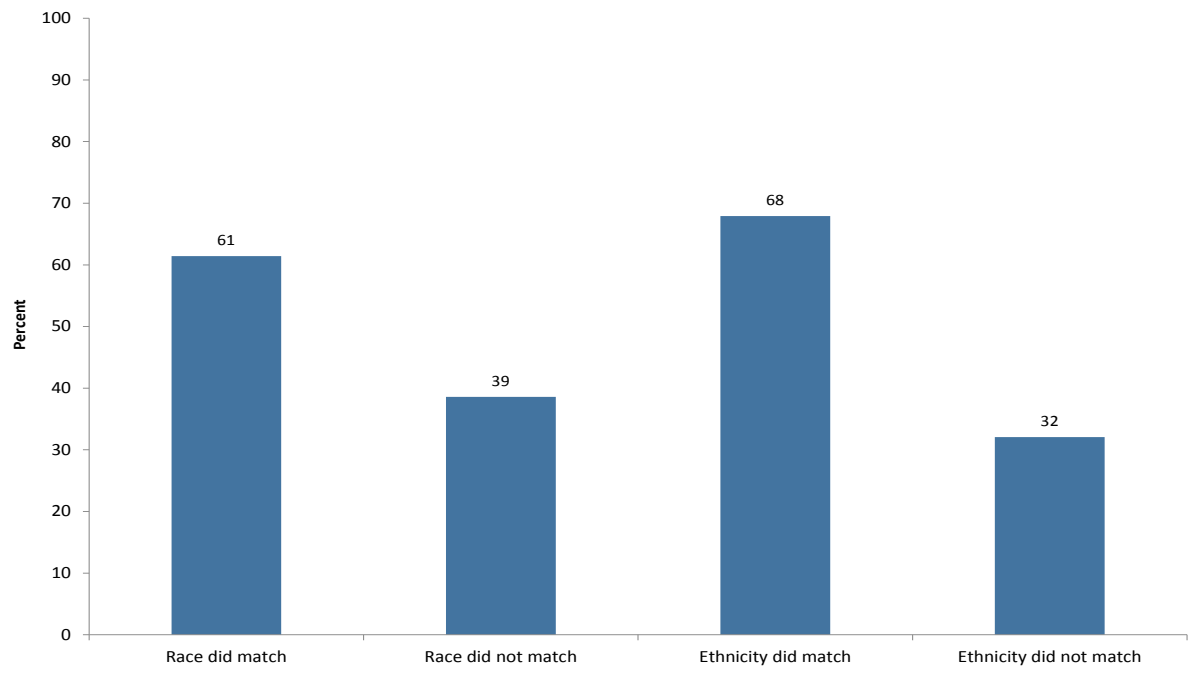
Respondent Race and Ethnicity

Neither race nor ethnicity are required fields in Medicaid enrollment forms, and as a result, this information is missing for many Medicaid enrollees in the state's dataset. Obtaining accurate information about enrollee's race and ethnicity is an important tool in addressing health equity. The survey asked respondents to self-identify their race and ethnicity, enabling comparison between state data and self-report data. Figure 3 shows these results.

Race categories on the Medicaid enrollment form do not match available race categories on the survey. To facilitate the best comparison, responses from the survey question allowing multiple race selections were used, and respondents who selected multiple races were rolled into a 'multiracial' category to align with the Medicaid enrollment forms. Race was consistent between state data and self-report data for 61% of respondents, and did not match for 39%. The most common mismatches were respondents who self-reported one or more races other than white, but were identified only as white by the state. State race data may overestimate the number of white enrollees.

Among outpatient survey respondents, ethnicity was consistent between state data and self-reported data for 68% of respondents. Ethnicity did not match for 32% of respondents. The most common mismatches were respondents who self-reported Hispanic or Unknown ethnicity, but were identified as non-Hispanic by the state. State ethnicity data may overestimate the number of non-Hispanic enrollees.

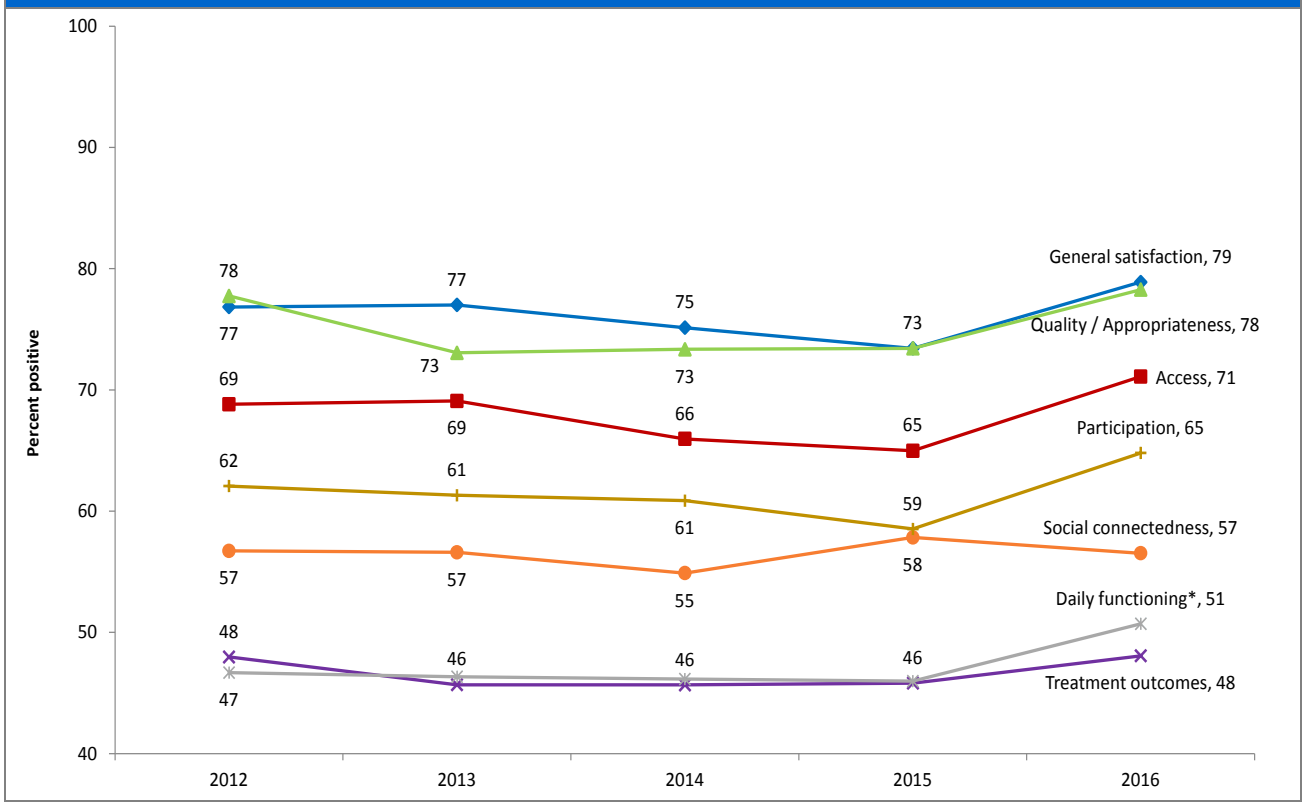
Figure 3. Comparison of State-Recorded and Self-Reported Race and Ethnicity Data, by Respondent.



Domain Satisfaction

Figure 4 shows the overall response to questions in each domain by enrollees served in outpatient settings from 2012 to 2016. The percentage of respondents satisfied with their daily functioning has trended significantly upward from 2012 to 2016.

Figure 4. Outpatient Survey Domain Scores, 2012–2015.



*Indicates statistically significant upward or downward trend (p<.05) over time for that domain.

Domain Satisfaction by Response Method

There were no differences in domain satisfaction between respondents who returned a paper survey in the mail or those who completed the survey online.

Domain Satisfaction by CCO

Table 4 shows domain scores by CCO. Note that survey questions asked the respondent about their current or most recent mental health service provider, not the CCO. In each domain, the CCO's domain score was compared to all other CCOs combined. Below are the highlights:

- **General satisfaction**: significantly more PCS-CO and TCHP respondents were satisfied than respondents in all other CCOs combined.
- **Access**: significantly more TCHP respondents were satisfied when compared to all other CCOs combined, while significantly fewer respondents from UHA and WVCH were satisfied with their access to services.
- **Quality/Appropriateness**: significantly more respondents from PCS-CO and TCHP were satisfied, while significantly fewer respondents in IHN were satisfied.
- **Treatment outcomes**: significantly more respondents at TCHP reported satisfaction, while significantly fewer EOCCO respondents were satisfied (note: GOBHI provides mental health services for EOCCO enrollees).
- **Daily functioning**: significantly more TCHP respondents were satisfied.
- **Participation**: significantly fewer IHN respondents were satisfied, while significantly more respondents from PCS-CO, TCHP, and WOAH reported satisfaction.

Table 4. Outpatient Domain Satisfaction by CCO, with 95% Confidence Intervals.

CCO	General satisfaction (CI)	Access (CI)	Quality/ Appropriateness (CI)	Treatment outcomes (CI)	Daily functioning (CI)	Social connectedness (CI)	Participation (CI)
AllCare	86 (77-95)	81 (70-91)	81 (71-92)	43 (30-57)	46 (33-59)	53 (40-65)	58 (44-72)
CHA	79 (65-94)	76 (60-91)	79 (65-94)	59 (41-77)	50 (32-68)	62 (44-80)	75 (59-91)
CPCCO	74 (60-89)	57 (41-74)	68 (52-83)	45 (28-62)	61 (44-77)	47 (30-64)	61 (44-77)
EOCCO	69 (56-81)	63 (50-76)	68 (55-80)	35 (22-48)*	44 (31-58)	50 (37-63)	58 (45-72)
FamilyCare	76 (70-82)	68 (62-75)	79 (73-85)	49 (42-56)	52 (45-59)	56 (49-63)	67 (60-74)
FFS	81 (72-89)	75 (66-84)	84 (76-92)	50 (40-60)	53 (43-64)	64 (54-74)	69 (59-79)
HealthShare	79 (75-83)	70 (65-74)	77 (73-81)	47 (42-52)	49 (44-53)	57 (52-61)	62 (57-66)
IHN	71 (62-80)	68 (59-77)	69 (60-79)*	48 (38-58)	43 (33-53)	56 (46-66)	55 (45-65)*
JCC	84 (72-96)	72 (58-87)	86 (74-97)	47 (30-64)	54 (38-71)	53 (37-69)	68 (51-84)
PCS-CO	93 (85-100)*	81 (69-93)	95 (88-100)*	63 (48-77)	60 (46-75)	60 (46-75)	85 (75-96)*
PCS-CG	85 (73-97)	79 (65-93)	81 (67-95)	52 (34-69)	64 (47-80)	68 (52-83)	70 (54-86)
PHJC	66 (49-82)	66 (49-82)	67 (50-84)	40 (22-58)	55 (37-72)	50 (33-67)	55 (37-73)
TCHP	84 (79-89)*	84 (79-89)*	86 (81-91)*	56 (49-63)*	59 (52-66)*	62 (55-69)	73 (66-79)*
UHA	71 (58-85)	56 (41-71)*	68 (54-83)	39 (24-54)	41 (26-57)	53 (39-68)	50 (34-66)
WOAH	85 (73-97)	79 (66-93)	84 (72-97)	42 (25-59)	38 (21-54)	53 (36-70)	84 (71-97)*
WVCH	77 (70-84)	62 (54-70)*	75 (68-82)	45 (37-53)	47 (39-55)	54 (46-62)	62 (54-70)

*Indicates statistically significant difference ($p<.05$) between CCO and all other CCOs grouped together.

Note: YCCO is not included in order to protect respondents' privacy because their sample size was less than 30. Also, GOBHI is not included because GOBHI members were not explicitly sampled; therefore, the number of responses was too small to perform any MHO-specific analyses.

Demographic Comparisons

Examining satisfaction according to client characteristics, such as age, gender, rural or urban location, and race can be useful to program managers and staff in determining strategies to improve client satisfaction. HealthInsight Oregon analysts used chi-square tests to identify where scores in each domain were significantly different, according to demographic characteristics.

Domain scores by age group

Respondents were split into three groups for analysis based on age at the time of the survey: 18–25 years (transition-age youth), 26–64 years, and 65 years or older.

Satisfaction in the treatment outcomes domain among transition-age youth ages 18–25 has trended significantly downward in the last 5 years: from 52% in 2012 to 43% in 2016.

Satisfaction in the daily functioning domain among adults ages 26 to 64 has trended significantly upward in the last 5 years: from 44% in 2012 to 50% in 2016.

Satisfaction among respondents age 65+ has trended significantly downward in three domains over the last 5 years: treatment outcomes, daily functioning, and participation.

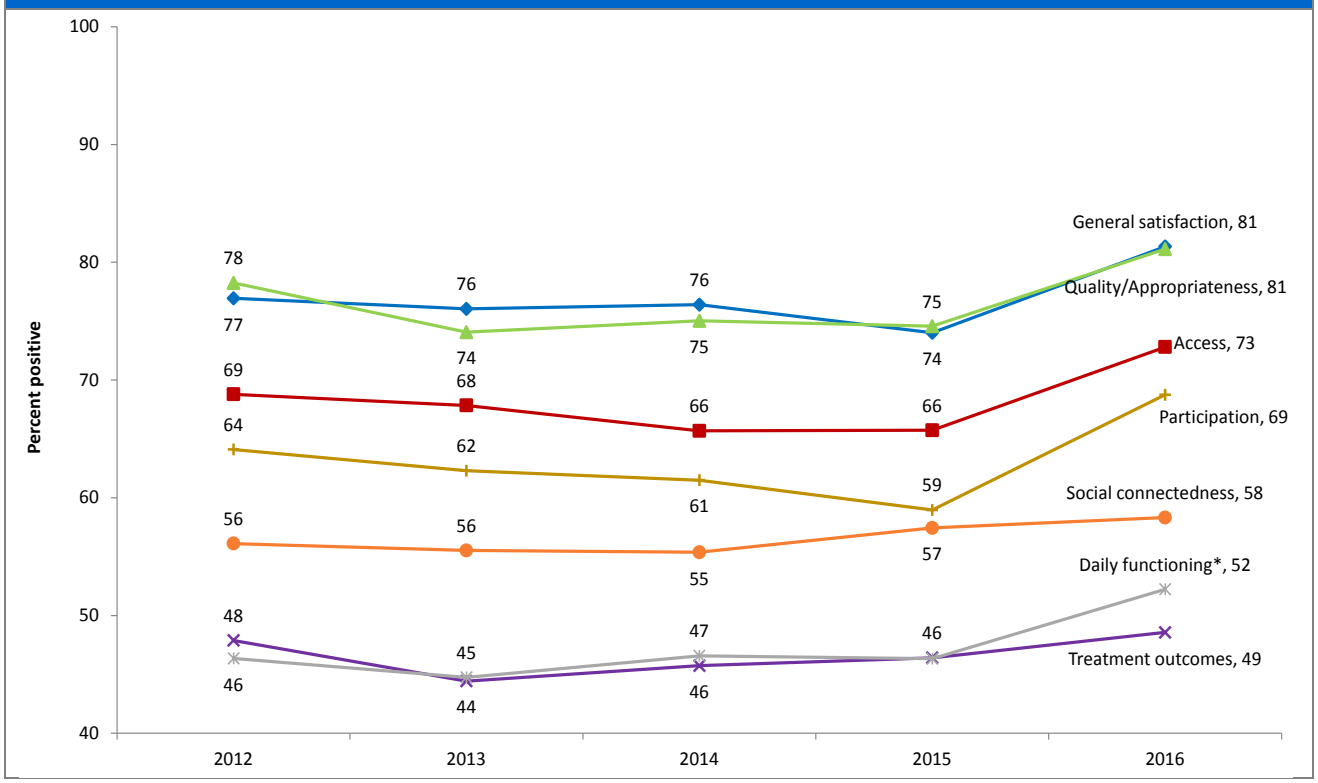
Domain satisfaction by gender

Figures 5 and 6 show domain satisfaction by gender over the past five years.

Satisfaction among male respondents has trended significantly downward over the last five years in three domains: general satisfaction, access, and quality/appropriateness.

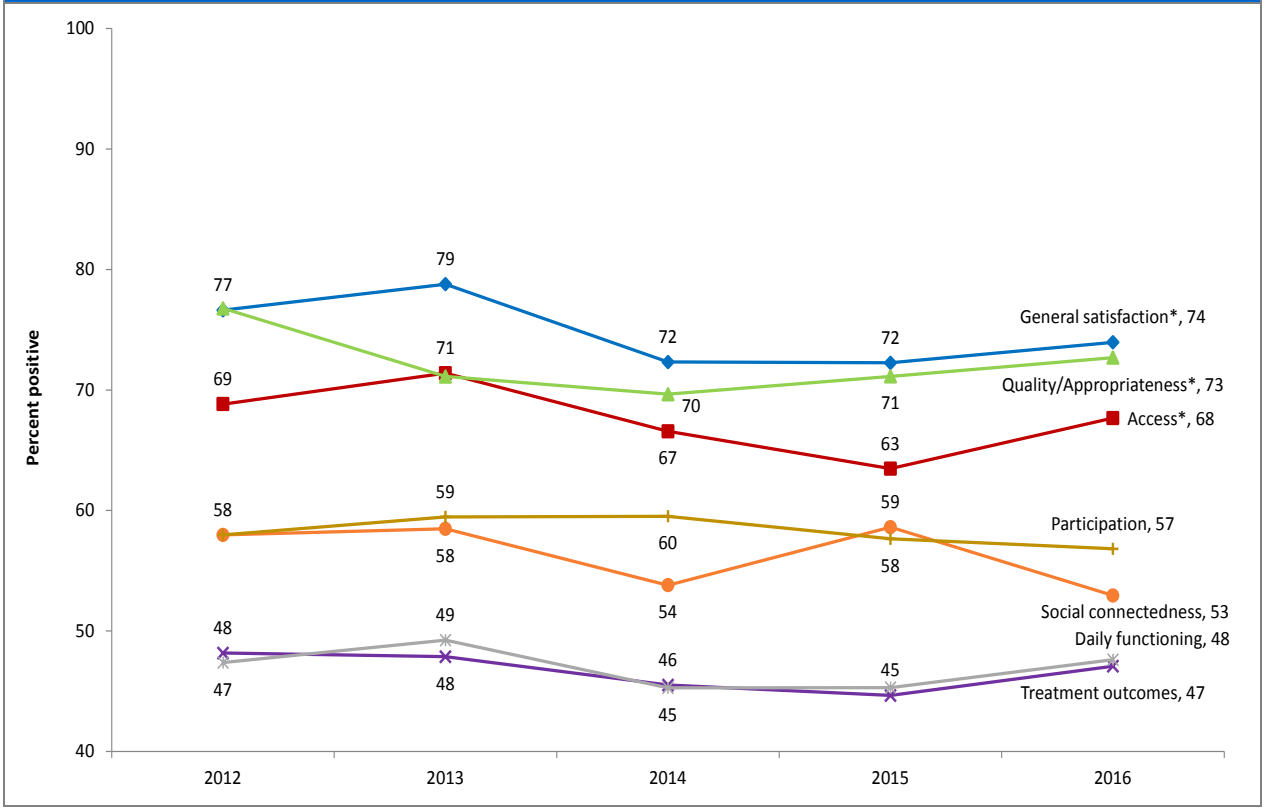
In contrast, satisfaction among female respondents has trended significantly upward over the last five years in the daily functioning domain.

Figure 5. 2012–2016 Domain Satisfaction by Gender: Female.



*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

Figure 6. 2012–2016 Domain Satisfaction by Gender: Male.



*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

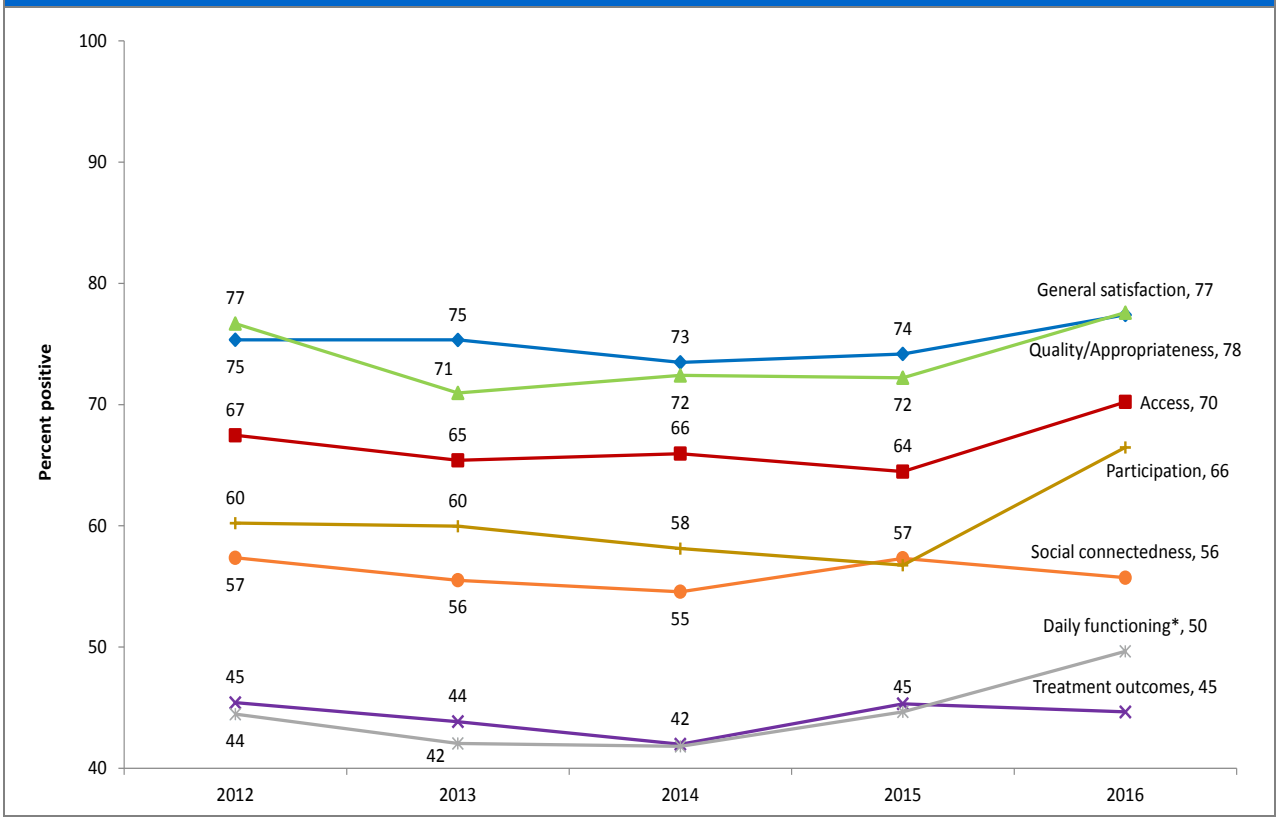
Domain satisfaction by rural/urban residence

Adult respondents were classified as rural or urban based on the ZIP code of their current residence, even though they may have received mental health services in another ZIP code. Classifications came from the Oregon Office of Rural Health.

Satisfaction among both urban and rural residents trended significantly upward in the daily functioning domain over the last five years, while all other domains showed no significant upward or downward trend. Slightly more urban respondents were satisfied in all domains except participation in 2016, where slightly more rural respondents reported satisfaction.

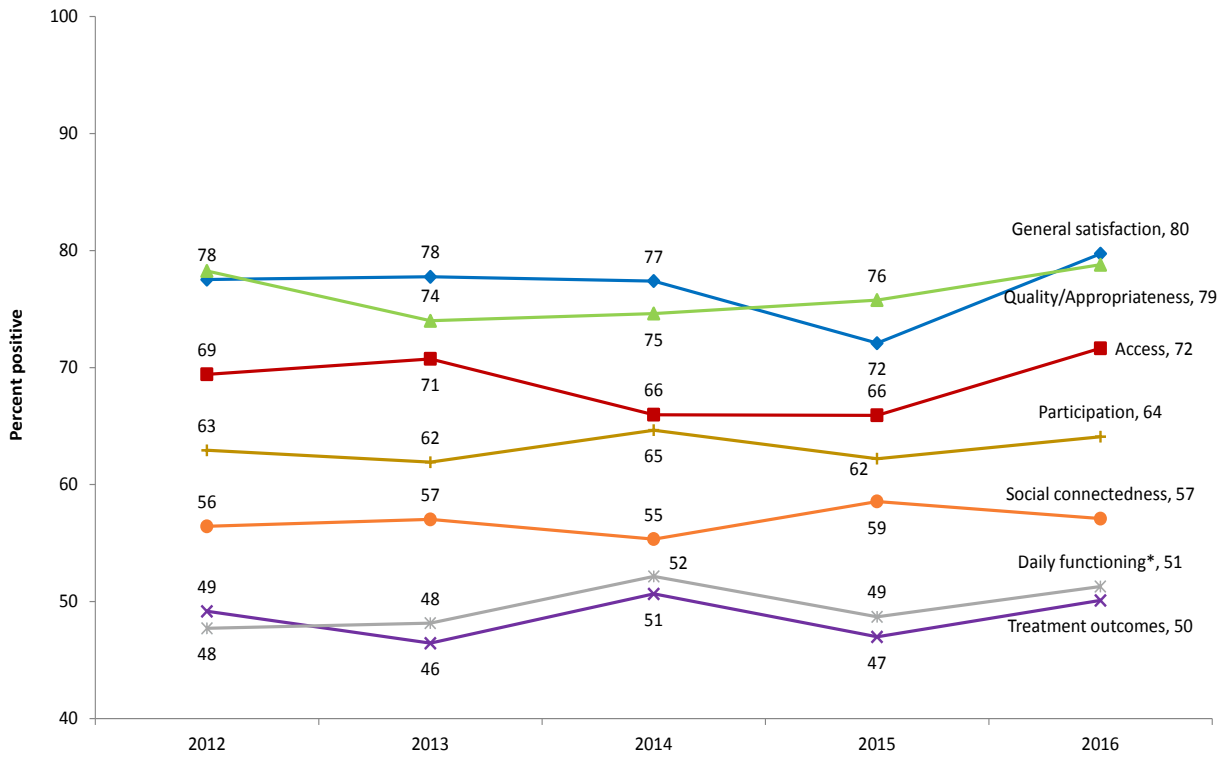
Figures 7 and 8 display the 2012–2016 results of respondent satisfaction by place of residence.

Figure 7. 2012–2016 Domain Satisfaction by Residence: Rural.



*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

Figure 8. 2012–2016 Domain Satisfaction by Residence: Urban.



*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

Domain satisfaction by race

In previous years, race information was pulled from the state MMIS dataset. Beginning in 2015, race information was self-reported for this survey.

The self-reported race question provided the option to select more than one race category, so respondents may be overcounted. Respondents with more than one race identity have the lived experience of each race and, therefore, are reflected in each category to give a more accurate depiction of differences in satisfaction according to race.

Table 5 displays satisfaction by the respondent's race (note: groups with fewer than 30 respondents are not included). Responses varied significantly among groups in the treatment outcomes domain. The white and multiracial groups had the greatest percentages (80%) of satisfied respondents in the general satisfaction domain. White respondents were more satisfied in the quality/appropriateness, daily functioning, and participation domains.

Black or African American respondents had the least satisfaction in the quality/appropriateness domain. The American Indian or Alaskan Native respondents had the least satisfaction in the treatment outcomes and participation domains, while this group and those respondents who declined to answer had the lowest satisfaction in general satisfaction.

Table 5. Domain Satisfaction by Race, 2016.

Race	General satisfaction	Access	Quality/ Appropriateness	Treatment outcomes*	Daily functioning	Social connectedness	Participation
American Indian or Alaskan Native	75	65	76	36	47	56	55
Asian	78	73	76	54	52	63	63
Black of African American	77	73	71	40	45	51	58
White	80	72	80	51	53	57	67
Multiracial	80	69	77	44	49	52	65
Other	76	73	77	45	48	66	61
Declined to answer	75	63	76	39	45	48	60

*Indicates a statistically significant difference between groups in that domain.

Domain satisfaction by ethnicity

Even though ethnicity information was self-reported this year, the results presented below are based on the state's MMIS data to allow comparison with the previous four years (self-reported race data were used for the first time in the 2015 survey analysis).

Figures 9–15 show the percentage of Hispanic and non-Hispanic respondents who were satisfied in each domain. Fewer than 30 respondents identified their ethnicity as "unknown" and, therefore, are excluded from these figures to protect their privacy.

Slightly more Hispanic respondents were satisfied than non-Hispanic respondents in most domains, although there were not statistically significant upward or downward trends in any domain. Among Non-Hispanic respondents, the percentage satisfied in the daily functioning domain has trended significantly upward in the last five years.

Figure 9. 2012–2016 Domain Satisfaction by Ethnicity: General Satisfaction.

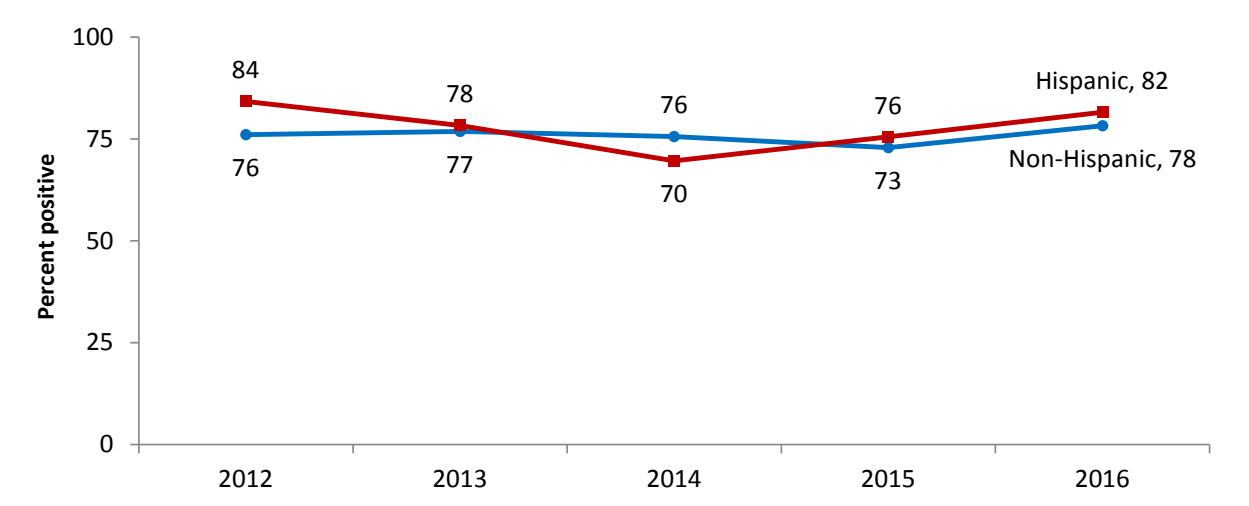


Figure 10. 2012–2016 Domain Satisfaction by Ethnicity: Access.

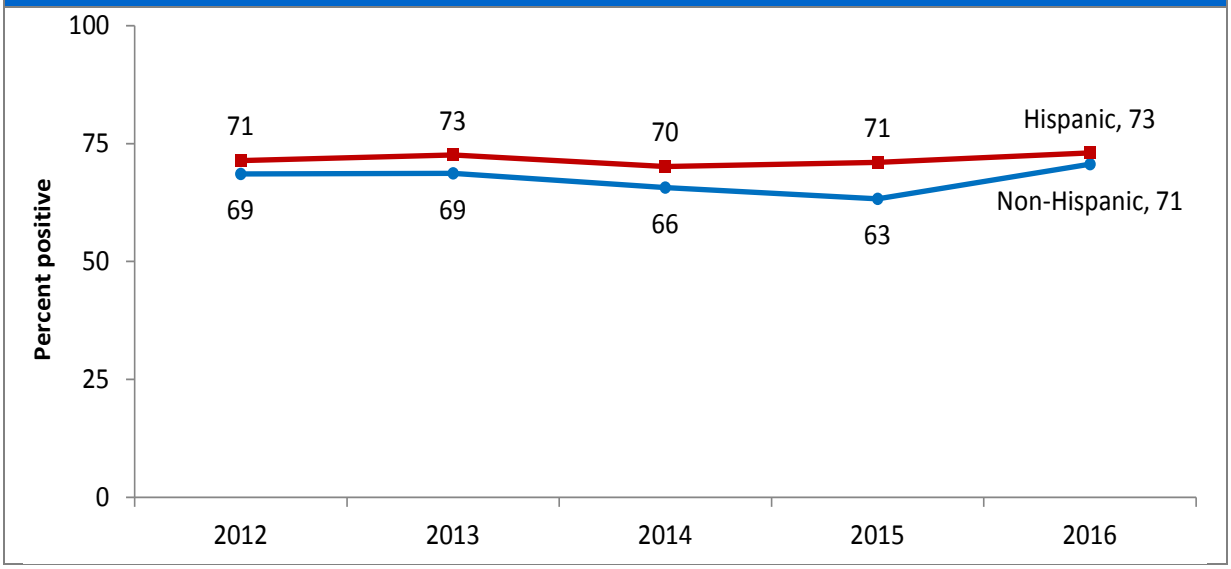


Figure 11. 2012–2016 Domain Satisfaction by Ethnicity: Quality/Appropriateness.

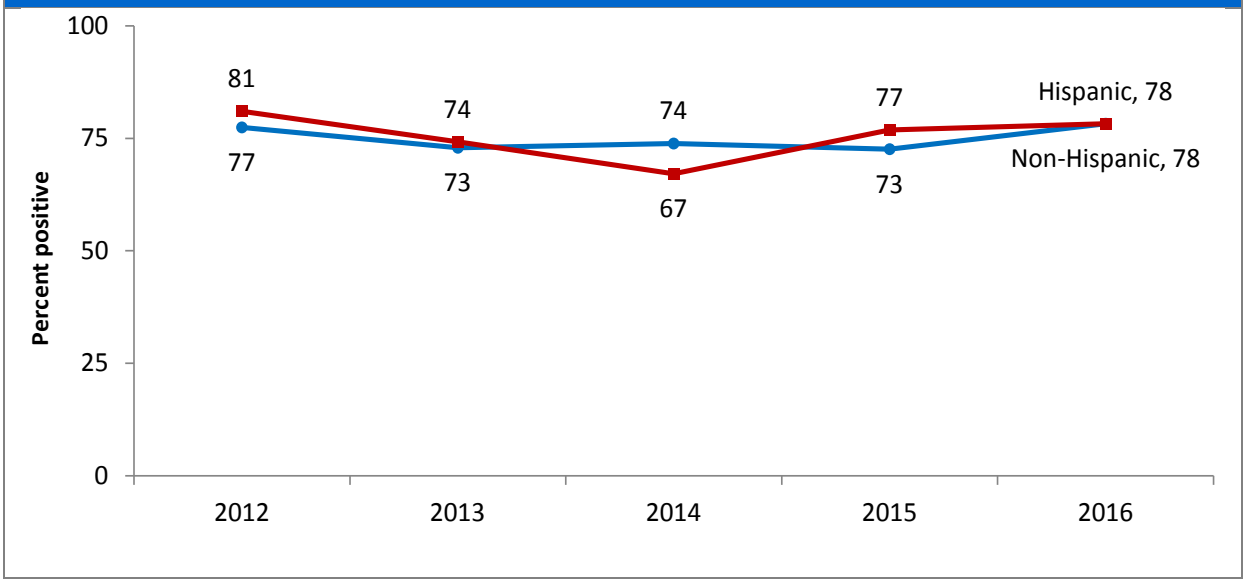


Figure 12. 2012–2016 Domain Satisfaction by Ethnicity: Treatment Outcomes.

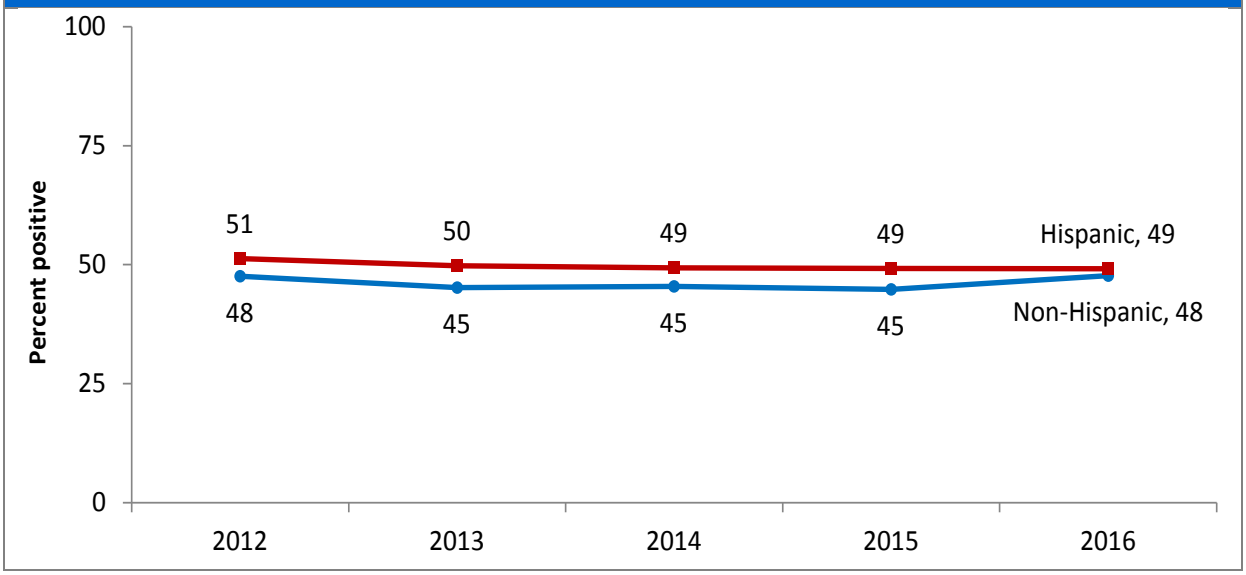
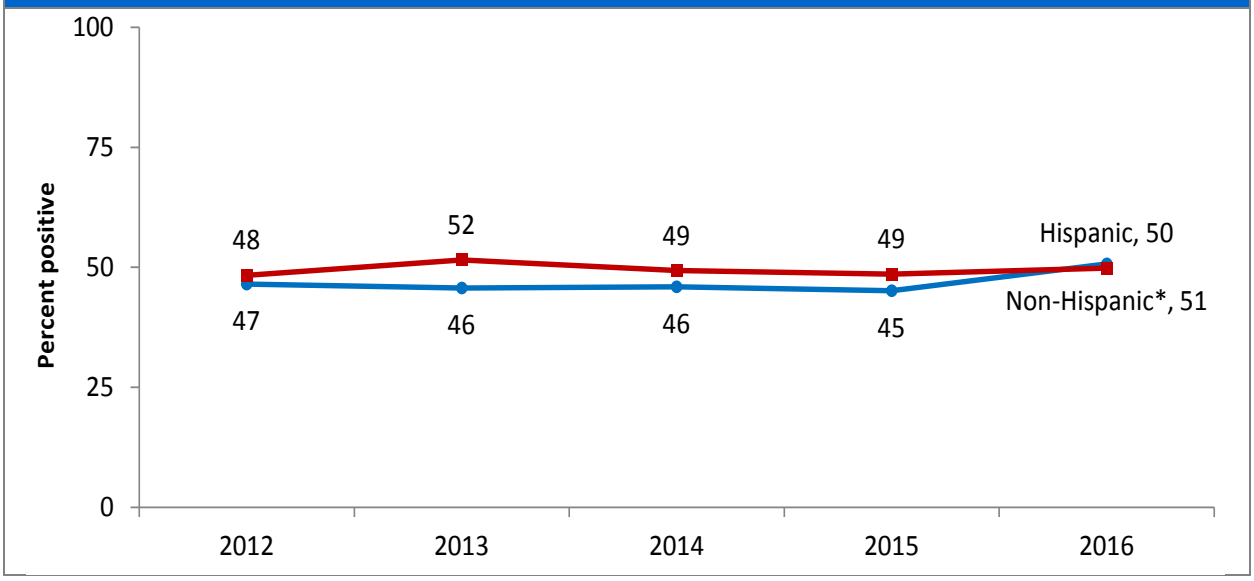


Figure 13. 2012–2016 Domain Satisfaction by Ethnicity: Daily Functioning.



*Indicates a statistically significant upward or downward trend (p<.05) for that group.

Figure 14. 2012–2016 Domain Satisfaction by Ethnicity: Social Connectedness.

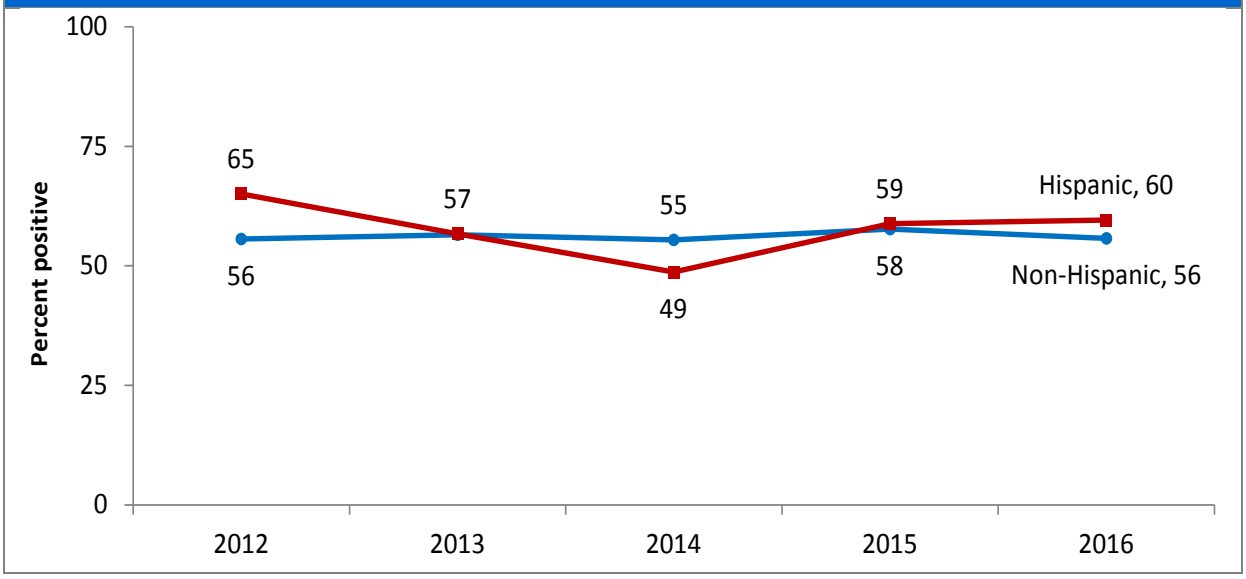
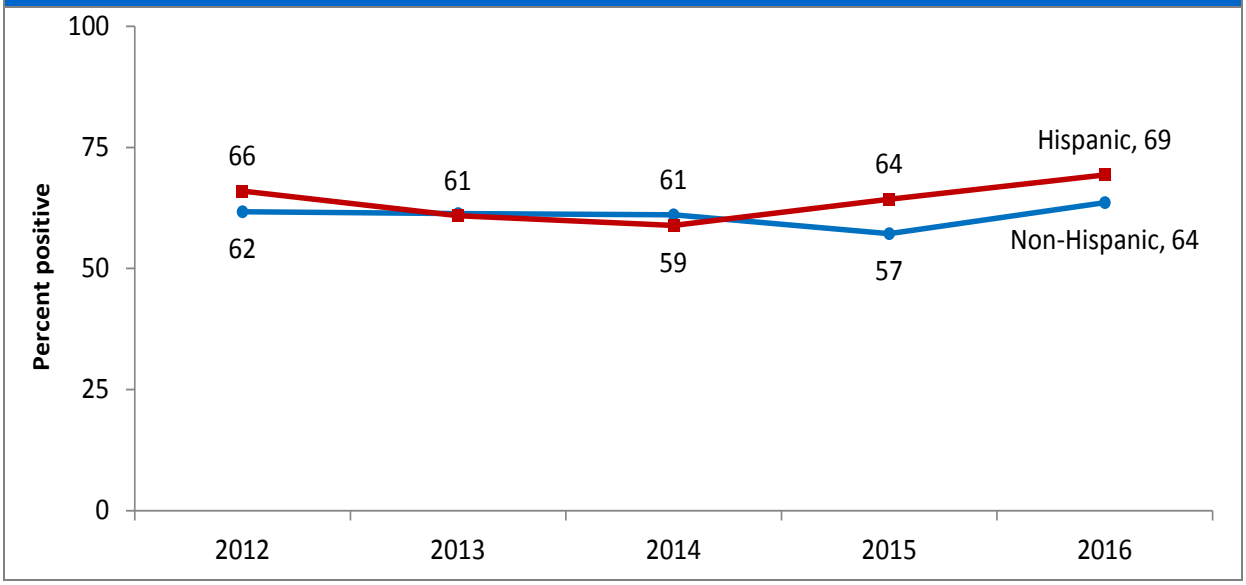


Figure 15. 2012–2016 Domain Satisfaction by Ethnicity: Participation.



Domain satisfaction by language

HealthInsight Oregon analyzed results by survey language. Table 6 presents results in 2016 between English, Spanish, and other language speakers. Spanish speakers had the greatest satisfaction in most domains, with significantly higher satisfaction in social connectedness.

In 2016, there were 1,248 English speakers and 43 Spanish speakers. There were 358 speakers of other languages, including Amharic, Arabic, Bosnian, Burmese, Chinese, Cambodian, Farsi, Hmong, Karen, Korean, Kurdish, Laotian, Nepali, Russian, Somali, Swahili, and Vietnamese.

There have been no significant upward or downward trends in any domain among English speakers over the last five years. There were too few Spanish and Other language respondents (<30) in at least one of the last five years to test domain satisfaction trends in either of those groups.

Table 6. Domain Satisfaction by Survey Language, 2016.

Language	General satisfaction	Access	Quality/ Appropriateness	Treatment outcomes	Daily functioning	Social connectedness*	Participation
English	79	70	78	47	49	56	65
Spanish	83	80	85	55	56	78	61
Other	78	72	80	51	56	54	64

*Indicates a statistically significant upward or downward trend ($p<.05$) for that language group.

Analysis of State-Added Questions

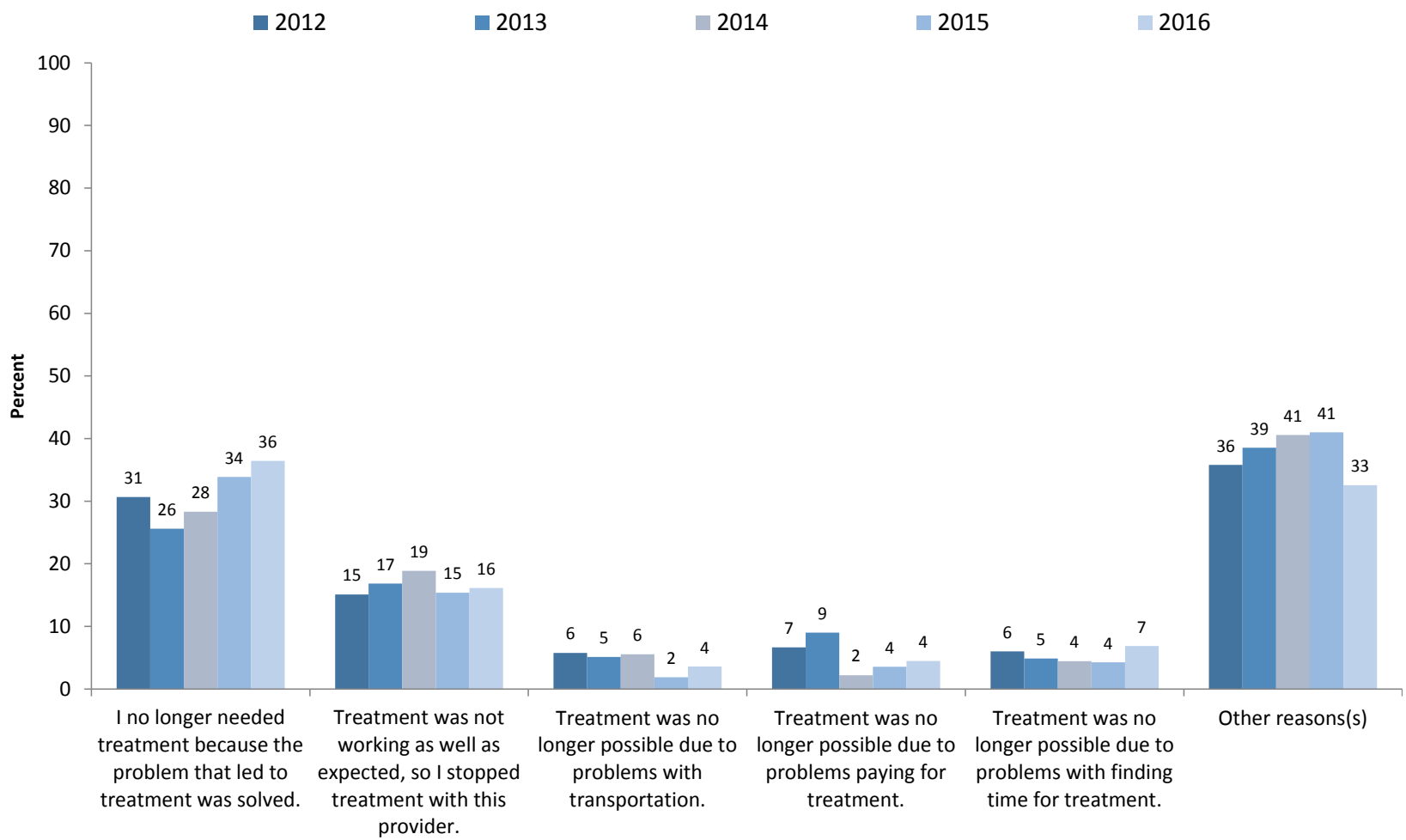
In addition to analyzing the data on MHSIP performance domains, HealthInsight Oregon analyzed responses to the survey questions related to the respondents' treatment status, housing, employment, income source, assistance during mental health crisis, expectations for treatment outcomes vs. actual outcomes, current and recent living situation, arrest history, and recreational use of alcohol or drugs. The survey also asked about primary care providers and overall health, including whether providers had discussed specific issues (such as weight loss and smoking) with the member. These are self-reported data and the usual cautions and limitations apply. The following tables and charts summarize these results.

Mental health treatment status

One question asked whether respondents were still receiving mental health services. Of 1,562 respondents, 1,125 (72%) were still receiving services, an increase from 64% in 2015, and 371 (23.8%) were not, a decrease from 31% in 2015. Sixty-six (4.2%) responded they did not know.

Respondents who were no longer receiving services were asked to select one main reason why. "I no longer needed treatment because the problem that led to treatment was solved" was the most commonly selected reason (36% in 2016). Figure 16 shows the responses to this question for the past five years.

Figure 16. Mental Health Treatment Status.



Service coordination

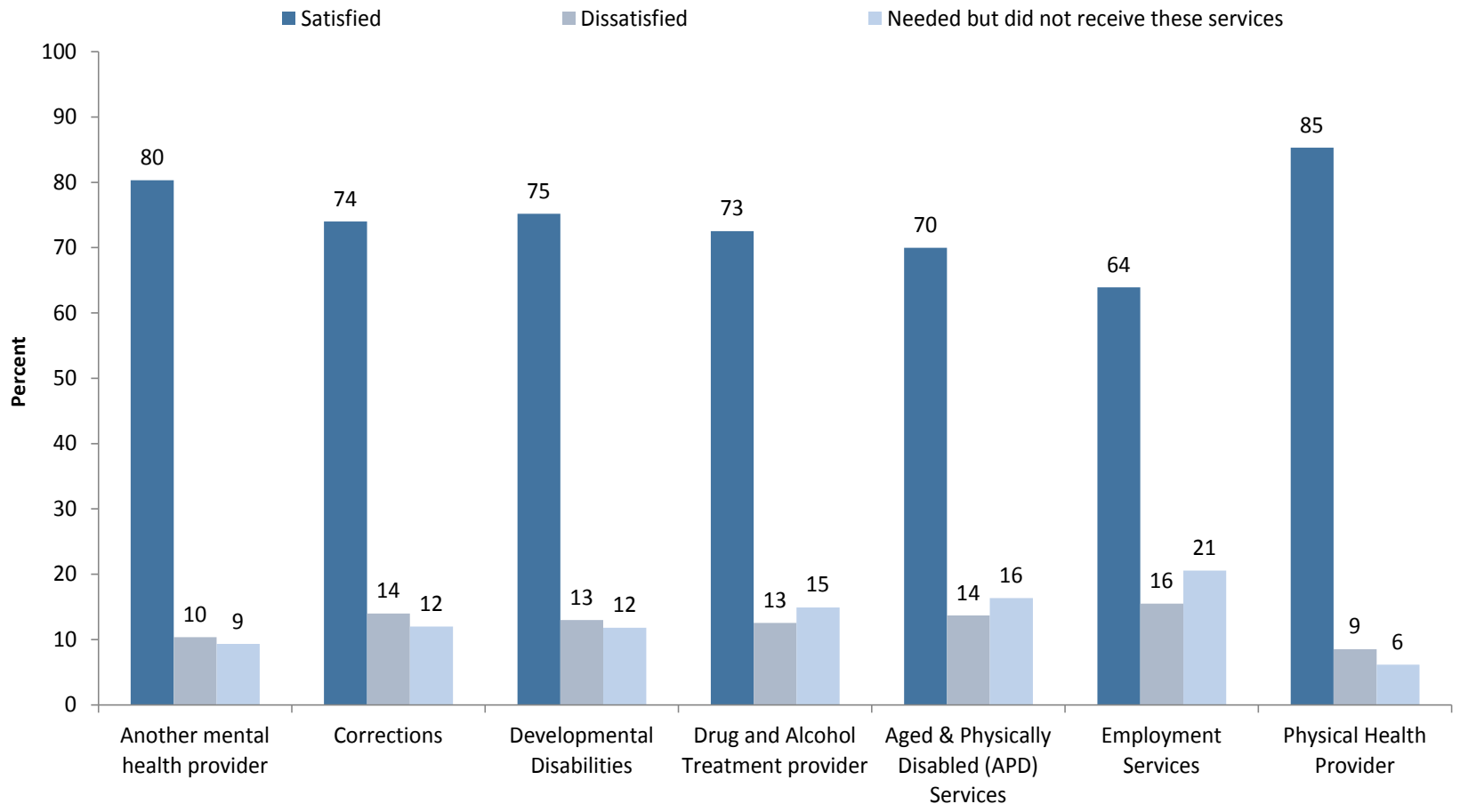
Another question asked respondents about their satisfaction with the willingness and ability of their current mental health provider to work together with other service providers.

Figure 17 shows that satisfaction was highest with collaboration between primary mental health providers and physical health providers (85%), and other mental health providers (80%). These results are consistent with 2015 findings. Satisfaction was lowest with collaboration between primary mental health providers and employment services (64%); the same category in which the most respondents (21%) said they needed but did not receive this service. While coordination with employment services has been the area with the least satisfaction over the past five years, the percentages of those reporting dissatisfaction has decreased.

The percentage of respondents who needed but did not receive services has shown a statistically significant downward trend over the last four years in the following areas:

- Corrections
- Developmental disabilities
- Drug and alcohol treatment provider
- Employment services
- Physical health provider

Figure 17. Satisfaction with Service Coordination.



Service expectations and results

The 2016 survey asked adults about the expectations and hopes they held when they began mental health treatment, and whether the treatment results met those expectations. As Figure 18 shows, the most frequent expectations were that the member would:

- Become less anxious or fearful (78%)
- Feel better about myself (74%)
- Become happier (64%)

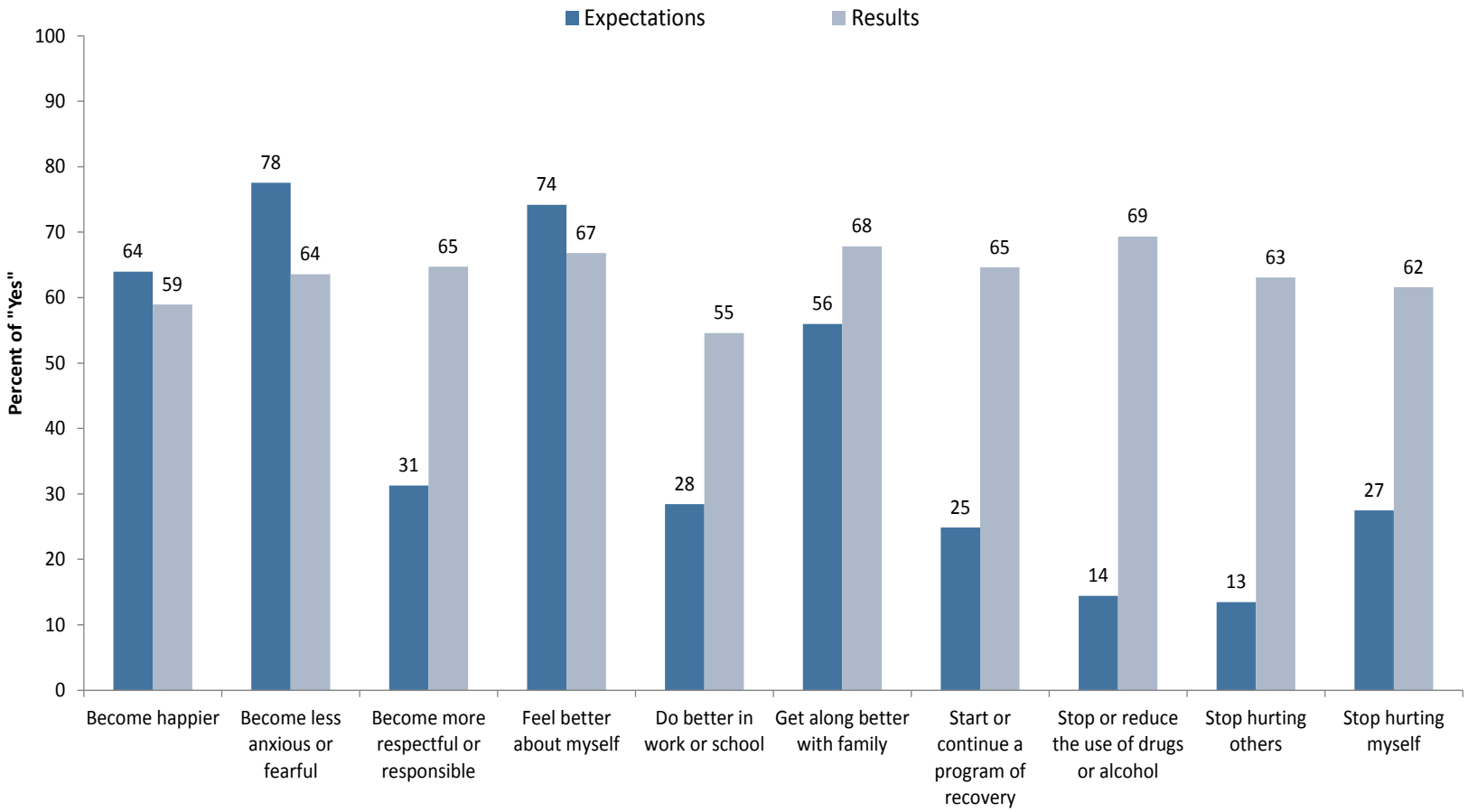
Among respondents with each expectation, we tabulated how many got the result they were expecting. The most frequently met expectations were:

- Stop or reduce use of alcohol or drugs (69%)
- Get along better with family (68%)
- Feel better about myself (67%)

The largest discrepancies between expectations and results were:

- Stop or reduce the use of drugs or alcohol (14% has this expectation, while 69% had this result)
- Stop hurting others (13% had this expectation, while 63% had the result)

Figure 18. Expectations for Mental Health Services: "What did you expect to happen as a result of receiving outpatient mental health services from your current (or most recent) mental health provider?" (N=1,649), and Results of Mental Health Services: "What has actually happened as a result of you receiving mental health services from this provider?"



Respondents could select all answers that applied; therefore, all were included in the denominator.

Primary care and overall health

Respondents were asked if they had a physical health care provider. Of the 1,540 individuals who answered this question, 91% reported that they had a primary health care provider, consistent with 2015.

Another question asked respondents if their doctor or mental health care provider had talked to them about any of the following:

- losing weight
- stopping or decreasing smoking
- how to reduce heart disease risk
- how to reduce risk for or manage diabetes
- benefits and side effects of psychiatric medication
- the possibility of reducing psychiatric medications
- gambling behavior
- use of alcohol or other drugs

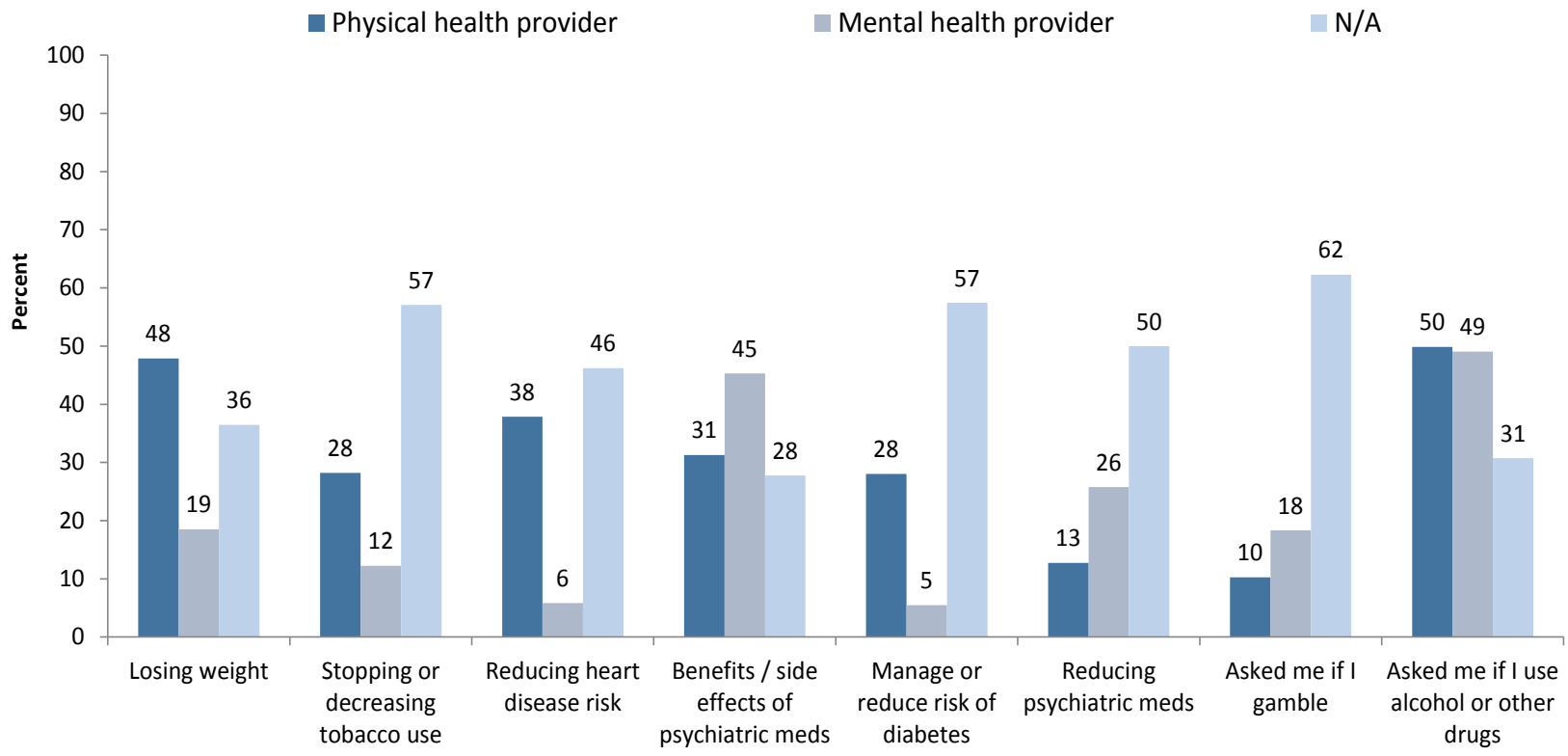
Figure 19 shows the 2016 responses to this question. Losing weight (48%) and use of alcohol and drugs (50%) were the most common items discussed by the physical health providers, while only 10% of respondents had been asked whether they gamble.

Responses indicating the same of the mental health provider were lower for most categories except benefits/side effects of psychiatric medications (45% for mental health providers vs. 31% for physical health providers), reducing psychiatric medications (26% for mental health providers vs. 13% for physical health providers), and gambling (18% for mental health providers vs. 10% for physical health providers).

For questions asked by physical health providers, most have decreased since 2013, with some up and down variation between years, except for the question about alcohol and drug use, which reached its highest response (50%) in 2016.

For questions asked by mental health providers, all decreased between 2013 and 2015, but increased slightly in 2016.

Figure 19. "My physical health provider (checkups, routine medical care and advice) or mental health service provider has talked to me about..." (N=1,649).

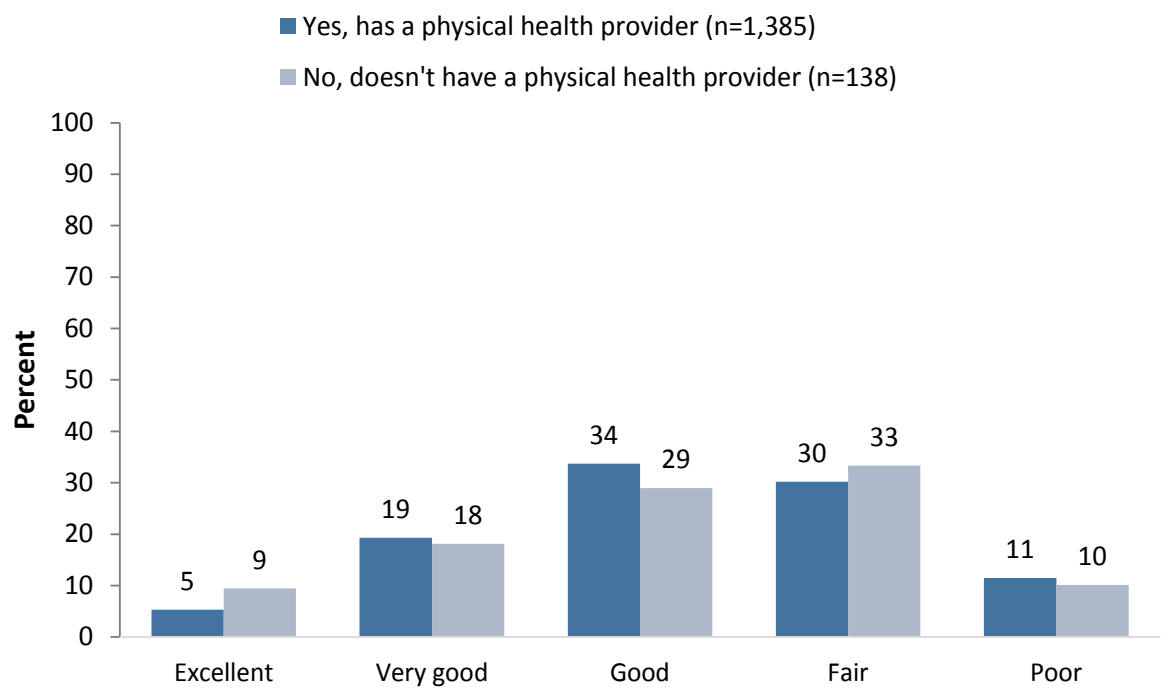


Respondents could select all answers that applied; therefore, all were included in the denominator.

Most respondents (91%) have a physical health care provider.

Figure 20 shows that health status among those with and without a physical health care provider is similar, with the greatest percentages of respondents indicating they were in good or fair health.

Figure 20. Health Status by Physical Health Care Provider.



Assistance by mental health provider

The survey asked respondents, where applicable, whether their most recent outpatient mental health provider had offered them choices of housing, helped them find a job or a better job, or assisted them with a crisis in a satisfactory manner. The results of these questions are presented below.

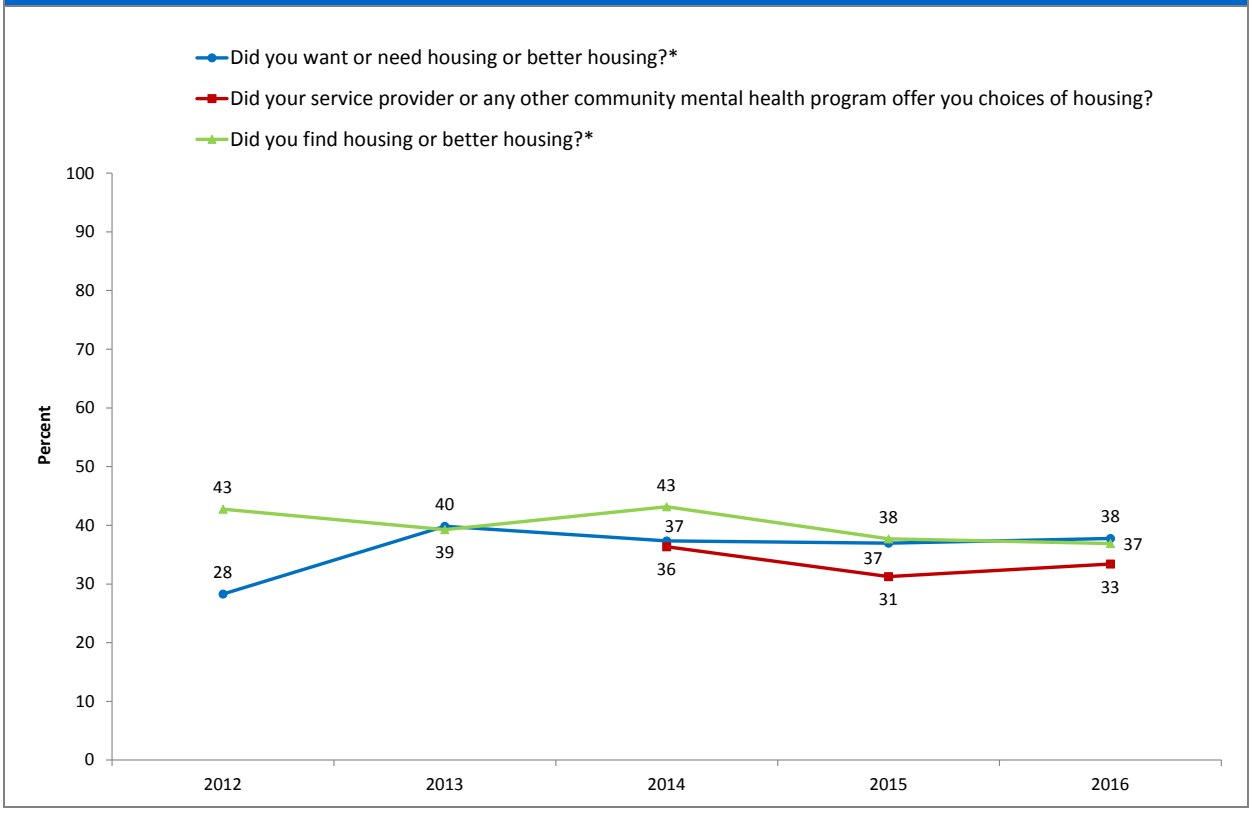
Housing

Figure 21 shows that 38% wanted or needed housing or better housing in 2016. The percentage of respondents who wanted or needed housing or better housing has trended significantly upward in the last five years.

Of those who answered "yes" to wanting or needing housing, 37% found housing or better housing. The percentage of respondents who found housing or better housing has trended significantly downward in the last five years.

Only 33% respondents indicated they were offered choices of housing from service providers or a community mental health program (this question was added in 2014). Of respondents who wanted or needed housing or better housing and whose provider offered them choices in housing, 56% actually found housing or better housing, compared to 24% of respondents whose provider did not offer them choices.

Figure 21. Provider Assistance with Housing.



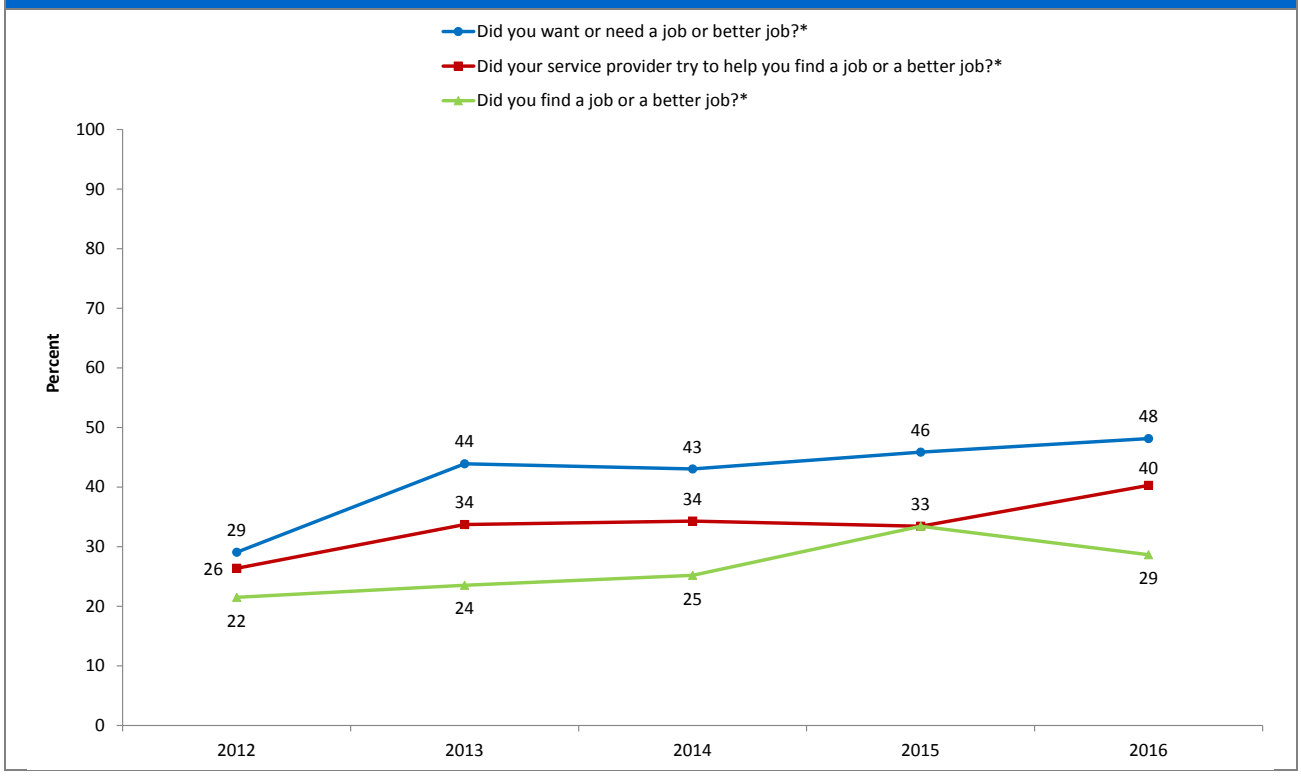
*Indicates a statistically significant upward or downward trend (p<.05) for that question.

Employment

In 2016, of those who wanted/needed a job or a better job and received assistance, 39% found work. Among those who wanted/needed a job or a better job but did not receive assistance, 21% found work.

Figure 22 shows a statistically significant upward trend in the percentage of respondents who wanted or needed a job or a better job in the last five years, from 29% to 48% in 2016. There are corresponding statistically significant upward trends in the percentage of people whose service provider tried to help them find a job or a better job (from 26% to 40%) and in the percentage of people who found a job or a better job (from 22% to 29%).

Figure 22. Provider Assistance with Employment.

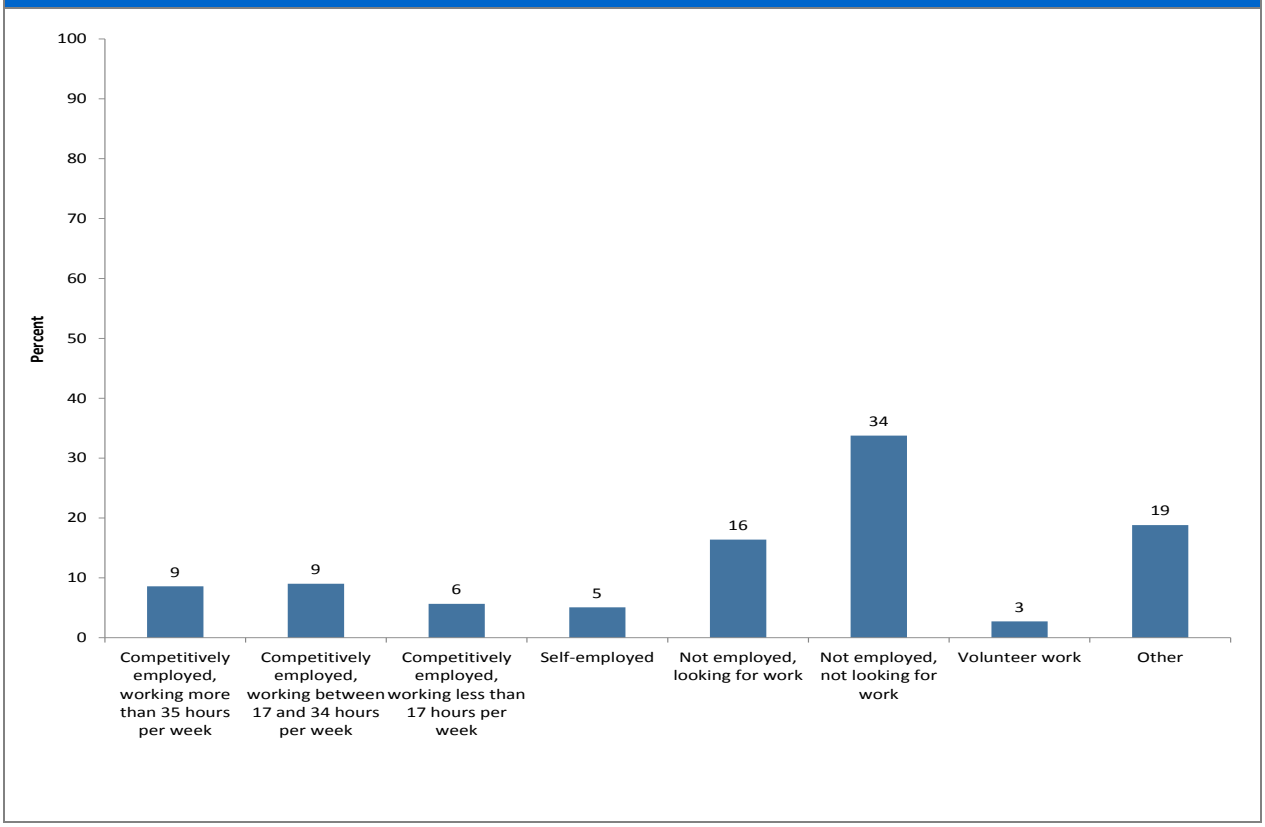


*Indicates a statistically significant upward or downward trend (p<.05) for that question.

Current employment status and income source

The 2016 survey contained three questions regarding employment and income. The first was "Are you currently employed?" Figure 23 shows that of 1,398 respondents who replied to this question, 34% were not employed and not looking for work (the same as 2015), while 16% were not employed but were looking for work, a slight increase from 14% in 2015. The survey defined competitive employment as "a regular job in the community that is not reserved for people with disabilities and that pays at least minimum wage."

Figure 23. Respondents' Employment Status (N=1,398).



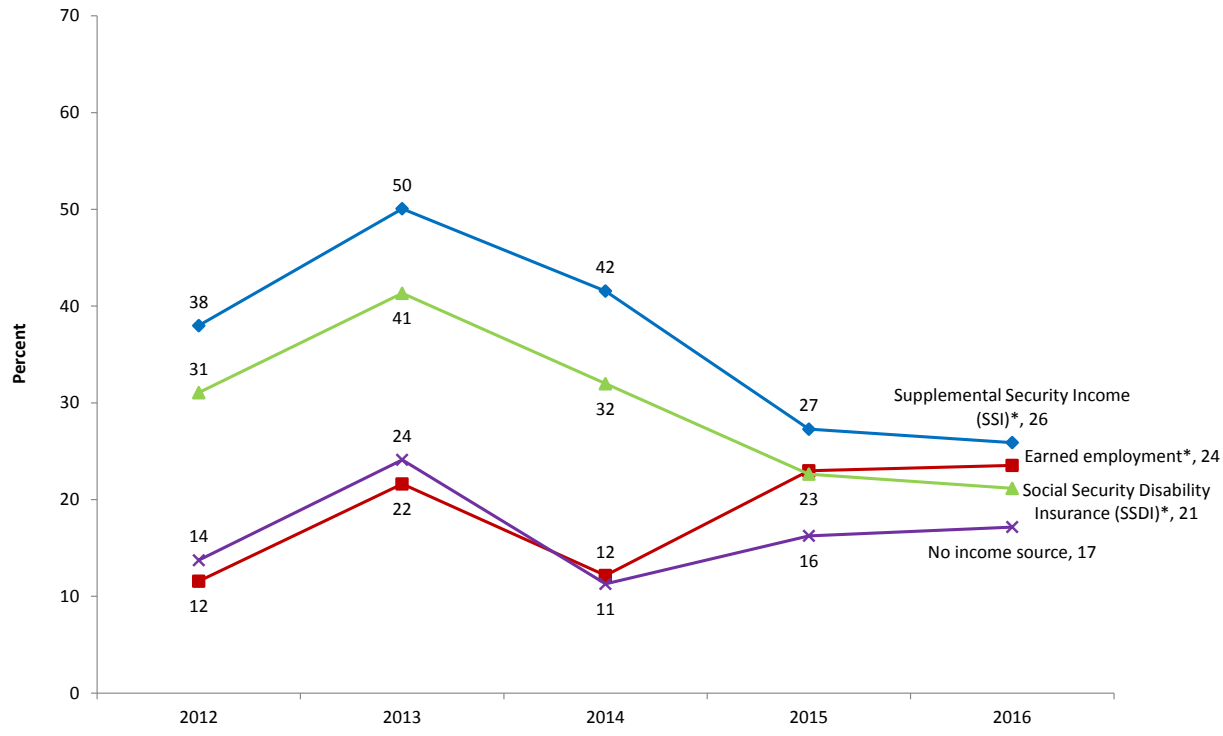
Almost 15% (14.8%) of respondents received assistance and supports to work, consistent with 2015 results. Of those who are receiving assistance and supports, 47% were unemployed.

- 11% were competitively employed, working less than 17 hours per week

- 11% were competitively employed, working between 17 and 34 hours per week
- 9% were competitively employed, working more than 35 hours per week
- 2% were doing volunteer work
- 3% were self-employed

The survey also asked about current source of income, giving respondents several options (they could select all that applied). As shown in Figure 24, the most commonly selected source was Supplemental Security Income (SSI) at 26%, and Social Security Disability Income (SSDI) at 21%, although both these income sources have statistically significant downward trends in the last five years. The percentage of respondents with income earned through employment has trended significantly upward in the last five years to 24% in 2016. And 17% of respondents had no income source.

Figure 24. Current Source of Income (N=1,649).



*Indicates a statistically significant upward or downward trend (p<.05) for that question.

Respondents could select all answers that applied; therefore, all were included in the denominator.

Assistance with mental health crisis

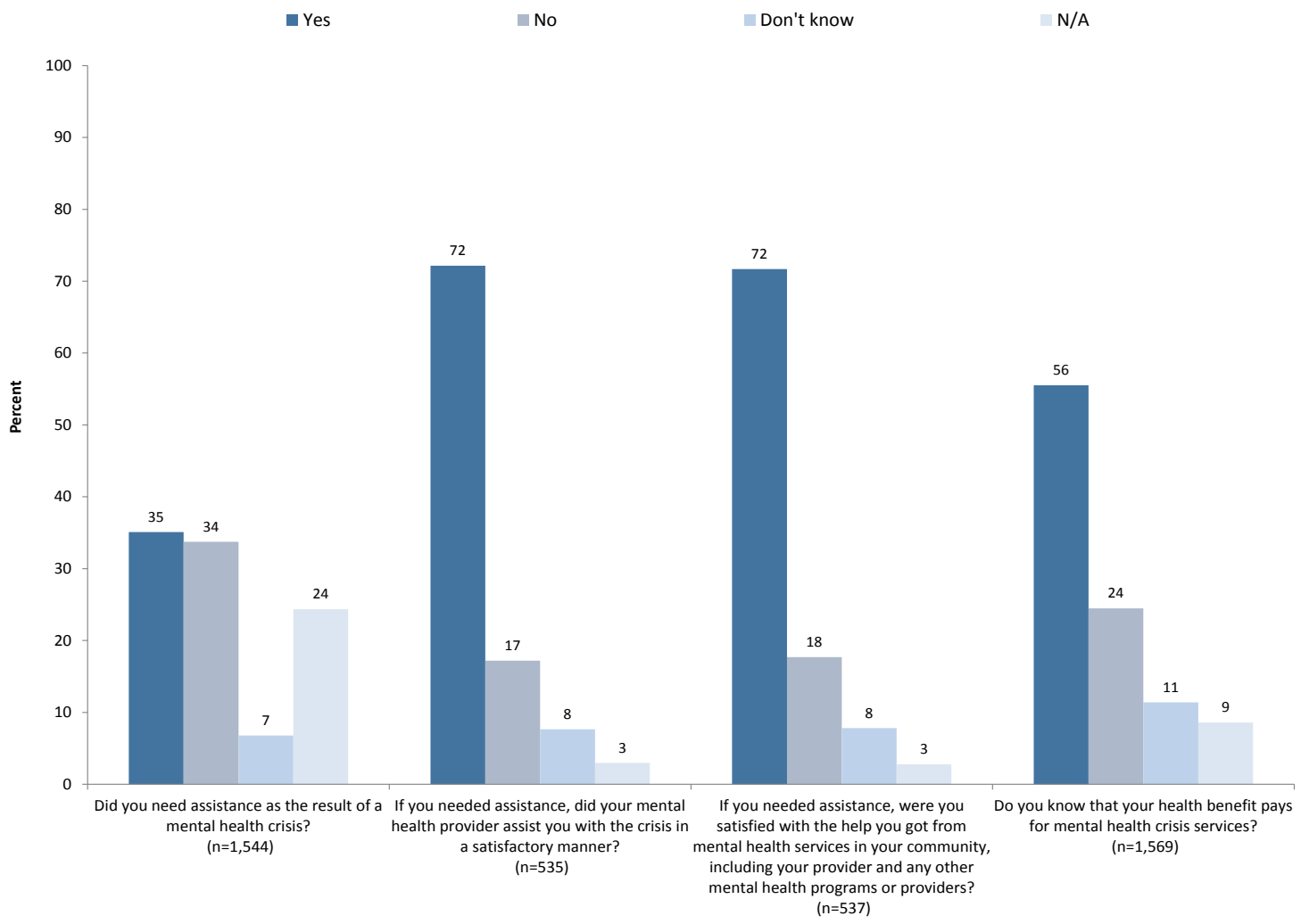
A provider's response to a member's mental health crisis is an integral part of care. State law dictates that service plans, required for each member, must include "proactive safety and crisis planning."[4] Figure 25 shows that 35% of respondents needed assistance as the result of a mental health crisis. If they needed assistance, a follow up question asked if their mental health care provider had assisted with the crisis in a satisfactory manner. Of the 535 who responded, 72% answered yes. Of those who needed assistance, 72% reported they were satisfied with the help they received. These results are similar to 2015.

A new question asked whether respondents knew that their health benefit pays for mental health crisis services:

- 56% responded "yes"
- 24% responded "no"
- 20% didn't know or indicated that this question was not applicable

[4] OAR 309-022-0140(3)(e), Service Planning and Coordination. Available at: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

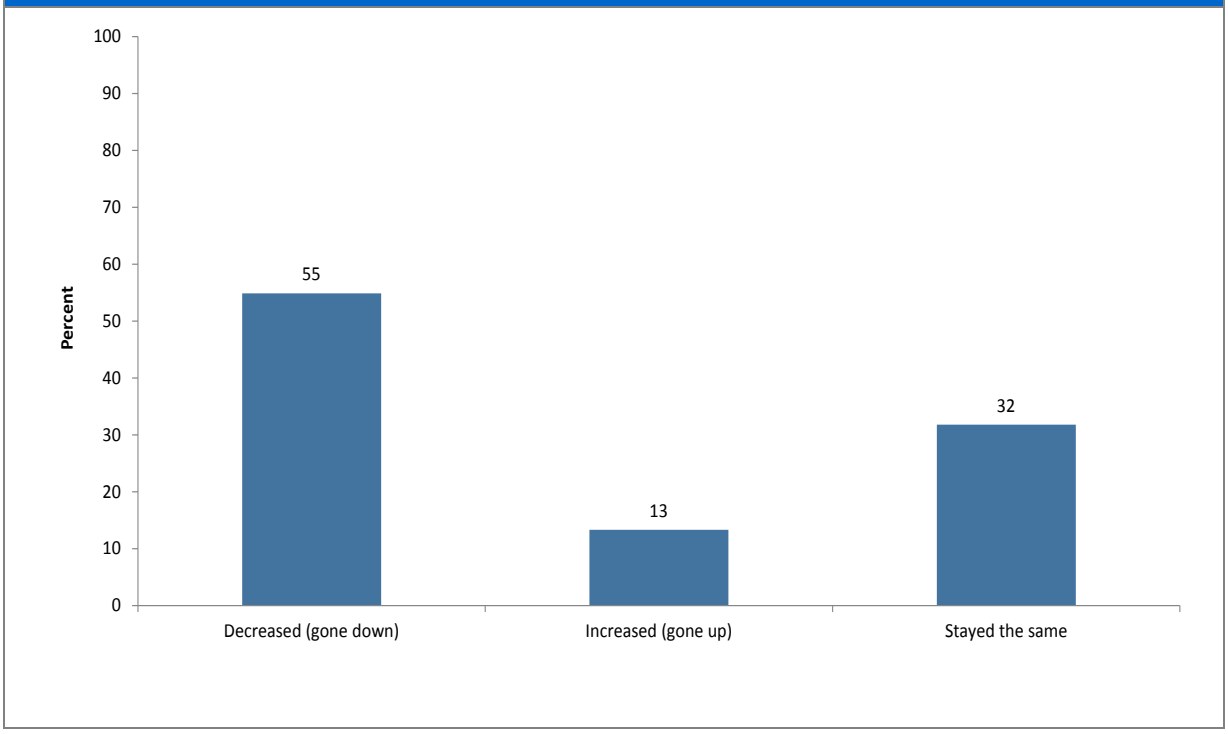
Figure 25. Provider Assistance During Mental Health Crisis.



Police encounters

Encounters with police, as defined for respondents in the survey, include "being arrested, hassled by police, or taken by the police to a shelter or crisis program." Most respondents (87%) did not have an encounter with police before starting services. Of those who reported encounters, 55% said they had decreased since starting services (Figure 26).

Figure 26. Encounters with Police (N=195). "Since you began receiving services from this provider, have your encounters with the police…"



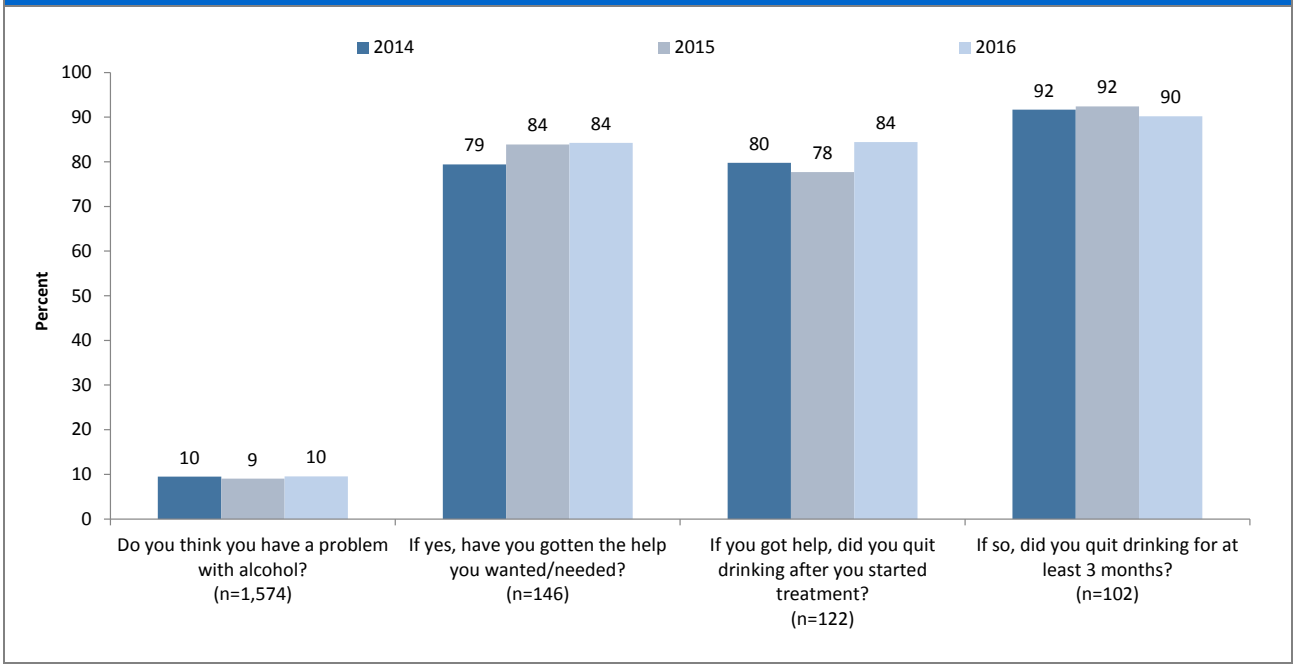
Arrest history

Two questions asked respondents about arrests before and after initiation of mental health services. Four percent of respondents reported being arrested in the 12 months before starting treatment, while 3% were arrested in the 12 months after starting treatment. These results are similar to 2015, with a decrease in the percentage of respondents reporting a pre-treatment arrest (6% in 2015 vs. 4% in 2016).

Alcohol and drug use

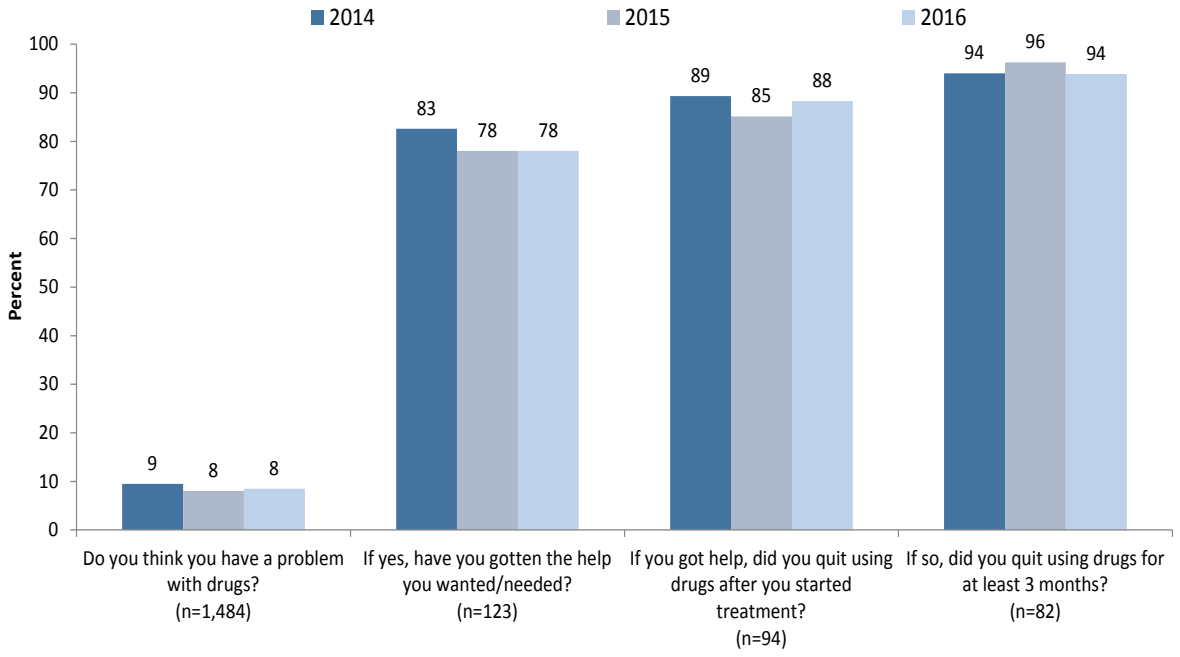
For some adults, mental illness and substance use disorder occur simultaneously. These co-morbidities can be complex to address, but must be addressed together to increase the odds of improvement. A series of questions addressed alcohol use (Figure 27). One in ten respondents thought that they had a problem with alcohol; of these, 84% had received the help they wanted or needed in 2016. Of those who got help, 84% quit drinking after starting treatment, and 90% quit drinking for at least 3 months. These results are similar to 2014 and 2015.

Figure 27. Questions Related to Alcohol Use: 2014–2016 Comparison.



The same question pattern was repeated for drugs (Figure 28). Eight percent of respondents though they had a problem with drugs. Of those who had a drug use problem, 78% got the help they wanted/needed in 2016. Of those who received help, 88% quit using drugs after starting treatment, while 94% quit using for at least 3 months.

Figure 28. Questions Related to Drug Use: 2014–2016 Comparison.



Trauma

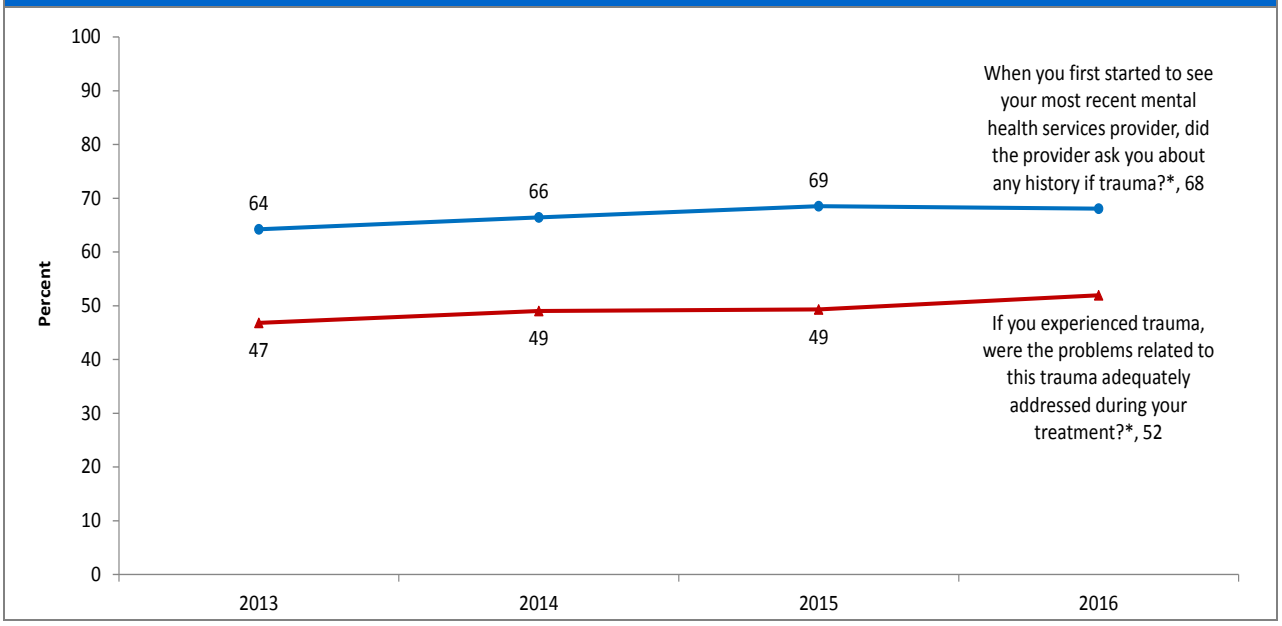
For many people, a history of trauma is interwoven with their mental illness. As defined for respondents in the survey:

> "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Providers must screen for trauma and include trauma-informed services in behavior support plans.[5]

The survey asked if the mental health service provider had asked about any history of trauma when starting treatment. Sixty-eight percent of the 1,565 respondents said "yes," a statistically significant upward trend in the last four years (Figure 29). Of those who have experienced trauma, 52% reported that it was adequately addressed during treatment, also a statistically significant upward trend since 2013 when the question was first included in the survey.

Figure 29. Trauma Screening, 2013–2016.



*Indicates a statistically significant upward or downward trend (p<.05) for that question.

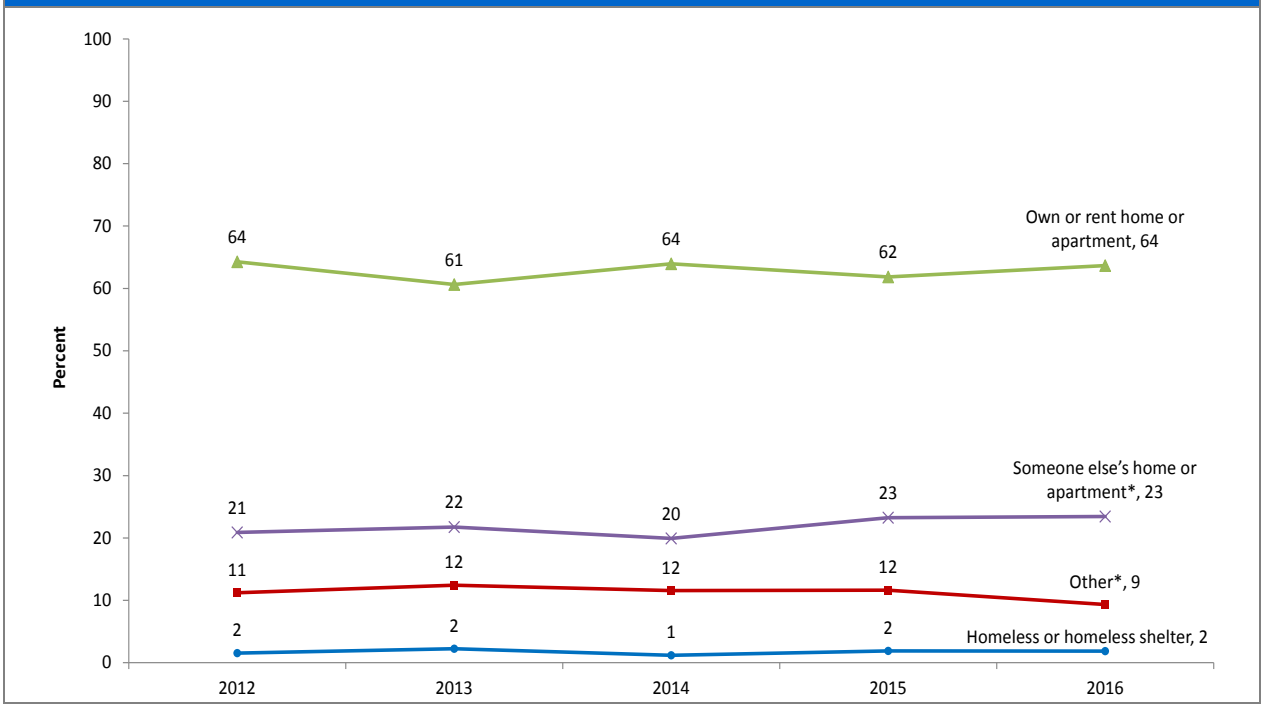
[5] OARs 309-022-0135 and 309-022-0165. Available at: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

Residence

Housing instability can cause stress and, therefore, an aggravation of mental health symptoms. Another question asked, "Where are you currently living?" The majority of respondents (64%) owned or rented a home or apartment, followed by 23% who resided in someone else's home or apartment. Fewer than 2% of respondents currently live in a substance abuse residential treatment facility, a skilled nursing facility, a crisis program, or a mental health residential treatment facility. These results are similar to last year.

Figure 30 shows four most commonly selected categories of residence from 2012 to 2016. The percentage of respondents living in their own home or apartment has not changed significantly over the past five years, while the percentage living in someone else's home or apartment trended upward. The percentage selecting "Other" trended downward, as did the percentage of those living in a skilled nursing facility (not shown in the figure below).

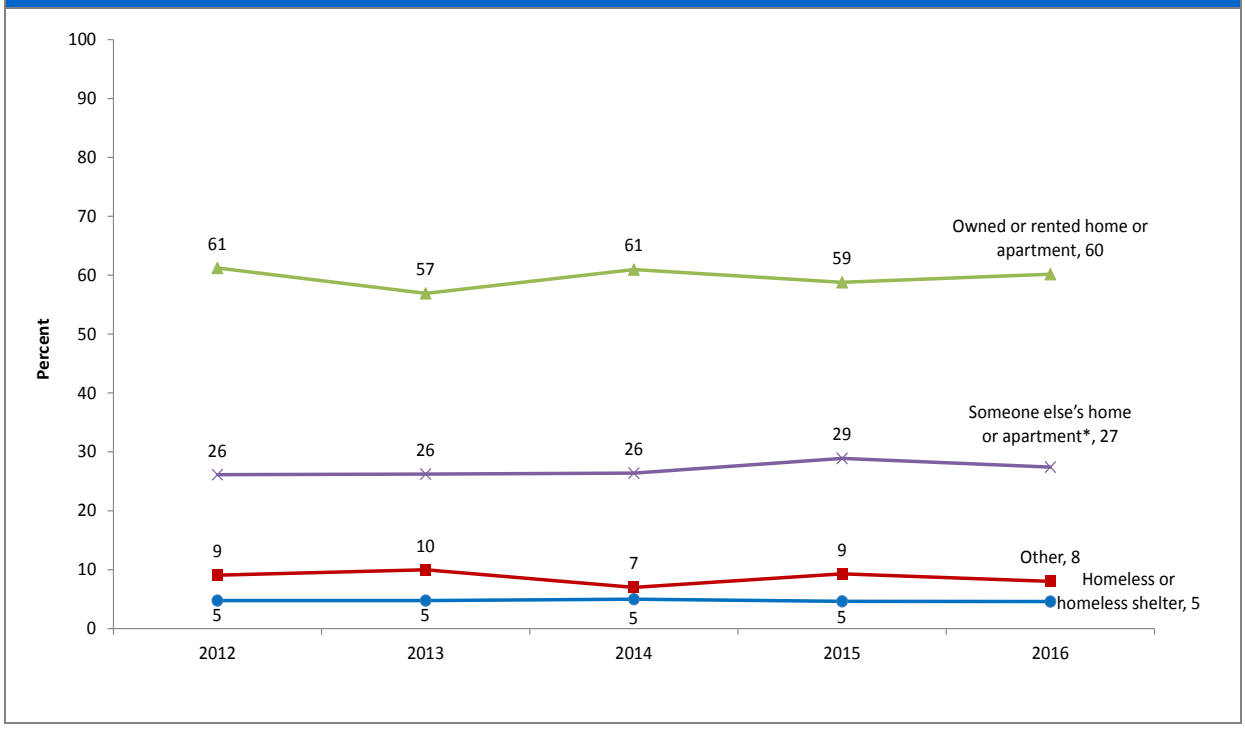
Figure 30. Respondent's Current Residence (N=1,566), 2012–2016.



*Indicates a statistically significant upward or downward trend (p<.05) for that category.

The survey also asked, "Have you lived in any of the following places in the last 12 months?" and listed 11 options that respondents could select (check all that applied, including "other"). "Own or rent home or apartment" was the most commonly selected response (60%), followed by "someone else's home or apartment" (27%). There was a statistically significant upward trend in the percentage of respondents who lived in someone else's home or apartment over the last five years (Figure 31), while there was a statistically significant downward trend in the percent of respondents who resided in a medical hospital, psychiatric hospital, or residential substance abuse treatment program (not shown in figure). The percentage of respondents who were homeless in the last year has remained stable at 5%.

Figure 31. Respondents' Residences in the Last 12 Months (N=1,649), 2012–2016.



*Indicates a statistically significant upward or downward trend (p<.05) for that category.

Respondents could select all answers that applied; therefore, all were included in the denominator.

RESIDENTIAL SURVEY RESULTS

HealthInsight Oregon mailed 1,507 residential surveys to valid addresses and received 297 responses for an overall response rate of 20%. This is similar to the response rate of 19% in 2015, but lower than the response rate of 29% in 2014. Most respondents, 264 (89%), completed the survey by mail, while 33 (11%) completed the survey online. This is an increase from the 7% online response rate in 2015 and the 8.3% rate in 2014.

Table 7 shows response rates by demographic characteristics of respondents served in residential settings. Response rates were lower across all categories this year.

Table 7. Residential Survey Response Rate by Gender, Age, Race, and Rural/Urban Residence.

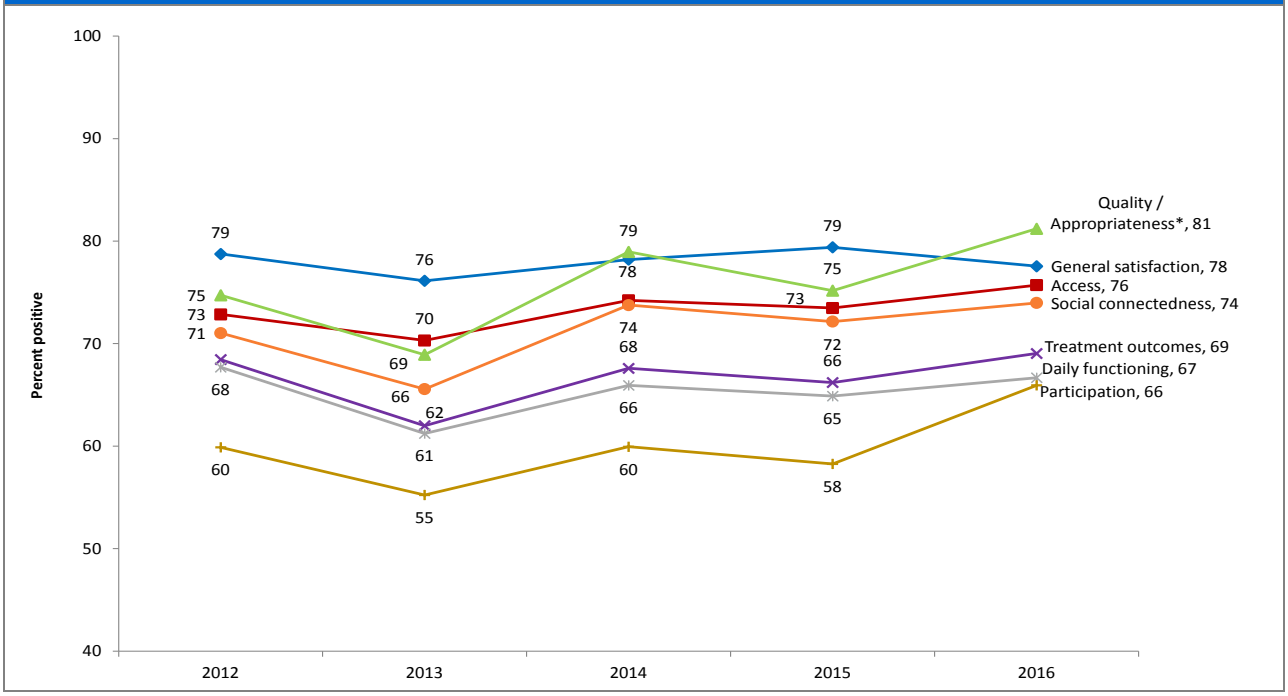
Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
Gender	Female	116	593	20
	Male	181	914	20
Age group	18-25	8	73	11
	26-64	244	1,262	19
	65+	45	172	26
Race	Non-White	25	147	17
	White (Caucasian)	259	1,284	20
	Unknown	13	76	17
Rural/Urban	Rural	101	492	21
	Urban	188	992	19
	Unknown	8	23	35
Language	English	296	1,473	20
	Spanish	0	2	0
	Other	1	32	3

Domain Satisfaction

In 2016, the percentage of respondents satisfied ranged from 66% for participation to 81% for quality and appropriateness. Compared to outpatient survey respondents, satisfaction was higher in every domain except general satisfaction.

Figure 32 shows the 2012–2016 scores for each of the seven domains. The percentage of respondents satisfied with the quality and appropriateness of their services has shown a statistically significant upward trend in the last five years, despite some variation between years.

Figure 32. Residential Domain Satisfaction, 2012–2016.



*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

Due to small numbers in the residential population, HealthInsight Oregon did not break down domain satisfaction by additional groups for comparison (e.g., race and ethnicity) in order to protect the respondents' privacy.

Analysis of State-Added Questions

HealthInsight Oregon analyzed responses to the survey questions related to treatment expectations and actual results, arrests, employment, income, primary care, general health, alcohol and drug use, trauma, service coordination, services received, and progress achieved in a residential setting. These are self-reported data and the usual cautions and limitations apply.

Of 277 respondents, 270 (97.5%) were still receiving services, 5 (1.8%) were not, and two (0.7%) did not know.

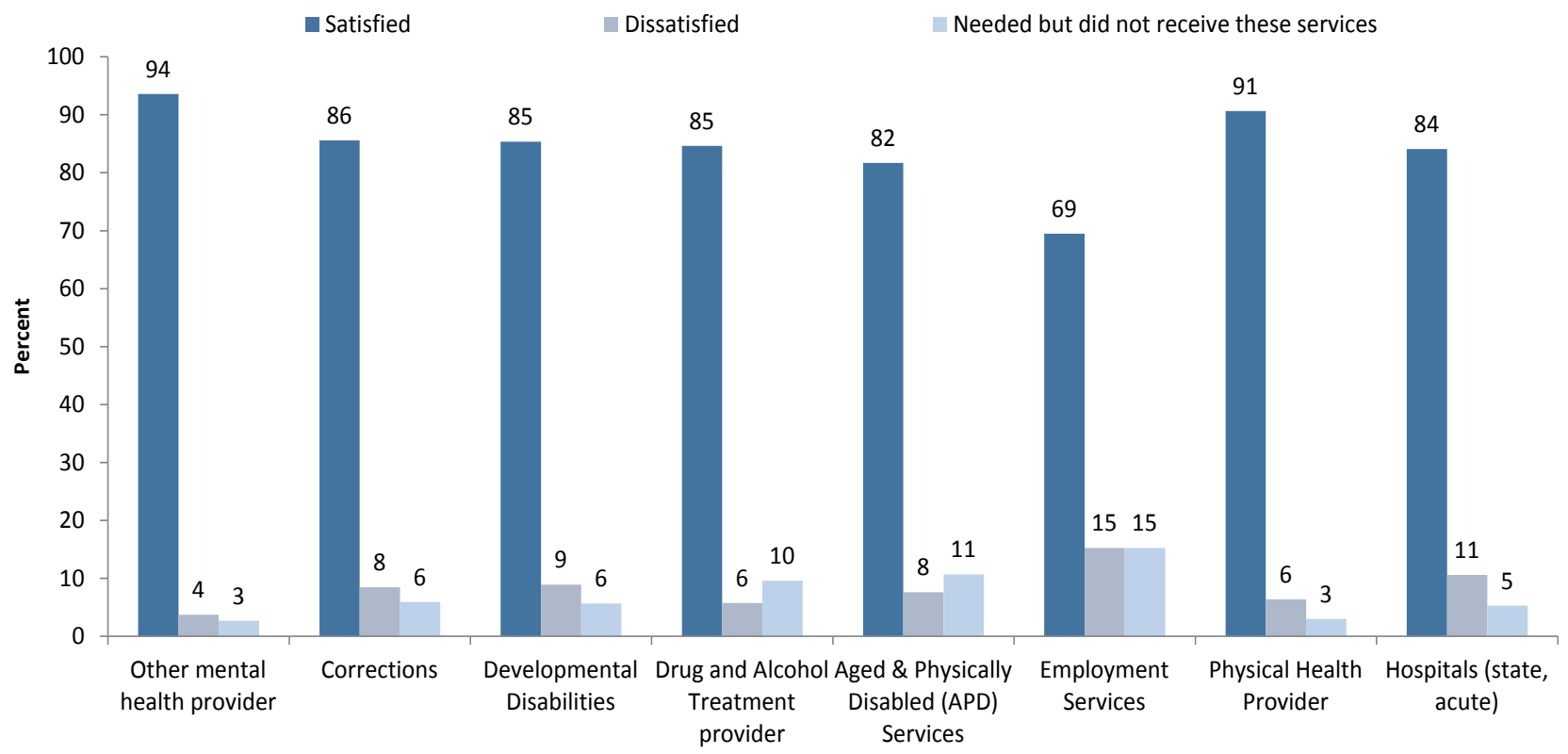
Service coordination

Many adults receiving residential mental health services and supports also receives services and supports from other agencies, including other mental health providers, corrections, developmental disabilities, drug and alcohol treatment providers, aged & physically disabled services, employment services, physical health providers, and hospitals. Respondents were asked about their satisfaction with the willingness and ability of their current mental health provider to work together with other service providers.

As Figure 33 shows, respondents were most satisfied with coordination between their current mental health provider and other mental health providers (94%) and their physical health provider (91%). Dissatisfaction was highest with employment services (15%) and hospitals (11%).

Over the last three years, the percentage of respondents satisfied with their current mental health provider's coordination with all other parties has remained stable.

Figure 33. Satisfaction with Service Coordination.



Treatment expectations and results

The 2016 survey asked respondents about the expectations and hopes they held when they began mental health treatment, and whether the treatment results met those expectations. As Figure 34 shows, the most frequent expectations were that the respondent would:

- Feel better about myself (69%)
- Become less anxious or fearful (67%)
- Become happier (64%)

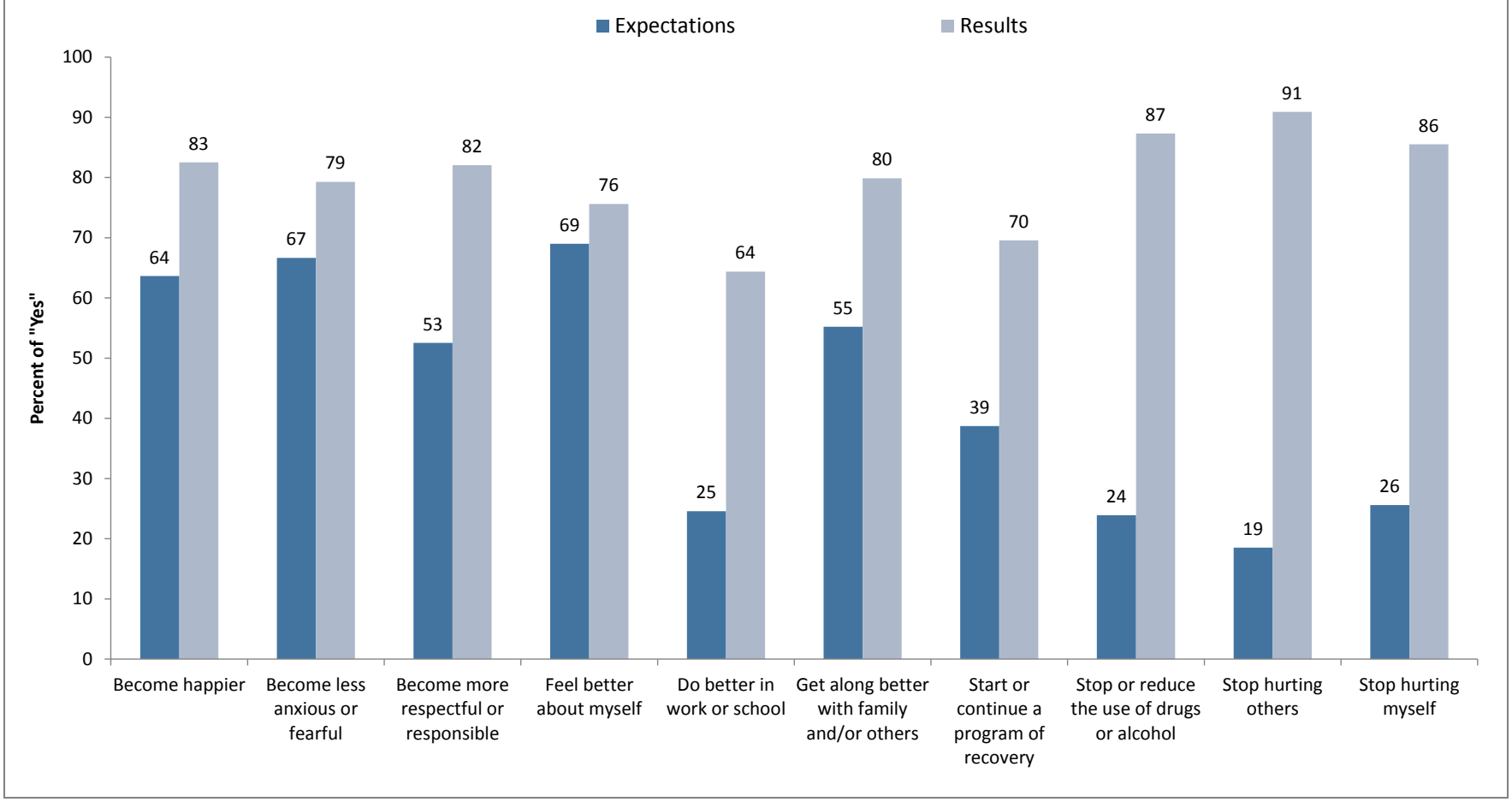
These findings are consistent with treatment expectations in previous years. Among respondents with each expectation, we tabulated how many got the result they were expecting. The most frequently met expectations were that they:

- Stop hurting others (91%)
- Stop or reduce the use of drugs or alcohol (87%)
- Stop hurting myself (86%)

Interestingly, these were also the three categories with the largest discrepancies between expectations and results.

- Stop hurting others (19% vs. 91%)
- Stop or reduce the use of drugs or alcohol (24% vs. 87%)
- Stop hurting myself (26% vs. 86%)

Figure 34. Treatment Expectations and Results.



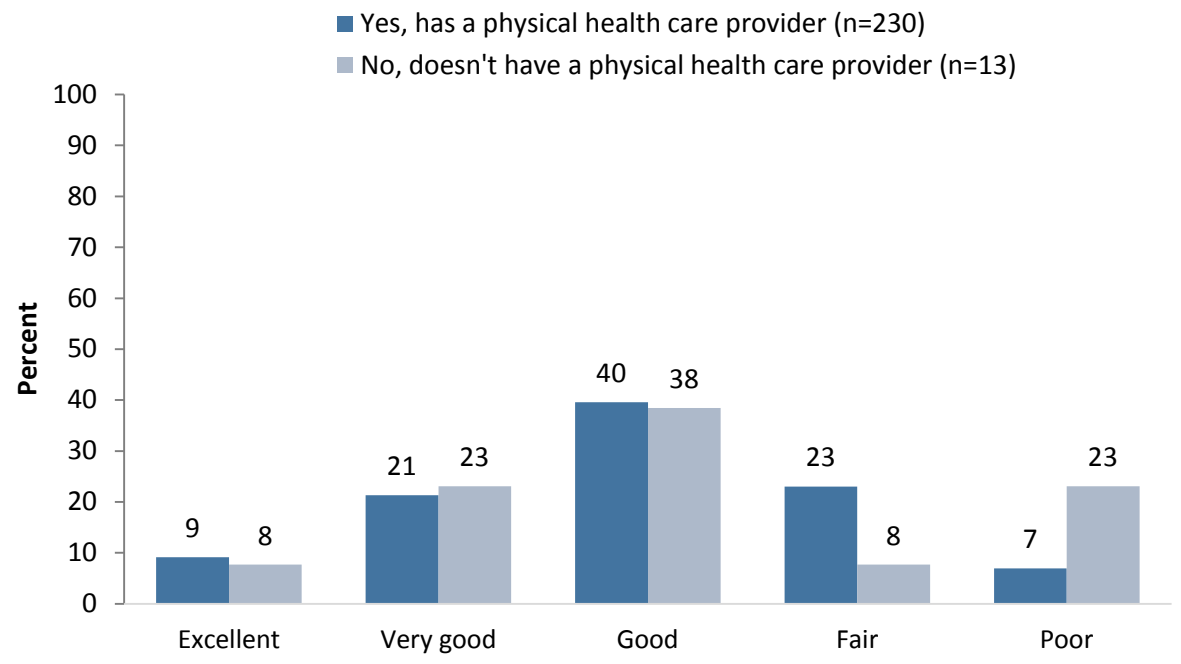
Respondents could select all answers that applied; therefore, all were included in the denominator.

Primary care and overall health

Of 284 respondents, 30.7% reported excellent or very good health, which is consistent with 2015 when 30.3% reported excellent or very good health.

Figure 35 shows that the reported health status of respondents with and without a physical health care provider was similar.

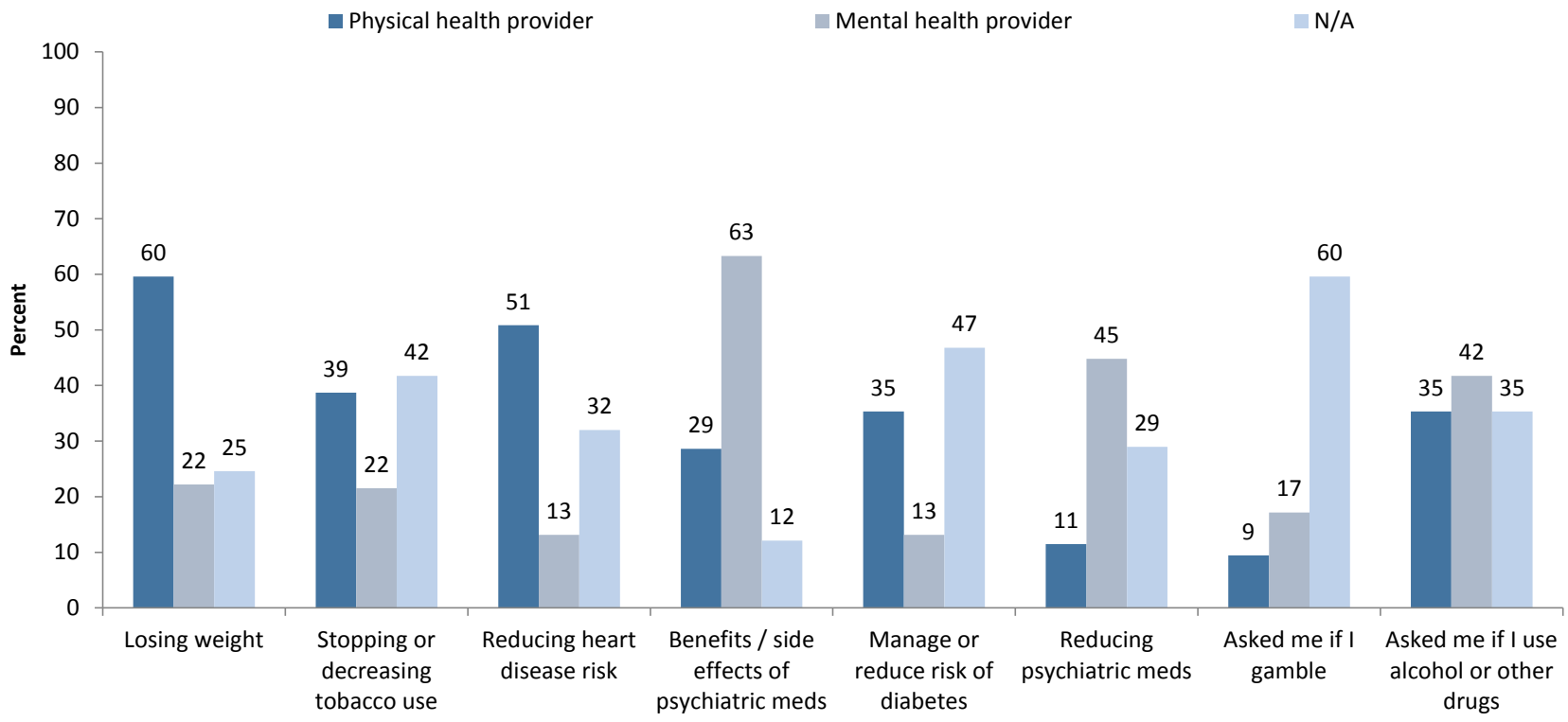
Figure 35. Health Status by Physical Health Care Provider.



The survey asked respondents to identify health topics that their doctor or mental health care provider had talked to them about. As shown in Figure 36, a distinction between conversation topics remains. Sixty percent of respondents said their physical health provider had talked to them about losing weight, while only 22% said their mental health provider had discussed the same. In contrast, 63% said their mental health provider had discussed benefits and side effects of psychiatric medications, while only 29% said their physical health provider had discussed the same. Conversations about alcohol and drugs are discussed with more similar frequency by physical and mental health providers, 35% and 42% respectively.

The percentage of respondents whose physical health providers discussed stopping or decreasing tobacco use, reducing heart disease risk, asked about gambling behavior, or asked about alcohol or other drug use has shown a statistically significant upward trend in the last four years (when these questions were added to the survey). The percentage of respondents whose mental health provider discussed losing weight has trended significantly downward in the last four years.

Figure 36. "My doctor or mental health service provider has talked to me about…" (N=297)

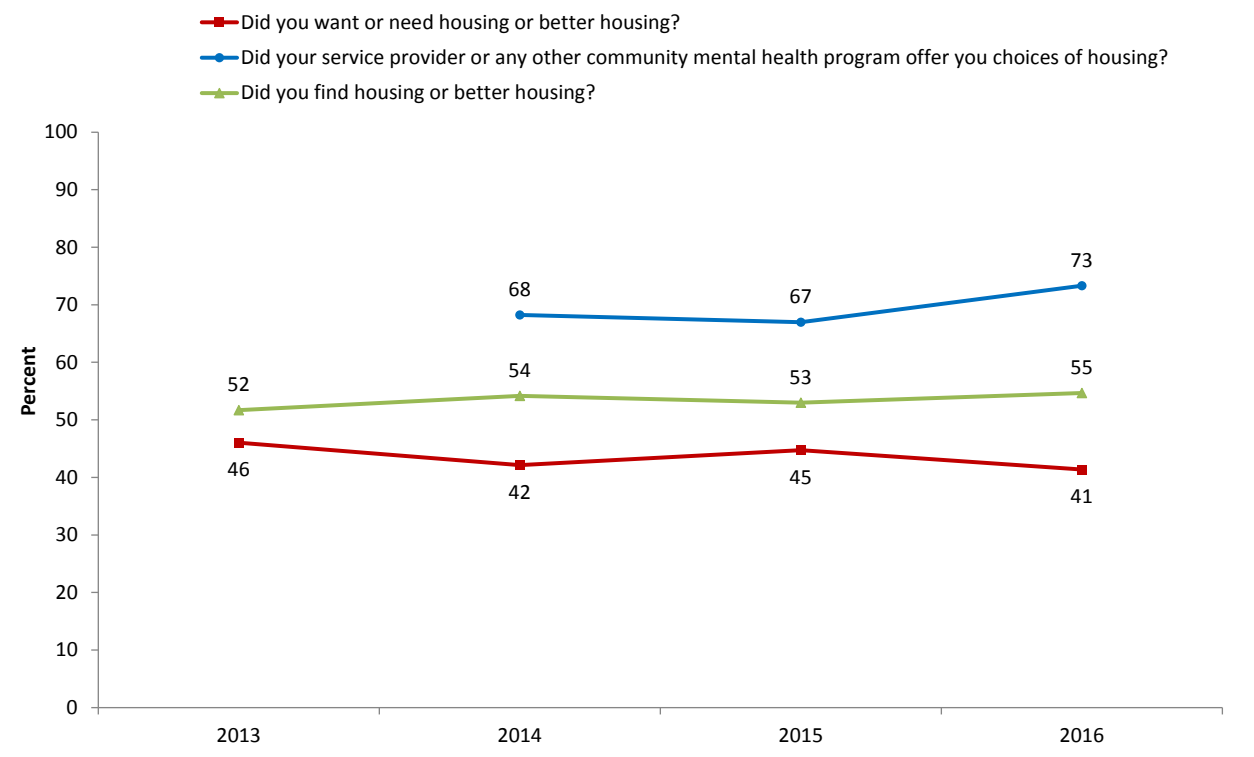


Respondents could select all answers that applied; therefore, all were included in the denominator.

Housing

Figure 37 shows that 41% wanted or needed housing or better housing in 2016. Of those who answered "yes" to wanting or needing housing, 55% found housing or better housing. Seventy-three percent of respondents indicated they were offered choices of housing from service providers or a community mental health program (this question was added in 2014). Of respondents who wanted or needed housing or better housing and whose provider offered them choices in housing, 68% actually found housing or better housing, compared to 25% of respondents whose provider did not offer them choices.

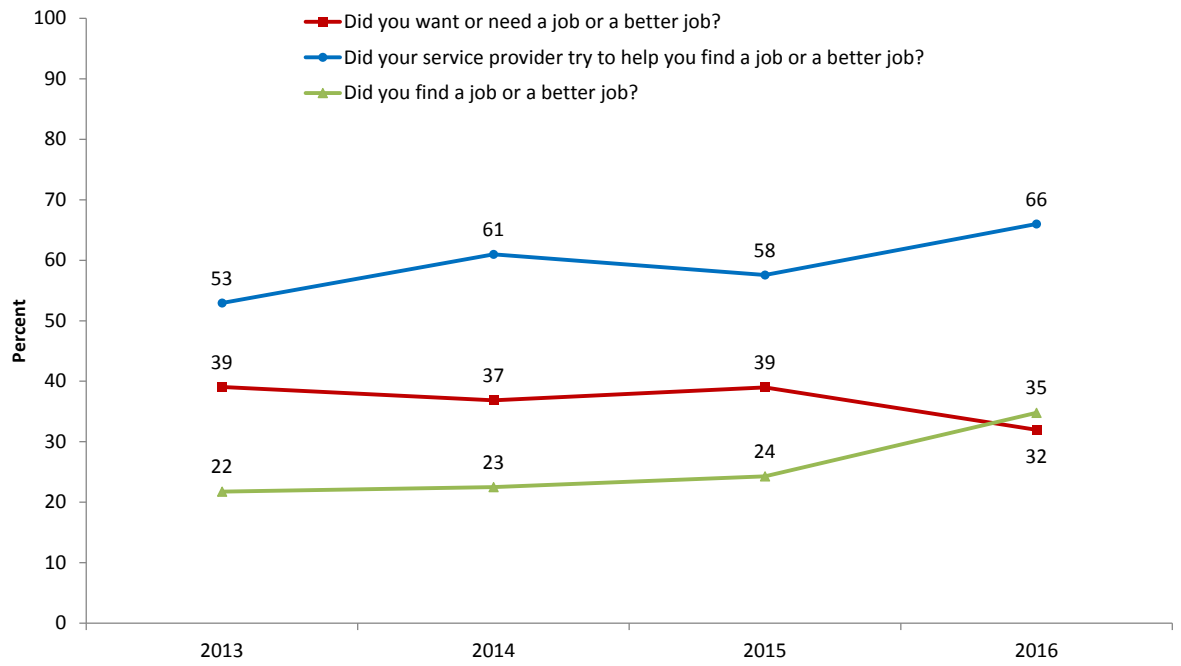
Figure 37. Provider Assistance with Housing, 2013–2016.



Employment

Figure 38 shows that 32% wanted or needed a job or a better job in 2016. Of those who wanted/needed a job or a better job and received assistance, 43% found work. Among those who wanted/needed a job or a better job but did not receive assistance, 21% found work.

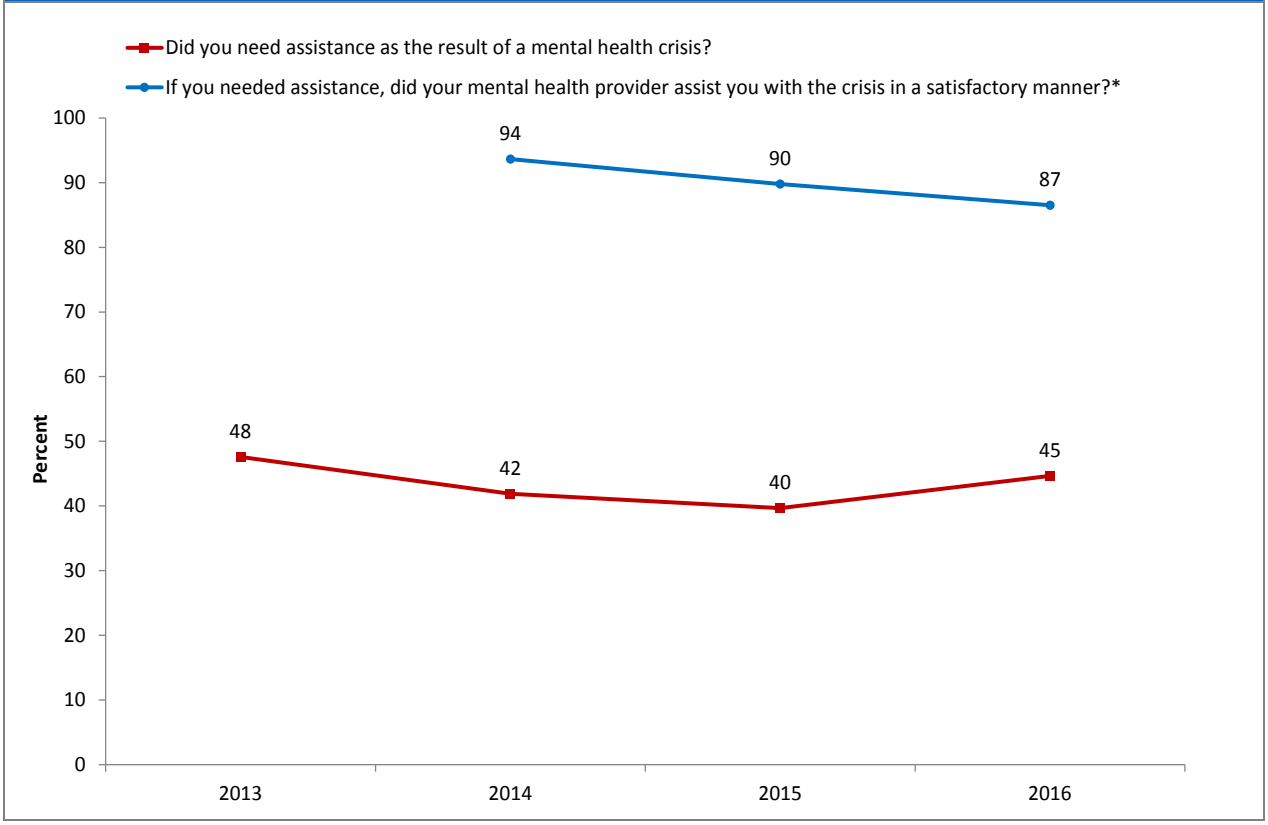
Figure 38. Provider Assistance with Employment, 2013–2016.



Assistance with mental health crisis

Figure 39 shows that 45% of respondents needed assistance as the result of a mental health crisis. If they needed assistance, a follow-up question asked if their mental health care provider had assisted with the crisis in a satisfactory manner. Of those who needed assistance, 87% reported they were satisfied with the help they received.

Figure 39. Provider Assistance with Mental Health Crisis, 2013–2016.

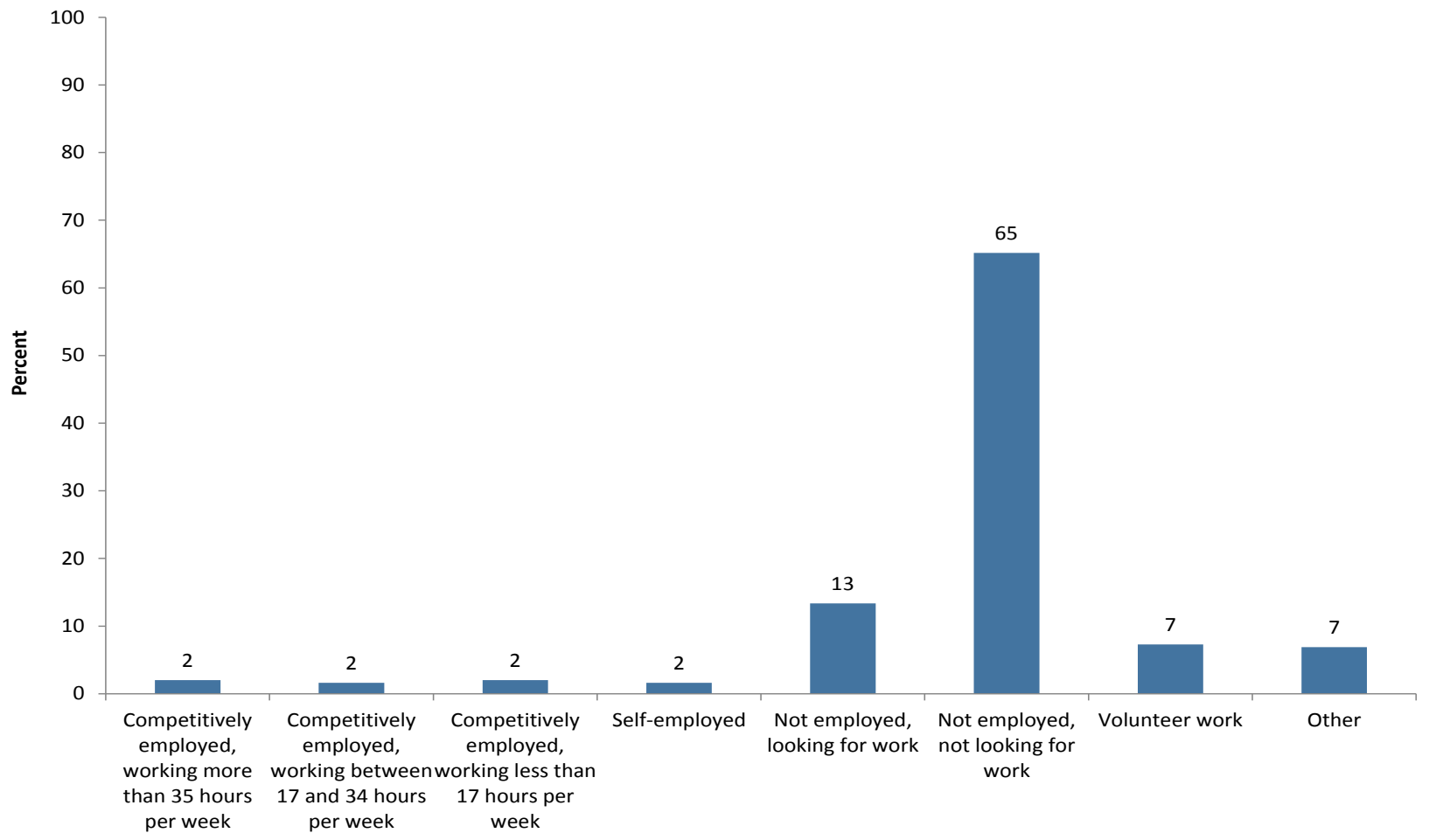


*Indicates a statistically significant upward or downward trend (p<.05) for that question.

Current employment status and income source

In response to the question, "Are you currently employed?", a majority (65%) of the 247 respondents reported that they were not employed and were not looking for work (Figure 40). This is a slight increase from 63% in 2015. Thirteen percent of respondents reported they were not employed but were looking for work.

Figure 40. Employment Status (N=247).

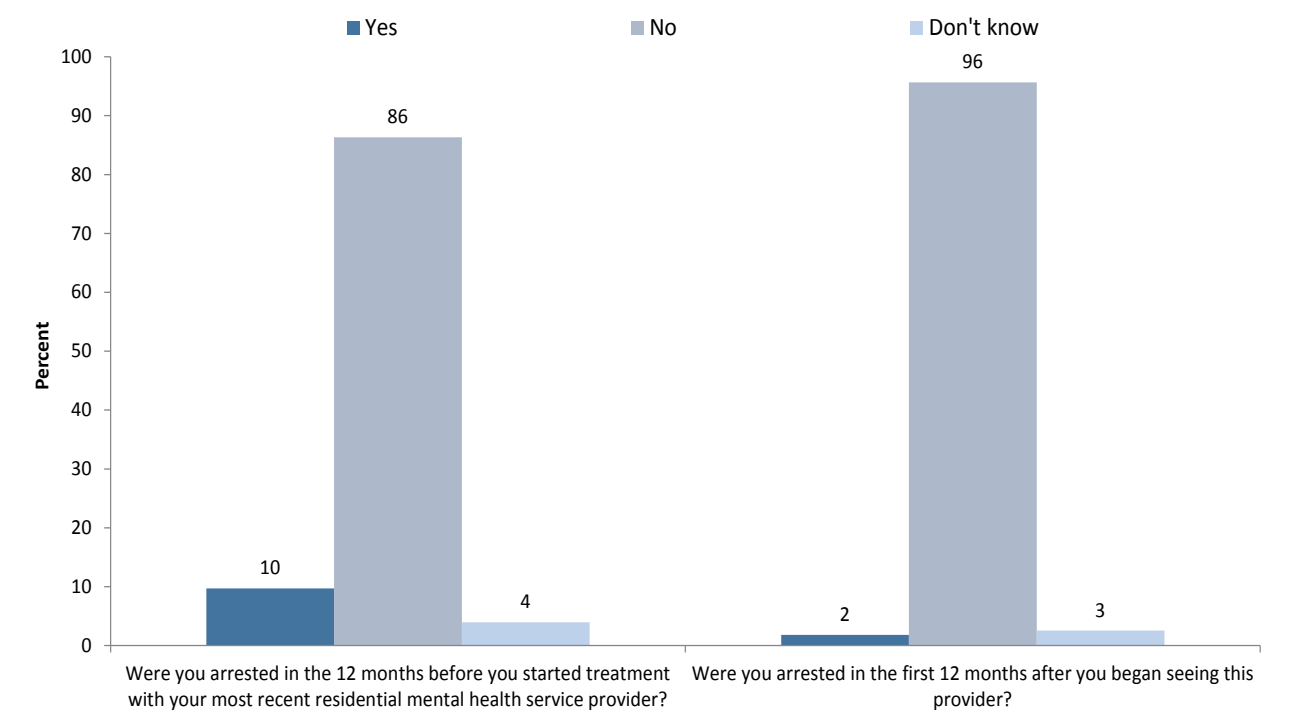


The survey also asked about current source of income and gave several options for respondents to select. Supplemental Security Income and Social Security Disability Insurance were the most common sources of income at 53% and 51%, respectively, in 2016. These results are consistent with findings in previous years.

Arrest history

Two questions asked about arrests before and after initiation of mental health services. As shown in Figure 41, 10% reported an arrest in the 12 months before beginning services with their current residential mental health service provider, while 2% reported an arrest after starting service. This is similar to the 2015 results.

Figure 41. Arrest History.



Another question asked about encounters with the police. Encounters include being arrested, hassled by police, or taken by the police to a shelter or crisis program. Since beginning treatment, 18% of respondents said their encounters

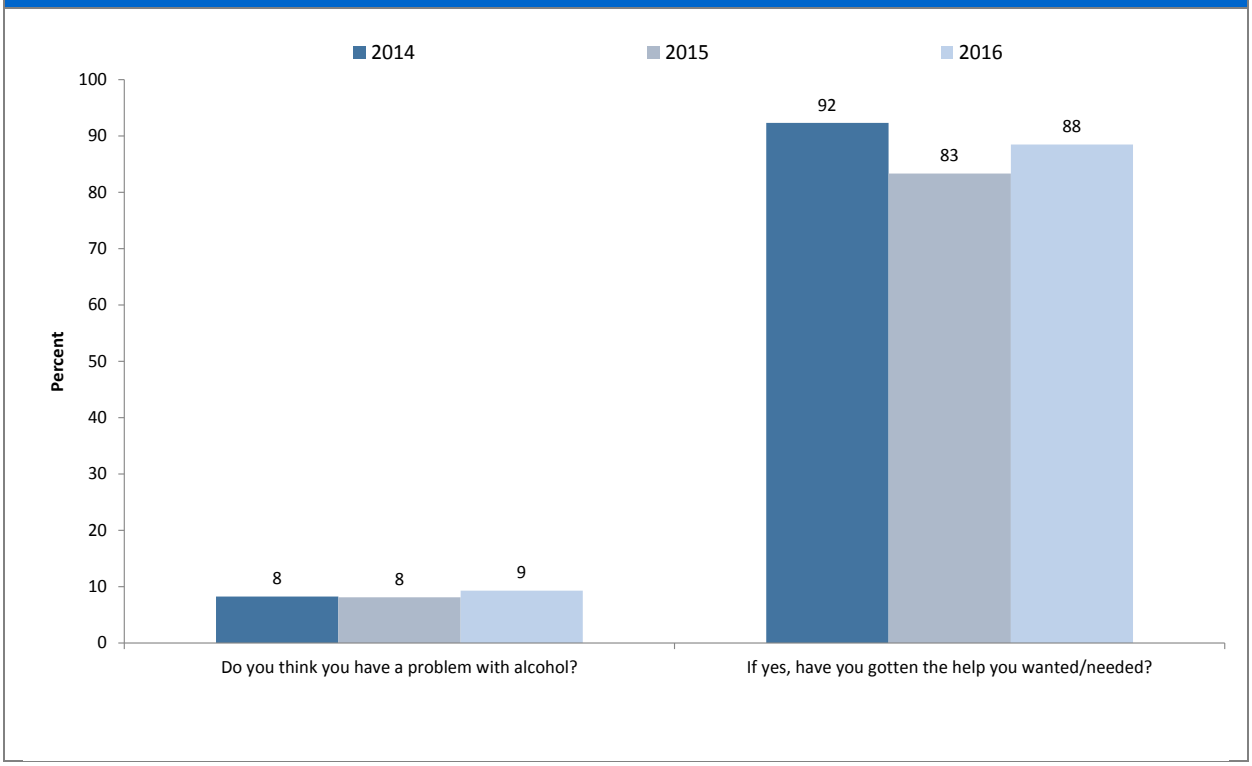
with police had decreased (up from 16%); 3% said their encounters had increased (the same as in 2015); 6% said their encounters had stayed the same; and 74% said the question did not apply because they had no encounters with the police (down from 77% in 2015).

Alcohol and drug use

The results of questions about alcohol and drug use appear in Figures 42 and 43.

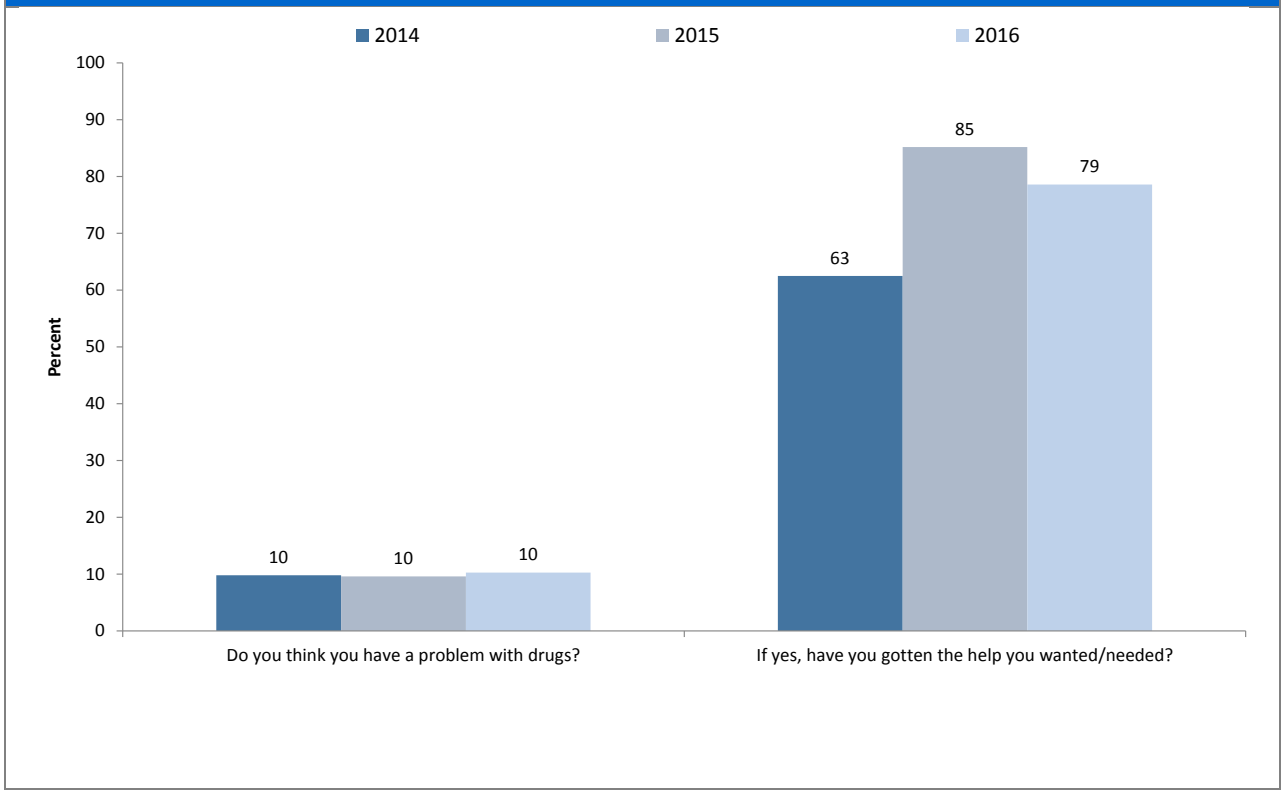
Over the past three years, since this question was added to the survey, the number of respondents indicating they have a problem with alcohol has remained stable (8% or 9%). The number reporting they received help decreased in 2015, but increased to 88% in 2016.

Figure 42. Alcohol Use: 2014–2016 Comparison.



The number of respondents indicating they have a drug problem has remained at 10% in the three years since this question was added. The number reporting that they received the needed help increased sharply in 2015, but decreased to 79% in 2016.

Figure 43. Drug Use 2014–2016 Comparison.



Some respondents (n=16; 6%) indicated that they had a problem with both alcohol and drugs. Of these, 94% received help for their alcohol problem and 88% received help for their drug problem.

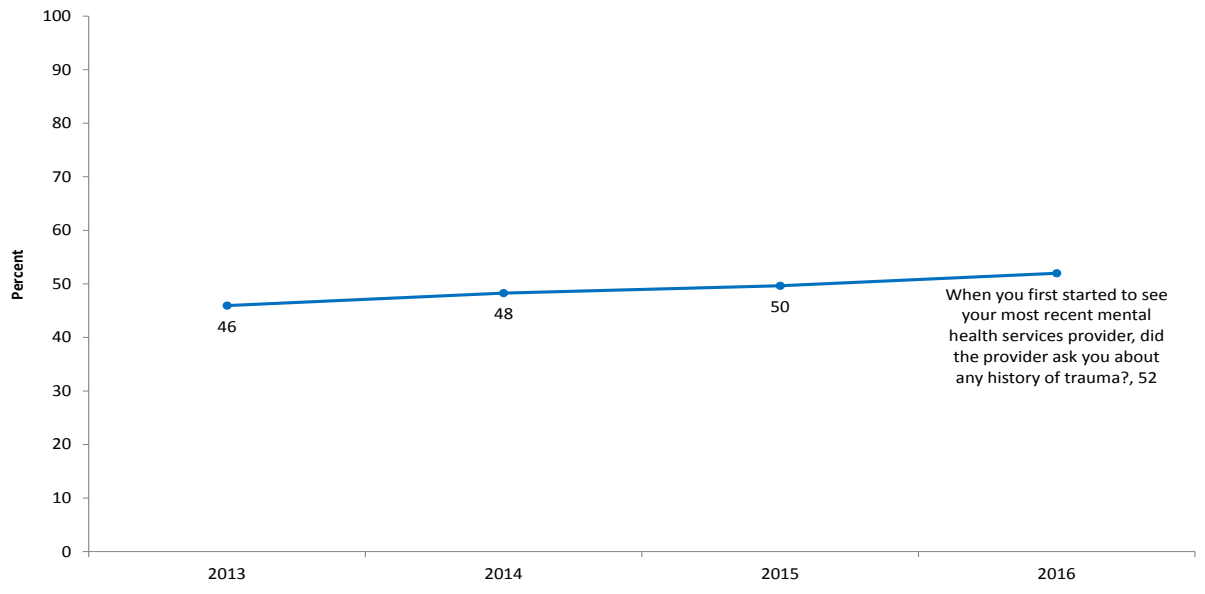
Trauma

For many adults, a history of trauma is interwoven with their mental illness. The following definition of trauma was provided in the adult residential survey:

> "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Providers must screen for trauma and include trauma-informed services in behavior support plans.[6] As Figure 44 shows, 52% of respondents indicated that they were asked about a history of trauma when the first started to see their most recent mental health services provider, a gradual increase (though not statistically significant) over the last four years when this question was added to the survey.

Figure 44. Trauma Screening, 2013–2016.



Among respondents with a history of trauma, 46% indicated that the problems related to that trauma were adequately addressed during treatment, while 27% indicated their problems were not adequately addressed and 27% were not sure.

[6] OARs 309-022-0135 and 309-022-0165. Available at: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

Residence

While respondents received services in a residential treatment setting sometime between June and December 2016, they might have moved before receiving the survey. Therefore, respondents were asked where they were currently living:

- 55% were living in a mental health residential treatment facility
- 13% reported owning or renting a home or apartment
- 7% were living in someone else's home or apartment
- 21% of respondents selected "other"

A second question asked respondents where they had lived in the past 12 months (respondents could select all options that applied). Fifty-six percent reported living in a residential treatment facility or home; 13% reported owning or renting a home or apartment; 8% were in a psychiatric hospital. Seventeen percent of respondents selected "other," and 2% had been homeless (Table 8). There were no significant upward or downward trends in living situations over the last four years.

Table 8. Respondents' Residences in the Last 12 Months, 2013–2016: Percentage of Responses.

Residence	2013	2014	2015	2016
Residential treatment facility or home	50	50	50	56
Other	18	22	21	17
Owned or rented home or apartment	12	13	17	13
Psychiatric hospital	7	9	9	8
Someone else's home or apartment	7	9	9	6
Medical hospital	6	8	5	5
Skilled nursing facility	5	4	3	3
Crisis program	4	3	3	2
Homeless or homeless shelter	3	3	2	2
Jail or correctional facility	2	3	2	2
Residential substance abuse treatment program	3	3	3	2

Living in residential care

The survey asked why respondents were living in a residential facility and gave eight options; respondents could select all that applied. As in 2015, the most common reasons were to get help taking care of oneself, for mental health treatment to get better, and for housing (Table 9).

Table 9. "Why are you living in a residential facility?" (N=297).

Responses	Number of responses	% of responses
I need help taking care of myself	123	41
I want mental health treatment so I can get better	117	39
I need housing	114	38
My guardian wants me to be here	58	20
I am civilly committed and the county wants me to be here	40	13
Other	38	13
I am under the jurisdiction of the Psychiatric Security Review Board or I have other legal requirements	35	12
I want addictions treatment so I can get better	17	6

Two follow-up questions asked "Since you've been here, do you feel like you've made progress in any of the following areas?" and "What types of services do you receive?" HealthInsight Oregon cross-tabulated responses to these two questions to determine whether a particular service array correlated with progress in Mental Health and Activities of Daily Living, the two domains that seemed to tie most closely to respondents' reasons for living in a residential care facility (see Table 9 above).

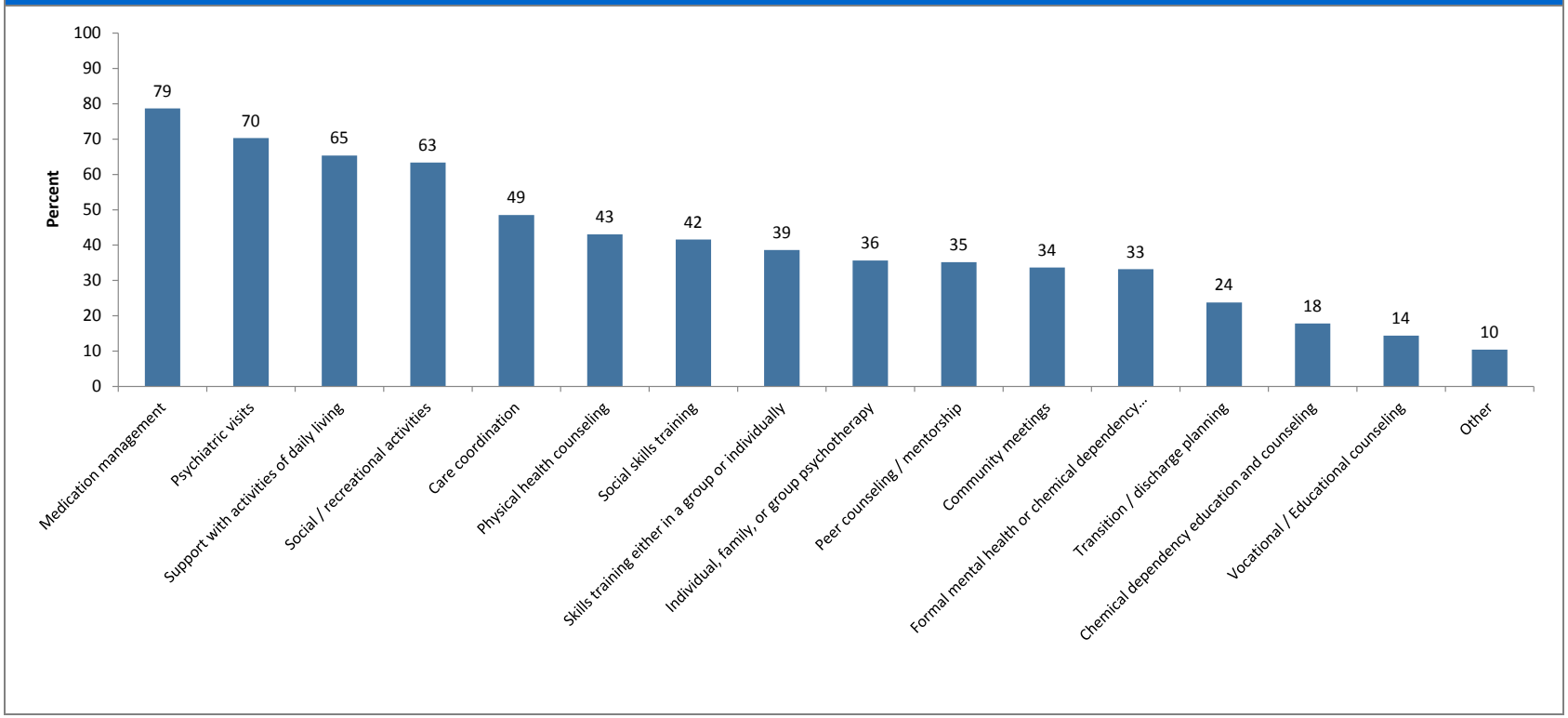
Among respondents who reported progress in their mental health, the most commonly cited services included: medication management (79%), psychiatric visits (70%), support with activities of daily living (65%), and social and recreational activities (63%). (See Figure 45.)

Similarly, among respondents who reported progress with their activities of daily living, the most commonly cited services included: medication management (77%), support with activities of daily living (71%), psychiatric visits (71%), and social and recreational activities (65%). (See Figure 46.) These four services were the most commonly cited services among respondents who reported progress in all areas identified in the survey.

Among those who reported progress in:

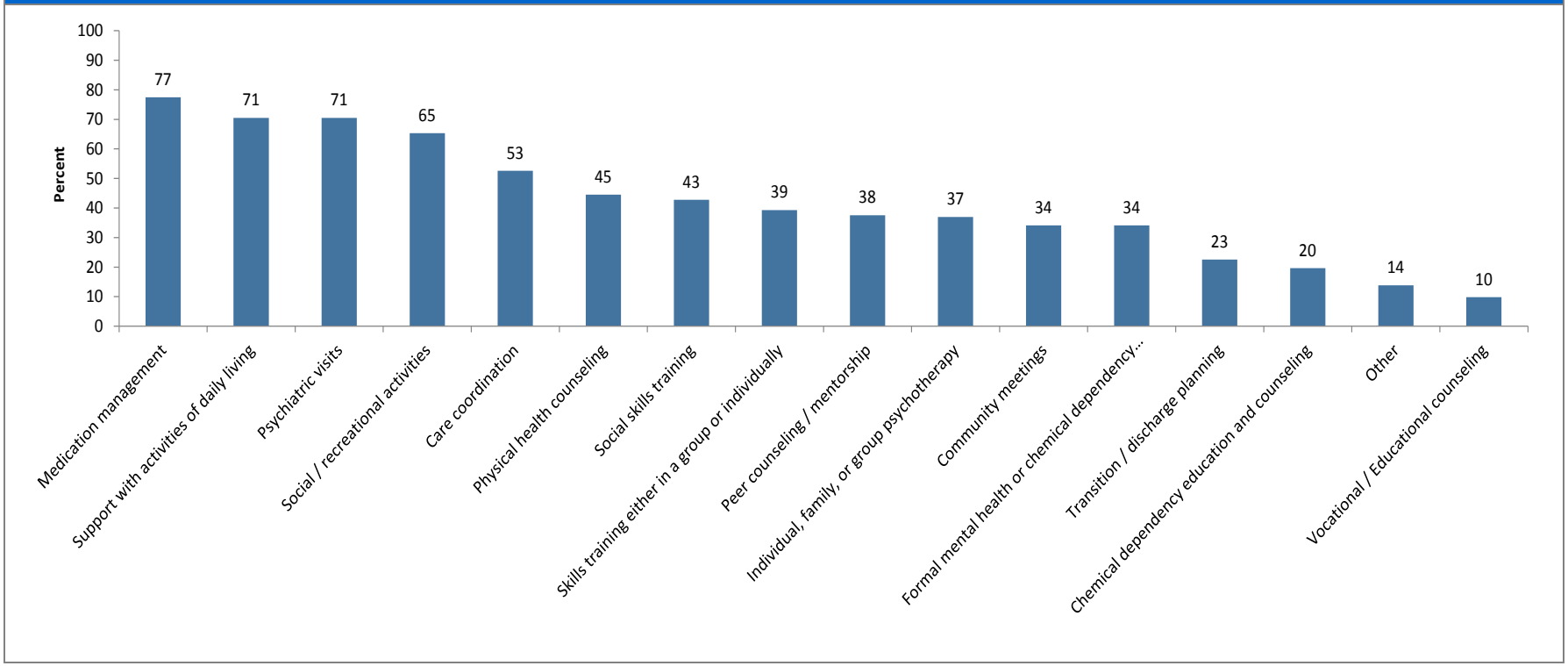
- job/school, 33% had received vocational/educational counseling
- physical health, 48% had received physical health counseling
- social/recreation, 42% had received social skills training
- substance use/abuse, 49% had received peer counseling/mentorship, 44% had received formal mental health or chemical dependency assessments and 43% had received chemical dependency education and counseling
- managing money, 37% had received skills training either in a group or individually

Figure 45. Services Received by Respondents who Have Made Progress in Mental Health. (N=202).



Respondents could select all answers that applied; therefore, all were included in the denominator.

Figure 46. Services received by respondents who have made progress in Activities of Daily Living. (N=173).



Respondents could select all answers that applied; therefore, all were included in the denominator.

Table 10 shows the types of services respondents received in residential care (they could select all services that applied) over the last five years. The percentage of respondents who received individual, family, or group psychotherapy has shown a statistically significant downward trend, while all other service types have remained stable.

Table 10. Types of Services Received in Residential Care, 2012–2016: Percentage of Responses.

Types of services	2012	2013	2014	2015	2016
Community meetings	28	25	27	24	27
Support with activities of daily living	60	54	44	55	55
Peer counseling/mentorship	31	26	28	28	30
Social skills training	35	33	33	35	35
Medication management	70	66	57	67	68
Individual, family, or group psychotherapy*	38	30	26	27	28
Care coordination	37	33	30	33	40
Transition/discharge planning	15	15	17	16	18
Social/recreational activities	51	48	39	50	53
Skills training either in a group or individually	37	31	31	34	32
Physical health counseling	33	32	29	32	34
Vocational/Educational counseling	13	9	16	12	10
Psychiatric visits	66	57	50	57	62
Chemical dependency education and counseling	17	14	12	12	15
Formal mental health or chemical dependency assessments	27	24	21	23	26
Other	13	7	8	13	11

*Indicates a statistically significant difference between years.

Independent living

The survey asked whether respondents felt ready for more independent living, and if not, why. Of 269 respondents, 48% said they did *not* feel ready for more independent living, the same as in 2015. Forty percent said they felt ready, and 12% were not sure.

Respondents selected several different reasons for not feeling ready for independent living (Table 11). As in previous years, the two most commonly selected reasons were "I like it here" (70%) and "I don't have the skills to live on my own" (61%).

Table 11. Reasons responders do not feel ready for independent living. (N=128).

Reasons	Number of responses	% of responses
I like it here	90	70
I don't have the skills to live on my own	78	61
I am worried that if I leave I won't get the help I need	57	45
I have lived on my own before and it did not work	57	45
My symptoms are too bad right now	52	41
I don't know where else I would go	50	39
I am worried that I will get sick again	50	39
My family does not want me to leave	38	30
I don't have a plan	29	23
Other	13	10
I don't feel like I have support from staff	11	9
I have legal issues that keep me here	8	6

Respondents indicated that, if they were ready to move to more independent living, 38% (of 297) would have the option to live in their own apartment or home; 37% didn't know where they would live; 14% would have the option to live with family or friends; and 12% selected "other." Respondents could select as many answers as they wished.

DISCUSSION AND RECOMMENDATIONS

Overall Survey Results

As in previous years, outpatient respondents were significantly less satisfied than residential and foster care respondents in most domains, with significant differences in general satisfaction, access, treatment outcomes, daily functioning, and social connectedness. This disparity could be attributed to the reasons people are in residential care to begin with (for example, needing a place to live and assistance caring for oneself, in addition to mental health treatment).

Survey Limitations

While a client survey has many benefits (e.g., ease of administration, first-hand experience reports, and client involvement), there are limitations as well. As in any survey, perceptions of social desirability may bias some results. This is especially true of questions on sensitive topics such as alcohol and drug use.

While the MHSIP domain portions of the survey have remained untouched, OHA has added or removed additional questions in the past. No substantive changes were made to the survey this year. Some of these added questions have not been validated, and it is unknown what effect, if any, they have on the validity of the preceding MHSIP items.

The length of the survey may deter some potential respondents. With seven printed pages and over 60 questions, the surveys may take significant time to complete, especially for some respondents with mental or cognitive challenges.

Mental or cognitive challenges may also have affected the respondents' ability to understand and respond accurately to some questions. For instance, a question on the residential survey asked about what services the client was receiving. A client might not know the administrative terms (e.g., social skills training, formal mental health or chemical dependency assessments) for the services received, so services may be under- or over-reported in some instances.

Other items on the surveys asked respondents to report events that occurred one year prior to the start of services. Any question that relies on memory must be interpreted with caution.

Finally, survey results are a combination of surveys completed on paper and returned by mail, and surveys completed online. There are potential differences in the way respondents answer the same questions in the two modes. Differences

in age, disability, treatment setting, or living situation between online and paper respondents may affect the way they answered the questions. Web respondents may feel more anonymous and therefore may be likely to answer more honestly than paper survey respondents. These differences were not the focus of this survey or analysis, but may be interesting to study in the future.

Recommendations

Response rates

A total of 1,946 enrollees returned their surveys by the deadline for an overall response rate of 18%, which is lower than the 2014 rate of 23% and the 2015 rate of 19%.

The outpatient survey had a response rate of 18%, which is a decrease from 19% in 2015 and 23% in 2014.

The residential survey had a response rate of 20%, which is higher than the response rate of 19% in 2015, but lower than the 29% in 2014.

- **OHA-HSD should continue efforts to increase awareness of the survey and work with CCOs and agency providers to maintain or improve this response rate.**

Outpatient Survey

Race and ethnicity data

Race and ethnicity data are missing for many Medicaid enrollees in the state's dataset because neither of these fields are required in MMIS. The surveys asked respondents to self-identify their race and ethnicity, which enabled comparisons between the state dataset and the self-reported data. This analysis found that the state ethnicity data overestimates the number of non-Hispanic enrollees, as well as the number of white enrollees.

Obtaining accurate race and ethnicity data is a key component of addressing health equity in Oregon, and the state should continue efforts to do so.

- **HealthInsight Oregon encourages OHA-HSD to work with the CCOs to gather and update these data at points of contact to obtain the most accurate race and ethnicity data. OHA-HSD could provide policy direction and technical assistance to CCOs to follow best practices in gathering these data to improve quality of care and reduce disparities.**

Satisfaction by age

Over the last 5 years, satisfaction with treatment outcomes has trended significantly downward in the 18–25 age group, from 52% in 2012 to 43% in 2016.

Also, satisfaction among respondents ages 65+ has trended significantly downward over the last 5 years in treatment outcomes, daily functioning, and participation.

- **OHA-HSD should work with the CCOs to explore reasons for these decreases.**

Satisfaction with treatment outcomes by race

The treatment outcomes domain had significant differences between racial groups in 2016, with the American Indian or Alaskan Native group and Black or African American group having the lowest satisfaction.

- **OHA-HSD should work with the CCOs to explore reasons for these differences, and provide culturally appropriate services.**

Satisfaction with service coordination

Over the last four years, there was a statistically significant decrease in respondents who needed but did not receive services in the following:

- Corrections
- Developmental disabilities
- Drug and alcohol treatment
- Employment services
- Physical health providers

- **OHA-HSD should work with the CCOs and providers to ensure that individuals are informed about and encouraged to use these services.**

Discussion of health topics with providers

The survey asked respondents if their physical or mental health care provider had talked to them about eight different issues.

Physical health providers discussed losing weight (48%) and use of alcohol and drugs (50%) the most out of the eight issues. While mental health providers most commonly discussed use of alcohol and drugs (49%) and the benefits/side effects of psychiatric medications (45%).

There were some discrepancies between mental and physical health providers in some areas, including reducing psychiatric medications (26% for mental health providers vs. 13% for physical health providers).

- **As CCOs strive to coordinate physical and mental health services, both physical and mental health care providers should discuss and communicate concerns/issues in providing services.**

Housing

The percentage of respondents who wanted or needed housing or better housing has trended significantly upward in the last five years, from 28% in 2012 to 38% in 2016. At the same time, the percentage of respondents who found housing or better housing has trended significantly downward, from 43% in 2012 to 37% in 2016.

- **OHA-HSD should work with CCOs and providers to ensure enrollees receive assistance with obtaining adequate housing.**
- **OHA-HSD should work with CCOs to explore new flexible spending options to assist enrollees with obtaining adequate housing.**

Employment

Over the past 5 years, the percentage of respondents who wanted or needed a job or better job has trended significantly upward, from 29% in 2012 to 48% in 2016. There are corresponding statistically significant upward trends in the percentage of people whose service providers tried to help them find a job or a better job

(from 26% to 40%), and in the percentage of people who found a job or a better job (from 22% to 29%).

- **OHA-HSD should work with the CCOs to ensure that enrollees receive supported employment and referrals to employment services. OHA-HSD should work with CCOs to explore new flexible spending options to assist enrollees in finding employment.**

Mental health crisis services

A new survey question asked whether respondents knew that their health benefit pays for mental health crisis services; 56% responded "yes," 24% responded "no," and 20% didn't know or indicated that this question was not applicable.

- **Since this benefit is available for all individuals, OHA-HSD should work with CCOs to increase awareness of it among members.**

Trauma treatment

In 2016, 68% of respondents indicated that their mental health provider had asked about a history of trauma when they started treatment. Positive responses to this question have trended upward, with statistical significance, over the last four years.

Of those who have experienced trauma, 52% reported that it was adequately addressed during treatment; also a statistically significant upward trend.

- **OHA-HSD and CCOs should continue to encourage providers to implement trauma-informed care.**

Residential Survey

Discussion of health topics with providers

The survey asked respondents to identify health topics that their doctor or mental health care provider had discussed with them. There were discrepancies between topics discussed by physical and mental health providers. For example, 60% of respondents said their physical health provider had talked to them about losing weight, while only 22% said their mental health provider had discussed the same. In contrast, 63% said their mental health provider had discussed

benefits and side effects of psychiatric medications, while only 29% said their physical health provider had discussed the same.

- **As CCOs strive to coordinate physical and mental health services, both physical and mental health care providers should discuss and communicate concerns/issues in providing services.**

Trauma treatment

Fifty-two percent of respondents indicated that they were asked about a history of trauma when the first started to see their most recent mental health services provider, which marks a gradual increase (though not statistically significant) over the last four years when this question was added to the survey.

Among respondents with a history of trauma, 46% indicated that the problems related to that trauma were adequately addressed during treatment, while 27% indicated their problems were not adequately addressed, and 27% were not sure.

- **OHA-HSD should continue efforts to focus on trauma-informed care across the state and across treatment settings.**

Services received in residential care

Since 2012, the percentage of respondents receiving psychotherapy (individual, family, or group) in residential care has shown a statistically significant downward trend. Other services have not changed significantly.

- **OHA-HSD and CCOs should investigate why significantly fewer respondents have reported receiving psychotherapy in residential settings.**

APPENDIX A

Survey Data Security and Quality Assurance Procedures

HealthInsight Oregon stored the electronic data for this survey in REDCap software on a secure server. Only essential team members had access to the raw data to perform data entry. Exported data files were also saved on the secure server, where access was limited. HealthInsight Oregon kept the original paper copies of the surveys in a secure location.

Data entry staff members were trained on entering the survey data, and other authorized staff checked every tenth survey to ensure consistent and correct data entry. HealthInsight Oregon maintained data quality on two tiers. First, built-in data checks in the REDCap software ensured that only valid field values could be entered, and enforced the use of custom codes to note missing or out-of-range data. For example, the application checked to make sure that the field corresponding to Question 1 was coded with 1–5 (Strongly Disagree to Strongly Agree), or 9 for NA, or 0 for missing or invalid response on the paper copy.

Second, SAS recheck programs written by the data analyst scanned each field of each survey response and checked for missing and out-of-range data or logic check problems.

Data Analysis Decisions

HealthInsight Oregon excluded from the analysis of a domain any survey responses lacking scores for more than one-third of the items for that domain. For example, a respondent would have to provide responses to at least two of the three items in the General Satisfaction domain to have his or her responses included in the data for that domain.[7] HealthInsight Oregon's analyst used univariate analyses to describe demographic variables and other frequencies; cross-tabulations to examine the relationship between different variables; trend tests to describe trends over time; and chi-square analyses to compute categorical statistical differences.[8]

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[7] Because of the method used to calculate the domain score, comparing a domain score with the aggregate scores for individual items within a domain can be misleading. As noted above, the domain score calculation excludes individual items to which the responder did not respond. However, responses to individual items in each domain are counted in the aggregate score for the individual item (but not in the domain score).

[8] In each data table, the number of reported responses may be lower than the total number of respondents to the survey, because different respondents may or may not have answered all the questions needed to calculate a particular domain score.

APPENDIX B - MHSIP SURVEY FORMS

Please contact HealthInsight Oregon for a copy of the survey forms.

2016 Oregon Youth Services Survey for Families and Youth Services Survey Report

Oregon Health Authority

January 2017

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OREGON

2016 Oregon Youth Services Survey for Families and Youth Services Survey Report

January 2017

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 1
INTRODUCTION 8
METHODOLOGY 9
Survey Methods 9
Domain Scoring Analysis 10
2016 YSS-F RESULTS 12
Survey Response 12
Respondent Race and Ethnicity 15
Domain Satisfaction 17
Domain satisfaction according to treatment setting 19
Domain satisfaction according to CCO 21
Demographic Comparisons 23
Domain satisfaction by child's age 23
Domain satisfaction by child's gender 24
Domain satisfaction by rural/urban residence 26
Domain satisfaction by child's race 28
Domain satisfaction by ethnicity 33
Domain satisfaction by survey language 38
Analyses of Additional Questions 42
Receiving services 42
Coordination of services 43
Satisfaction with coordination between systems 46
Caregivers' expectations about the results of their children's mental health treatment 49
Child's service plan 51
Health status 52
Psychotropic medications 53
School attendance 54
Mental health crisis 56
Child's arrest history 58

Alcohol and drug use 59
History of trauma 60
Housing stability 61
2016 YOUTH SERVICES SURVEY RESULTS 62
Survey Response 63
Domain Satisfaction 66
Domain Satisfaction by Gender 70
Domain Satisfaction by Residence 72
Domain Satisfaction by Ethnicity 74
Analyses of Additional Questions 77
Open-ended questions 77
Living situation during past six months 77
Utilization of physical health care services 78
Medication 80
Arrest history 80
School absences 82
COMPARISON OF YOUTH AND CAREGIVER RESPONSES 83
Medication 87
DISCUSSION AND RECOMMENDATIONS 89
Overall Survey Results 89
Survey Limitations 89
Highlights and Recommendations 90
APPENDIX A: SURVEY FORMS IN ENGLISH AND SPANISH A-1
APPENDIX B: SURVEY DATA SECURITY AND QUALITY ASSURANCE PROCEDURES B-1

INDEX OF TABLES AND FIGURES

Table 1. YSS-F Response Rate by CCO. 13

Table 2. YSS-F Response Rate by Treatment Setting. 14

Table 3. YSS-F Response Rate by Demographic Characteristics. 14

Table 4. Domain Satisfaction by CCO, with 95% CI, 2016. 22

Table 5. Percent (n) of Responders Satisfied with Coordination of Agency-Specific Services by CCO, 2016. 48

Table 6. Child's or Young Person's Individual Services and Supports Plan Supports the Following: 51

Table 7. YSS Response Rate by Treatment Setting. 64

Table 8. YSS Response Rate by Demographic Characteristics. 64

Table 9. YSS Response Rate by CCO. 65

Table 10. YSS Domain Scores by Demographic Characteristics. 69

Table 11. Living Arrangements in the Previous Six Months, Five-Year Comparison. 78

Table 12. Utilization of Physical Healthcare Services in the Past Year. "In the last year, did you see a medical doctor (or nurse) for a health checkup or because you were sick?" 79

Table 13. Youth and Caregiver Perceptions of Treatment Services (Percent who Strongly Agree/Agree with each Statement), 2016 (n=486). 83

Table 14. YSS-F and YSS Domain Scores, 2012–2016. 86

Figure 1. Comparison of State-Recorded and Self-Reported Race and Ethnicity Data, by Respondent. 16

Figure 2. 2012–2016 Comparison of YSS-F Domain Satisfaction. 18

Figure 3. Domain Satisfaction by Treatment Setting with 95% Confidence Intervals. 20

Figure 4. 2012–2016 Domain Satisfaction by Child or Young Person's Gender: Female. 24

Figure 5. 2012–2016 Domain Satisfaction by Child's or Young Person's Gender: Male. 25

Figure 6. 2012–2016 Domain Satisfaction by Residence: Rural. 26

Figure 7. 2012–2016 Domain Satisfaction by Residence: Urban. 27

Figure 8. 2012–2016 Domain Satisfaction by Race: Appropriateness. 29

Figure 9. 2012–2016 Domain Satisfaction by Race: Treatment Outcomes. 29

Figure 10. 2012–2016 Domain Satisfaction by Race: Participation. 30

Figure 11. 2012–2016 Domain Satisfaction by Race: Cultural Sensitivity. 30
Figure 12. 2012–2016 Domain Satisfaction by Race: Access. 31
Figure 13. 2012–2016 Domain Satisfaction by Race: Social Connectedness. 31
Figure 14. 2012–2016 Domain Satisfaction by Race: Daily Functioning. 32
Figure 15. 2012–2016 Domain Satisfaction by Ethnicity: Appropriateness. 34
Figure 16. 2012–2016 Domain Satisfaction by Ethnicity: Treatment Outcomes. 34
Figure 17. 2012–2016 Domain Satisfaction by Ethnicity: Participation. 35
Figure 18. 2012–2016 Domain Satisfaction by Ethnicity: Cultural Sensitivity. 35
Figure 19. 2012–2016 Domain Satisfaction by Ethnicity: Access. 36
Figure 20. 2012–2016 Domain Satisfaction by Ethnicity: Social Connectedness. 36
Figure 21. 2012–2016 Domain Satisfaction by Ethnicity: Daily Functioning. 37
Figure 22. 2012–2016 Domain Satisfaction by Language: Appropriateness. 38
Figure 23. 2012–2016 Domain Satisfaction by Language: Treatment Outcomes. 39
Figure 24. 2012–2016 Domain Satisfaction by Language: Participation. 39
Figure 25. 2012–2016 Domain Satisfaction by Language: Cultural Sensitivity. 40
Figure 26. 2012–2016 Domain Satisfaction by Language: Access. 40
Figure 27. 2012–2016 Domain Satisfaction by Language: Social Connectedness. 41
Figure 28. 2012–2016 Domain Satisfaction by Language: Daily Functioning. 41
Figure 29. Reasons Why Child or Young Person No Longer Receiving Services 42
Figure 30. Percentage of Caregivers whose Children Received Services from Specific State-Funded, Non-Mental Health Agencies/Systems, According to whether that Child Was Served by Wraparound, 2016. 45
Figure 31. Percent of Caregivers Satisfied with Coordination of Agency-Specific Services for Children and Youth, 2016. 46
Figure 32. Expectations for the Child's or Young Person's Mental Health Treatment, and Results of Mental Health Services. "I expected my child would…" 50
Figure 33. Presence of a Primary Health Care Provider or Other Practitioner, According to Child's or Young Person's Health Status. 52
Figure 34. Psychotropic Medications Prescriptions, 2012–2016. 54
Figure 35. School Suspensions or Expulsions Pre- and Post-Service Initiation. 55
Figure 36. Mental Health Crisis and Provider Assistance. 57

Figure 37. Youth's Encounters with Police since Receiving Mental Health Treatment, Ages 14–18. "Since your child began to receive mental health services from this provider, have his or her encounters with the police…" 58

Figure 38. Status Substance Abuse Treatment for Youth Ages 13–17. 59

Figure 39. Provider Asking About Trauma; Trauma Addressed in Treatment. 60

Figure 40. 2012–2016 Comparison of YSS Domain Satisfaction. 67

Figure 41. Domain Satisfaction by Treatment Setting with 95% Confidence Intervals. 68

Figure 42. 2012–2016 YSS Domain Satisfaction by Youth's Gender: Female. 70

Figure 43. 2012–2016 YSS Domain Satisfaction by Youth's Gender: Male. 71

Figure 44. 2012–2016 YSS Domain Satisfaction by Residence: Rural 72

Figure 45. 2012–2016 YSS Domain Satisfaction by Residence: Urban 73

Figure 46. 2012–2016 Domain Satisfaction by Ethnicity: Appropriateness 74

Figure 47. 2012–2016 Domain Satisfaction by Ethnicity: Treatment Outcomes. 75

Figure 48. 2012–2016 Domain Satisfaction by Ethnicity: Participation. 75

Figure 49. 2012–2016 Domain Satisfaction by Ethnicity: Cultural Sensitivity 76

Figure 50. 2012–2016 Domain Satisfaction by Ethnicity: Access 76

Figure 51. Current Use of Medications for Emotional/Behavioral Problems, 2012–2016 Comparison 80

Figure 52. Arrest History, 2012–2016 Comparison 81

Figure 53. Medication Use as Reported by Youth and Caregivers 87

Figure 54. In the last year, did you see a medical doctor (or nurse) for a health check-up or because you were sick? (YSS-F and YSS respondent pairs): 2015 and 2016 comparison. 88

EXECUTIVE SUMMARY

In 2016, the Oregon Health Authority (OHA) Health Services Division (HSD) surveyed family members/caregivers[1] of children and youth enrolled in the Oregon Health Plan (OHP) about their perceptions of the mental health services delivered to their children and youth between May 1 and December 31, 2015. OHA HSD also surveyed young people ages 14 to 17 years about their perceptions of services they received during the same period.

The Youth Services Survey for Families (YSS-F) instrument asked questions about caregivers' perception of services delivered in seven performance domains:

- **Access to Services:** service location, frequency and availability of appointments, and responsiveness of staff
- **Appropriateness of Services:** general satisfaction, someone for child or young person to talk to, family had providers that stuck with them, received the right services, and received the right quantity of services
- **Cultural Sensitivity:** staff respect of client, family, cultural/ethnic background, and religious/spiritual beliefs
- **Daily Functioning:** ability to take care of needs, reduction in symptoms, and participation in meaningful activities
- **Family Participation in Treatment**: family's participation in determining treatment goals and comfort asking questions
- **Social Connectedness:** friendships, belonging, and social supports
- **Treatment Outcomes:** client's ability to deal with problems and crisis, control life, relationships with family, functioning in social situations and school or work, housing, and reduction in symptoms

The 2016 YSS-F replicated previous surveys by asking caregivers to report their perceptions of the coordination of services among different mental health care providers, between mental and physical health care providers, and between

[1] The survey was mailed to parents and guardians, as well as to residential treatment centers. This report refers to survey respondents as "family members" or "caregivers" throughout.

mental health care providers and state government agencies that provide other services for children and youth. These services include child welfare, the Oregon Youth Authority, local juvenile justice, education, developmental disabilities services, and substance abuse treatment providers. The survey also included questions about children's school attendance, arrest history, alcohol and drug abuse, primary health care providers, psychotropic medications, and history of trauma.

The Youth Services Survey (YSS), like the YSS-F, included a cluster of questions designed to assess young people's perceptions of their experiences with mental health services, including access, appropriateness, cultural sensitivity, participation, and treatment outcomes. The YSS also asked young people about where they had lived in the past six months, school absences, utilization of health care services, medication for emotional/behavioral problems, and arrest history.

Oregon's 16 coordinated care organizations (CCOs) manage physical, behavioral, and dental health services for their assigned OHP enrollees. Per Oregon's Medicaid demonstration waiver, Oregon must conduct statewide standardized surveys of consumers' experience of care (satisfaction) and allow for plan-to-plan comparisons.

OHA-HSD will use the survey findings to help guide its ongoing efforts to improve the quality of state-funded mental health services and supports for children and their families. CCOs should use information from all satisfaction surveys (YSS-F, YSS, CAHPS, etc.) when assessing the quality and appropriateness of care provided, and incorporate this information into their ongoing care integration efforts.

Survey Results

The YSS-F had 3,212 responses from caregivers of 13,794 children and youth for an overall response rate of 23%. This is an increase from the 2015 survey, but similar to other recent years. The YSS had 1,025 responses from 5,714 young people who received a survey for an overall response rate of 22%, also an increase from the 2015 survey and similar to other recent years.

Survey respondents had the option of filling out a paper questionnaire or completing an online survey form. Incentives in the form of a $10 gift card were

offered for completing the survey online. Seventy-two percent of YSS-F respondents completed the survey online, an increase from 55% in 2015. Seventy-five percent (75%) of YSS respondents completed the survey online, an increase from 60% in from 2015.

Highlights of Survey Results

Youth Services Survey for Families (YSS-F)

Overall domain satisfaction

- Satisfaction in all domains increased slightly in 2016, while satisfaction in the cultural sensitivity, outcomes, and social connectedness domains have trended significantly upward since 2012.

Satisfaction by treatment setting

- Satisfaction with residential and day treatment access was significantly lower in 2016 than satisfaction with outpatient access, although satisfaction with treatment outcomes and daily functioning has trended significantly higher in the last five years.
- Satisfaction with access and social connectedness has increased significantly among caregivers of children and youth in day treatment settings in the last five years.
- Satisfaction with social connectedness has significantly increased among caregivers of children and youth in outpatient treatment in the last five years.

Fee-for-service (FFS)

- Significantly fewer FFS respondents were satisfied with access when compared to all other CCOs.

Satisfaction by rural vs. urban residence

- Satisfaction among rural respondents has not trended upward or downward in the last five years. Among caregivers in urban areas, however, satisfaction has increased in three domains.

Satisfaction by race and ethnicity

- Satisfaction among American Indian or Alaskan Native respondents has decreased in two domains; satisfaction among White respondents has increased in four domains; and satisfaction among Black or African American respondents has increased in two domains.
- Satisfaction among Hispanic respondents has decreased in four domains over the last five years, while satisfaction among non-Hispanic respondents has increased in six domains over the last five years.

System of Care/Wraparound program

- Participation in the wraparound program did not increase satisfaction with service coordination. Dissatisfied respondents often identified the mental health provider's lack of communication or unwillingness to reach out to others as a key factor.

Treatment expectations vs. results

- Expectations and results of treatment are often similar (e.g., become happier), but sometimes there are discrepancies. The largest discrepancies between expectations and results were in
    - stopping or reducing the use of drugs or alcohol (7% had that expectation, while 48% reported that result)
    - starting or continuing a program of recovery (11% expectation; 50% result)
    - stopping hurting himself or herself (23% expectation; 54% result)
    - stopping hurting others (17% expectation; 36% result)

Health status

- Health status decreases among children and youth without a primary care health provider: 95% of children and youth with excellent or very good health status had a primary health care provider; this dropped to 92% of children and youth with good health; 86% of those with fair health status, and 81% of those with poor health status.

Medication

- Psychotropic medication prescribing has trended significantly downward over the last five years from 38% in 2012 to 31% in 2016.

School attendance

- School attendance appeared to improve with mental health services:
  - 23.9% reported an increase in number of days in school
  - 40.0% of respondents indicated that the number of days their child had been in school was about the same
  - 6.6% reported a decrease in school attendance

Mental health crisis

- The percentage of youth experiencing a mental health crisis has shown a statistically significant downward trend from 26% to 25%, while the percentage of caregivers who were satisfied with the mental health provider's response has also shown a significant downward trend from 68% to 65%.

Police encounters

- Of respondents whose child had ever encountered the police, 65% reported a decrease in encounters, while 21% reported that encounters had stayed the same and 14% reported an increase in encounters.

Alcohol and drug treatment

- There is still a need for increased access to alcohol and drug treatment: 23% of caregivers of youth ages 13–17 believed that their child either has used or now uses alcohol or drugs. Of these, fewer than half (44%) reported the youth had received treatment or other help, and of those who did receive help, 61% thought the treatment or other help provided what the youth needed.

Trauma-informed care

- Trauma-informed care is not provided consistently: 58% of respondents said their child was asked if they had a history of trauma. If the child or young person had experienced serious trauma, 53% of respondents felt the

problems related to this trauma were adequately addressed during treatment.

Youth Services Survey (YSS)

Overall domain satisfaction

- Over the last five years, the percentage of respondents that were satisfied with their treatment outcomes has shown a significant downward trend.

Satisfaction by language

- Spanish-speaking respondents were significantly more satisfied than all other language speakers in three domains, while English-speaking respondents have shown a significant decreasing trend in satisfaction with treatment outcomes.

Satisfaction by gender

- Girls have shown a significant downward trend in satisfaction with treatment outcomes over time, and were less satisfied with treatment outcomes than boys in 2016 as in previous years.

Satisfaction by rural vs. urban residence

- Rural respondents have shown a significantly decreasing trend in satisfaction with treatment outcomes over time, while urban respondents' satisfaction has remained consistent.

Living situation

- The percentage of respondents who lived with one or both parents or another family member has increased in the last five years, while the percentage who lived in a foster home decreased.

Court appearances

- Court appearances have trended significantly downward while the percentage of youth that were arrested by the police has remained stable.

Primary care provider visits

- Most (77%) respondents saw a doctor in the last year. These visits are a good opportunity to provide well-care services; however, CCO incentive

measure reporting showed that only 32% of Medicaid enrollees ages 12–21 received a well-care visit.

- **Among the paired adolescent/caregiver respondents, the proportion of youth who only saw a provider in a hospital emergency room doubled from 5% to 10% between those with and without a primary care provider, and the proportion who saw a provider in a clinic or office dropped from 76% to 45% if they had a primary care provider.**

Medication

- Psychotropic medication use has not changed in the last 5 years: 43% of respondents are currently taking medication for their emotional/behavioral problems, and 91% were told about possible side effects.
  - **Among the paired adolescent/caregiver respondents, more adolescents reported taking a medication for their emotional/behavioral problems than their caregivers, suggesting that caregivers were not always aware of the medications their child was taking. More caregivers were told what side effects to watch out for than their adolescent children.**

INTRODUCTION

The Mental Health Statistics Improvement Program (MHSIP) designed and validated the YSS-F to measure caregivers' perceptions of their child's experiences with mental health services.[2] The survey has been used annually since 2002 to measure caregivers' satisfaction with their child's experience with mental health services in seven domains:

- Access to services
- Appropriateness of services
- Cultural sensitivity
- Daily functioning
- Family participation in treatment
- Social connectedness
- Treatment outcomes

Over the years, the state has widened the scope of the YSS-F by 1) including in the survey population the families of children and youth who received services in psychiatric residential and psychiatric day treatment facilities, 2) adding questions about the coordination of services for children and youth, both within the mental health system and between mental health care providers and other state-funded agencies, and 3) adding questions about children's and youth's school attendance, arrest history, and use of alcohol or drugs.

The YSS is a MHSIP tool designed for adolescents ages 14–17 who receive mental health services. Acumentra Health, now HealthInsight Oregon, has conducted the YSS since 2011. The state has not widened the scope of the YSS, and continues to use the original validated version published by the MHSIP. The YSS includes the same domains as the YSS-F, excluding the daily functioning and social connectedness domains.

This year, as in previous years, the survey sample was determined by HSD, and included a representative sample by CCO and an oversample of racial minorities.

[2] The YSS-F is endorsed by the National Association of State Mental Health Program Directors.

METHODOLOGY

The YSS-F is designed to assess responses from caregivers of children and youth who received state-funded mental health services from May 1, 2015, through December 31, 2015, as identified by claims and encounter data from OHA's Medicaid Management Information System (MMIS) operated by HSD. The YSS is intended to collect responses directly from adolescent service recipients identified in the same manner.

The YSS-F instrument presents questions designed to measure respondent perception of the performance and services of mental health service providers in the domains of access to services, family participation in treatment, cultural sensitivity, appropriateness of services, social connectedness, treatment outcomes, and daily functioning. The YSS presents similar questions in the above domains, excluding social connectedness and daily functioning. Both surveys use a 5-point Likert scale, with responses ranging from "Strongly Agree" (5) to "Strongly Disagree" (1). There are no reverse scored items.

The 2016 YSS-F and YSS questionnaires were fielded in English and Spanish, according to the member's primary language identified in Oregon's MMIS.

Survey Methods

The 2016 survey population included a random sample of 16,200 children and youth ages 1–17 who received mental health services between May and December 2015. Within this sample, 5,714 young people ages 14–17 who received services during that period were identified to receive the YSS. OHA pulled the sample, ensuring at least 244 survey recipients in each CCO and over-sampling minority race and ethnic populations. Greater Oregon Behavioral Health Incorporated (GOBHI), is the mental health organization for individuals whose mental health services are not covered under a CCO. GOBHI was not specifically sampled for this population.

HSD classified the children and youth by the setting in which they received mental health services. If a child or young person received services at more than one level of care, they were identified in the highest level of care.

- The **Psychiatric Residential Treatment** group consisted of children and youth who received at least one day of psychiatric residential treatment services. This group comprised 2.1% of the surveys distributed.
- The **Psychiatric Day Treatment** group consisted of children and youth who received at least one day of psychiatric day treatment services, but who did not receive psychiatric treatment in residential settings. This group comprised 2.8% of the surveys distributed.
- The **Outpatient Treatment** group consisted of children and youth who received only outpatient mental health services. This group comprised 95.1% of the surveys distributed.

HealthInsight Oregon mailed letters to eligible caregivers and young people in May 2016 informing them about survey objectives. The letters instructed recipients how to access the online survey using a unique password, and informed recipients that if they did not complete the online survey within three weeks, they would receive a paper questionnaire by mail. Letters sent to caregivers and young people offered them a $10 gift card as an incentive for completing the online survey.

The letters, like the surveys themselves, were available in both English and Spanish, depending on the family's language preference identified in the state enrollment data.

In June 2016, the first follow-up letter and survey was mailed to caregivers and young people. After filtering out incorrect addresses and respondents who had already returned the survey, HealthInsight Oregon mailed a second survey form to non-responding caregivers in July and to young people in August. Each time recipients were offered the incentive for completing the survey online.

Please refer to Appendix A for survey data security and quality assurance procedures.

Domain Scoring Analysis

HealthInsight Oregon calculated scores of the respondents' perception of the services provided for each performance domain, with higher Likert scores representing higher levels of positive perception (e.g., 4 = "Agree" and 5 =

"Strongly Agree"). Data from surveys lacking responses for more than one-third of the items for a domain were excluded from the analysis of that domain.

Domain scores were calculated for a particular respondent by averaging the scores on all answered items for a domain (as long as at least two thirds of the items were answered). An average score greater than 3.5 represented positive perception of mental health services provided for the child in that domain. For example, the treatment participation domain contains three items:

- "I helped to choose my child's services."
- "I helped to choose my child's treatment goals."
- "I participated in my child's treatment."

A respondent's score for this domain was calculated if the respondent reported a score for at least two of the three items in the domain. If a respondent answered all three and reported the scores 3, 4, and 5, respectively, the average of those scores would be (3+4+5)/3 = 4. Since 4 is greater than 3.5, this respondent would be considered satisfied within the participation domain.[3] **Throughout this report, we reference the percentage of respondents satisfied in various domains. This refers to the percentage of respondents whose domain score was >3.5.**

[3] The number of responses reported in each data table may be lower than the total number of survey respondents, as some respondents may not have answered all items needed to calculate a particular domain score.

2016 YSS-F RESULTS

This section presents results of the YSS-F, including responses about satisfaction with coordination of various services and about expectations for treatment and results of treatment. The Additional Analyses section, beginning on page 42, contains responses to questions about young people's alcohol or drug use and treatment, as well as questions about young people's school attendance and arrest history before and after receiving services.

Details of the YSS results begin on page 62.

Survey Response

From the 13,794 YSS-F surveys mailed to valid addresses, 3,212 respondents returned a survey form or completed the survey online by the completion deadline for an overall response rate of 23%. Individuals who refused to complete the survey by calling or writing were excluded from the denominator for the response rate calculation. More respondents filled out the survey online than by mail this year.

HealthInsight Oregon's survey analysis excluded data from surveys received after the deadline of September 15, 2016.

OHA contracted with 16 CCOs and one mental health organization (MHO) to manage OHP mental health services during the survey period. HealthInsight Oregon analyzed some of the results by CCO.

Table 1 displays the YSS-F responses from caregivers whose children received outpatient, psychiatric residential, and psychiatric day treatment services from each CCO. Response rates varied according to CCO. The number of surveys sent excludes surveys that were sent to bad addresses and recipients who opted out of the survey.

Table 1. YSS-F Response Rate by CCO.

CCO	Number of responses	Number of surveys sent	Response rate (%)
AllCare	120	510	24
Cascade Health Alliance (CHA)	72	288	25
Columbia Pacific CCO (CPCCO)	66	293	23
Eastern Oregon CCO (EOCCO)	104	511	20
FamilyCare Health	458	1,660	28
Health Share of Oregon	687	3,113	22
InterCommunity Health Network (IHN)	208	822	25
Jackson Care Connect (JCC)	64	318	20
PacificSource Community Solutions–Central Oregon (PCS-CO)	137	640	21
PacificSource Community Solutions–Columbia Gorge (PCS-CG)	52	212	25
Primary Health of Josephine County (PHJC)	38	211	18
Trillium Community Health Plan (TCHP)	375	1,607	23
Umpqua Health Alliance (UHA)	47	196	24
Western Oregon Advanced Health (WOAH)	56	257	22
Willamette Valley Community Health (WVCH)	377	1,679	22
Yamhill Community Care Organization (YCCO)	76	350	22
Greater Oregon Behavioral Health Inc. (GOBHI) MHO*	16	40	40
Fee-for-service (FFS)	259	1,087	24
Total	**3,212**	**13,794**	**23**

*GOBHI is not a CCO, but a Medicaid managed mental health care organization. GOBHI members were not explicitly sampled, so the number of responses was too small to perform any MHO-specific analyses.
Note: Surveys sent exclude opt-outs and bad addresses.

Table 2 presents the YSS-F survey response rate by the type of facility in which the respondent's child or young person received treatment.

Table 2. YSS-F Response Rate by Treatment Setting.

Setting	Number of responses	Number surveys sent	Response rate (%)
Outpatient	3,081	13,113	23
Psychiatric Day	70	291	24
Psychiatric Residential	61	390	16
Total	**3,212**	**13,794**	**23**

Note: Surveys sent exclude opt-outs and bad addresses. All surveys were sent to the most current address on file for the child or youth, so the caregiver/respondent could have been the foster parent, residential facility administrator, caseworker, or other adults currently living with the child.

Table 3 shows response rates by member demographics as they are noted in Medicaid enrollment data. Response rates were similar between the gender, age groups, and race categories (around 23% or 24%). Recipients of the English language survey had a higher response rate than recipients of the Spanish language survey (23% vs. 16%). Recipients of the English language survey whose primary language was not English returned a survey had the highest response rate at 25%.

Table 3. YSS-F Response Rate by Demographic Characteristics.

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
Gender	Female	1,573	6,544	24
	Male	1,639	7,250	23
Age group	0–5	322	1,302	25
	6–12	1,547	6,594	23
	13–17	1,343	5,898	23

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
Race	Non-white	508	2,114	24
	White (Caucasian)	2,096	8,715	24
	Race unknown	608	2,965	21
Location of residence	Rural	1,168	5,137	23
	Urban	2,016	8,492	24
	Unknown	28	165	17
Language	English	1,982	8,525	23
	Spanish	175	1,126	16
	Other	1,055	4,143	25

Note: Surveys sent exclude opt-outs and bad addresses.
All demographic information comes from state Medicaid enrollment data.

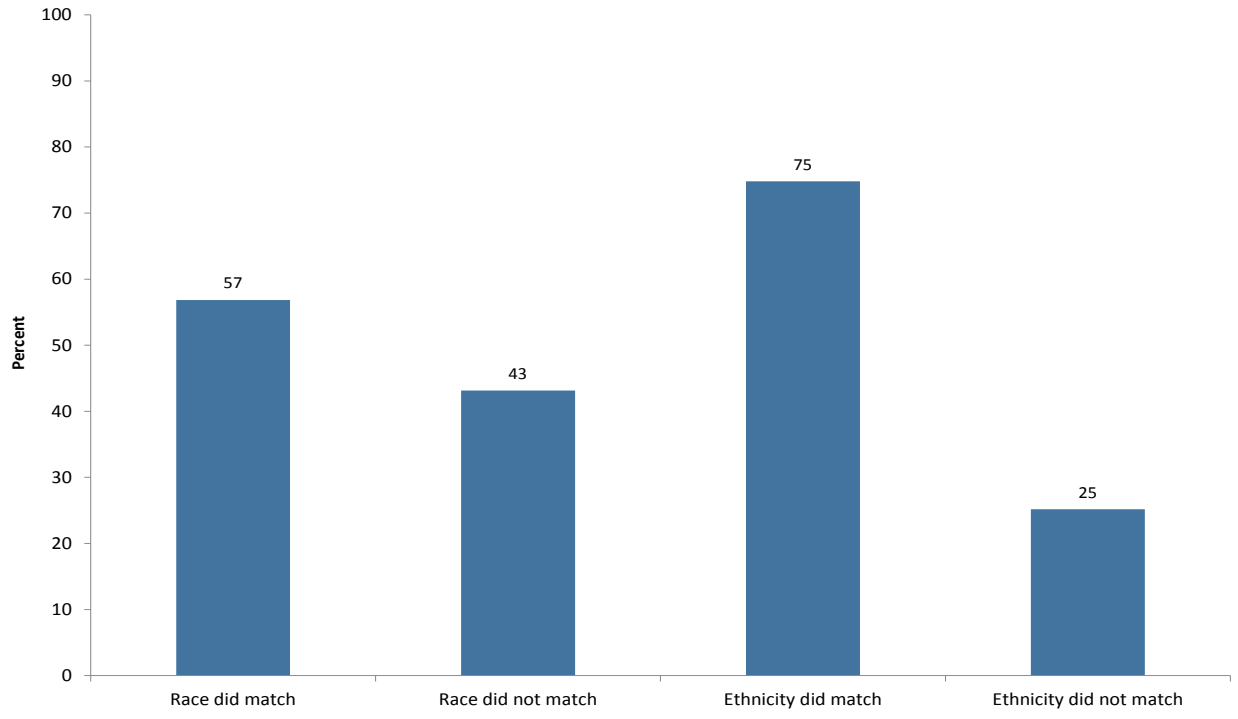
Respondent Race and Ethnicity

Neither race nor ethnicity are required fields in Medicaid enrollment forms, and as a result this information is missing for many Medicaid enrollees in the state's dataset. Obtaining accurate information about enrollee's race and ethnicity is an important tool in addressing health equity. The survey asked respondents to self-identify their race and ethnicity, enabling comparison between state data and self-reported data. Figure 1 shows these results.

Among YSS-F respondents, ethnicity was consistent between state data and self-reported data for 75% of respondents (25% did not match). Overall, state ethnicity data overestimates the number of non-Hispanic enrollees.

Race categories on the Medicaid enrollment form do not match race categories on the survey. To facilitate the best comparison, responses from the survey question allowing multiple race selections was used, and respondents who selected multiple races were rolled into a "multiracial" category. Race was consistent between state data and self-reported data for 57% of respondents, and did not match for 43%. Overall, state race data overestimates the number of white enrollees.

Figure 1. Comparison of State-Recorded and Self-Reported Race and Ethnicity Data, by Respondent.

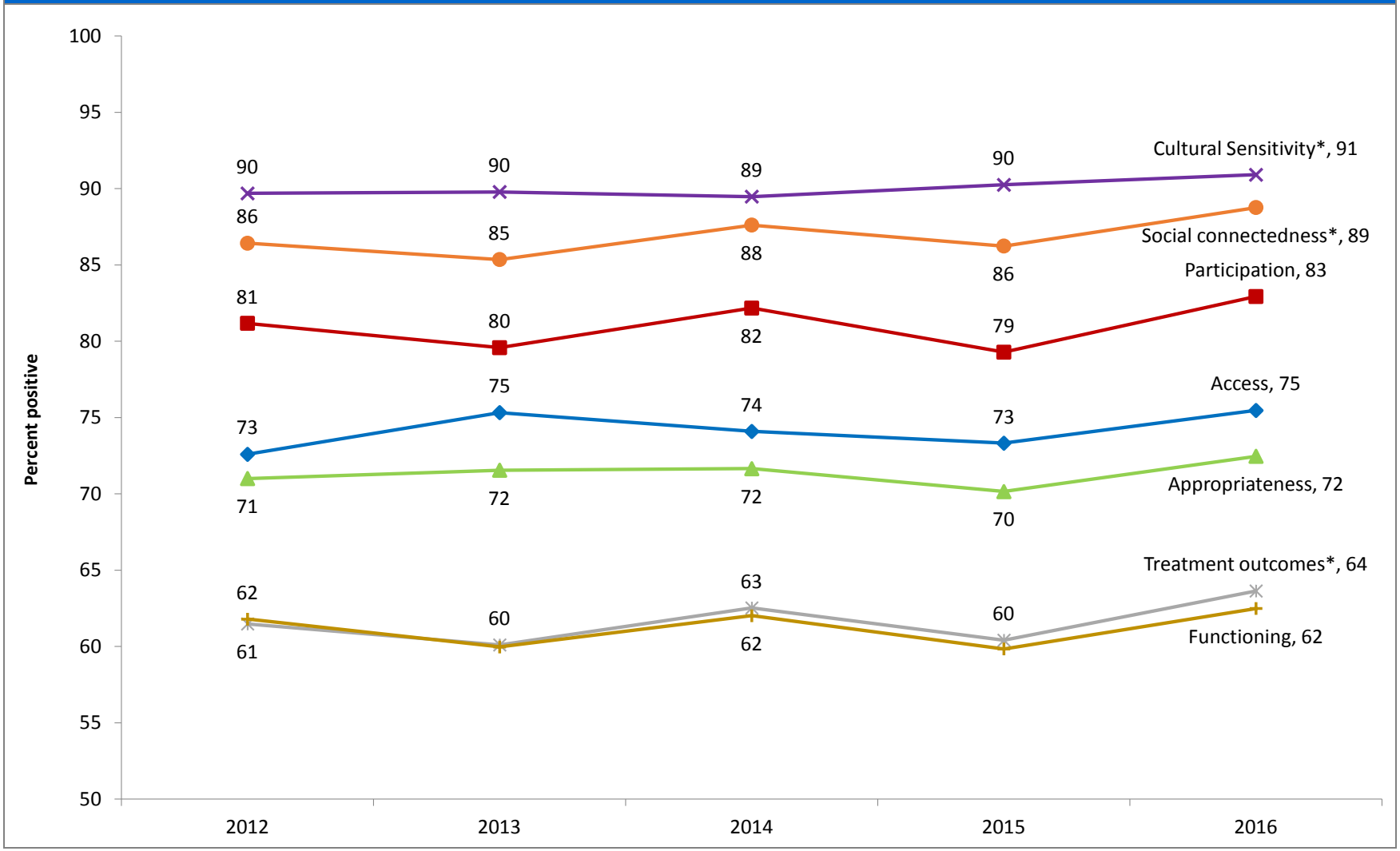


Domain Satisfaction

The satisfaction according to domain represents the percentage of respondents who were satisfied in that domain (see Methodology, page 9, for further explanation).

Figure 2 shows that overall, the percentages of respondents satisfied in each domain have remained relatively stable over the past five years. Satisfaction in all domains increased slightly in 2016, while the percentages of respondents satisfied in the cultural sensitivity, social connectedness and treatment outcomes domains have trended significantly upwards since 2012.

Figure 2. 2012–2016 Comparison of YSS-F Domain Satisfaction.



*Indicates statistically significant upward or downward trend (p<.05) over time for that domain.

Domain satisfaction according to treatment setting

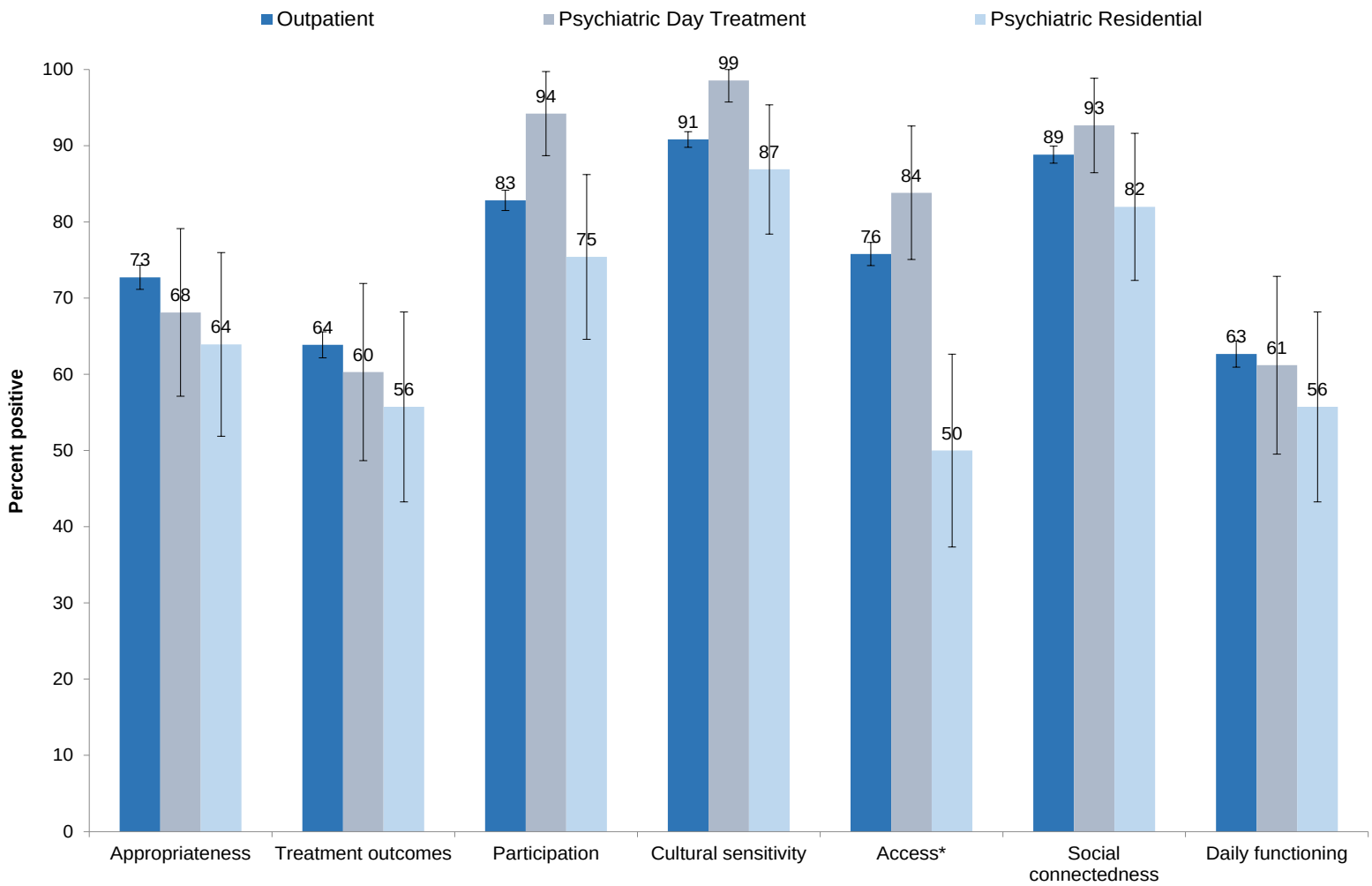
Figure 3 shows the 2016 satisfaction by domain, with 95% confidence intervals (CIs), by treatment setting. The CI indicates the upper and lower limits within which the score would be expected to fall 95 times if 100 identical surveys were conducted.

The percentage of caregivers satisfied decreased as level of care increased in the appropriateness, treatment outcomes, and daily functioning domains, while a greater percentage of caregivers of children and youth in psychiatric day treatment reported satisfaction in the participation, cultural sensitivity, and social connectedness domains. To test for statistical significance, the psychiatric residential and psychiatric day treatment groups were combined and compared against the outpatient group. A significantly smaller percentage of caregivers of children and youth in psychiatric residential treatment were satisfied with access.

The following notable trends were observed over the past five years:

- **Outpatient treatment settings**: The percentage of caregivers that were satisfied in the social connectedness domain has significantly increased in the last five years. Satisfaction in all other domains has remained stable.
- **Psychiatric day treatment settings**: The percentage of caregivers that were satisfied in the access and social connectedness domains has significantly increased in the last five years. Satisfaction in all other domains has varied over the years, without a significant upward or downward trend.
- **Psychiatric residential treatment settings**: The percentage of caregivers that were satisfied in the treatment outcomes and daily functioning domains has significantly increased in the last five years. Satisfaction in all other domains has varied over the years without a significant upward or downward trend.

Figure 3. Domain Satisfaction by Treatment Setting with 95% Confidence Intervals.



*Indicates a statistically significant difference (p<.05) between treatment settings.

Domain satisfaction according to CCO

Table 4 shows the 2016 percentage of respondents satisfied in each domain, with the 95% confidence interval displayed, according to CCO. Note that the survey questions asked respondents to rate their satisfaction with services delivered by contracted service providers, not satisfaction with the CCO itself.

Because GOBHI MHO was not sampled, not enough responses were received to present the mental health organization's results (n=16).

The percentage of satisfied respondents in each CCO was compared against all other CCOs combined. Some notable findings include:

- CPCCO had significantly fewer satisfied respondents in the appropriateness, cultural sensitivity, and daily functioning domains than all other CCOs.
- PHJC had significantly fewer satisfied respondents in the appropriateness domain than all other CCOs, although satisfaction was lower in CPCCO.
- FamilyCare had significantly more satisfied respondents in the appropriateness and participation domains.
- EOCCO had significantly fewer satisfied respondents in the participation domain than all other CCOs combined.
- Significantly fewer FFS respondents were satisfied with access when compared to all other CCOs, while IHN had significantly more satisfied respondents in the access domain than all other CCOs combined.
- CHA and UHA had significantly fewer satisfied respondents in the social connectedness domain.

Table 4. Domain Satisfaction by CCO, with 95% CI, 2016.

CCO	Appropriateness (CI)	Treatment Outcomes (CI)	Participation (CI)	Cultural Sensitivity (CI)	Access (CI)	Social Connectedness (CI)	Daily Functioning (CI)
AllCare	76 (69-84)	65 (56-73)	86 (79-92)	87 (81-93)	81 (74-88)	88 (82-94)	65 (56-73)
CHA	64 (53-76)	63 (52-75)	77 (67-87)	89 (81-96)	84 (75-93)	80 (71-90)*	61 (50-73)
CPCCO	54 (42-66)*	52 (40-64)	68 (56-79)*	80 (70-90)*	74 (63-85)	83 (74-92)	49 (37-61)*
EOCCO	70 (61-79)	60 (51-70)	75 (66-83)*	87 (81-94)	83 (75-90)	87 (80-93)	60 (51-70)
FamilyCare	79 (75-82)*	67 (62-71)	88 (85-91)*	93 (90-95)	76 (72-80)	91 (88-94)	64 (60-69)
Health Share	71 (68-75)	63 (59-66)	85 (82-87)	93 (91-95)	76 (72-79)	89 (86-91)	63 (59-66)
IHN	78 (73-84)*	67 (60-73)	84 (79-89)	95 (92-98)	82 (76-87)*	91 (87-95)	65 (58-71)
JCC	72 (61-83)	64 (52-76)	75 (64-86)	95 (90-100)	79 (69-89)	88 (79-96)	61 (49-73)
PCS-CO	74 (66-81)	64 (56-72)	80 (73-87)	95 (91-99)	78 (71-85)	92 (87-96)	63 (55-71)
PCS-CG	79 (68-90)	69 (57-82)	88 (79-97)	94 (88-100)	67 (55-80)	84 (74-94)	71 (59-83)
PHJC	58 (42-74)*	59 (44-75)	74 (60-88)	95 (87-100)	81 (68-93)	87 (76-98)	59 (44-75)
TCHP	71 (66-75)	66 (61-71)	82 (78-86)	89 (86-93)	72 (67-76)	90 (87-93)	66 (61-71)
UHA	70 (57-83)	51 (37-65)	79 (67-90)	89 (81-98)	85 (75-95)	79 (67-90)*	49 (35-63)
WOAH	75 (64-86)	59 (46-72)	79 (68-89)	87 (78-96)	73 (61-85)	94 (88-100)	63 (50-75)
WVCH	74 (70-79)	65 (60-70)	84 (80-87)	90 (87-93)	72 (67-76)	88 (85-91)	62 (57-67)
YCCO	64 (53-75)	59 (48-70)	84 (76-92)	87 (79-94)	76 (66-86)	85 (77-93)	59 (48-70)
FFS	69 (63-75)	59 (53-65)	82 (77-86)	88 (84-92)	69 (63-74)*	89 (85-93)	59 (53-65)

*Indicates statistically significant difference ($p<.05$) between CCO and other CCOs grouped together.

Demographic Comparisons

Domain satisfaction by child's or young person's age

Caregivers' satisfaction scores were clustered into groups based on the current age of the child or young person who had received services: 0–5, 6–12, and 13–17. Key findings are listed below:

- **Ages 0–5**: Significant increase in the last five years in the percentage of respondents satisfied in the cultural sensitivity and participation domains. All other domains remained consistent.
- **Ages 6–12**: Significant increase in the last five years in the percentage of respondents satisfied in the social connectedness domain. All other domains remained consistent.
- **Ages 13–17**: Significant increase in the last five years in the percentage of respondents satisfied in the treatment outcomes domain. All other domains remained consistent.

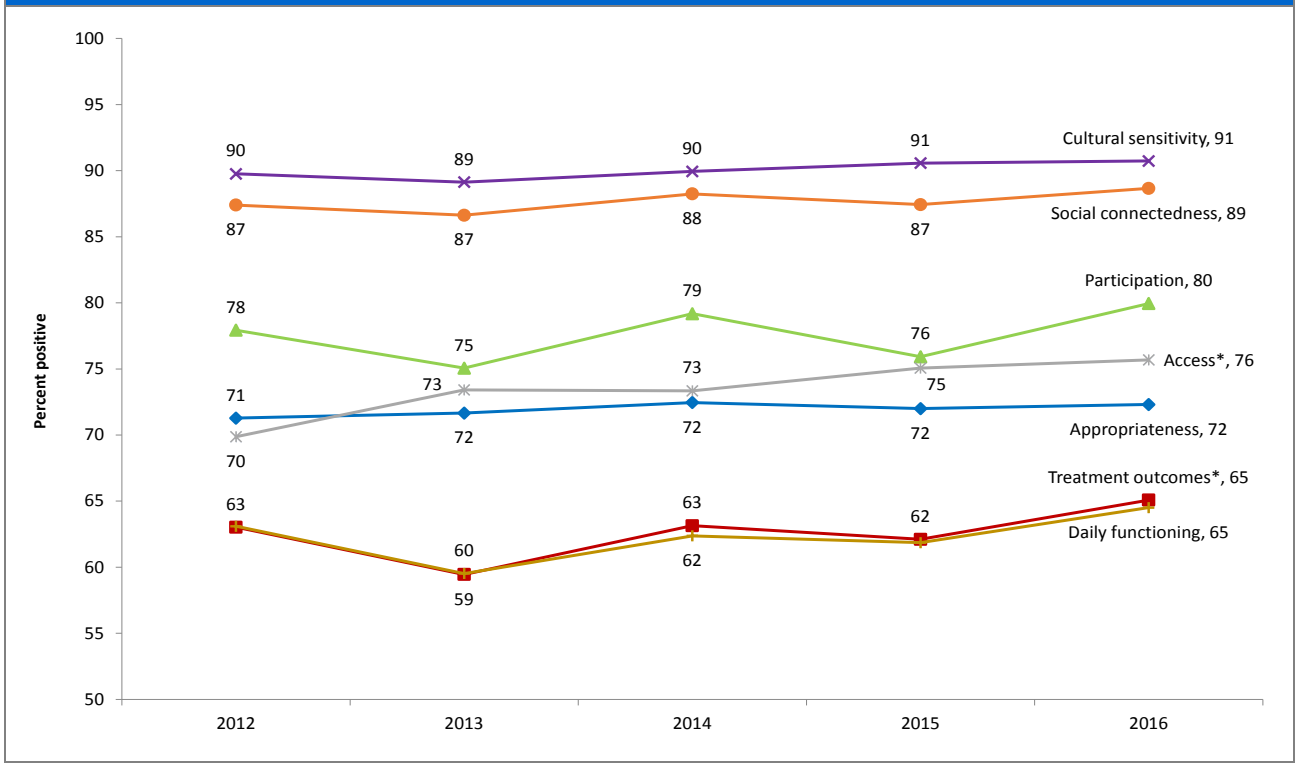
Consistent with previous years, caregivers of youth ages 13–17 were the least satisfied in all domains.

Domain satisfaction by child's or young person's gender

Domain satisfaction according to gender was similar between boys and girls. Over the last five years, a significantly increasing percentage of caregivers of girls reported satisfaction in the treatment outcomes and access domains, while a significantly increasing percentage of caregivers of boys reported satisfaction in the social connectedness domain (see Figures 4 and 5).

From 2012 to 2016, a significantly increasing percentage of caregivers of girls was satisfied with treatment outcomes and access. Other domains varied slightly year to year, with most increasing in 2016, though not significantly.

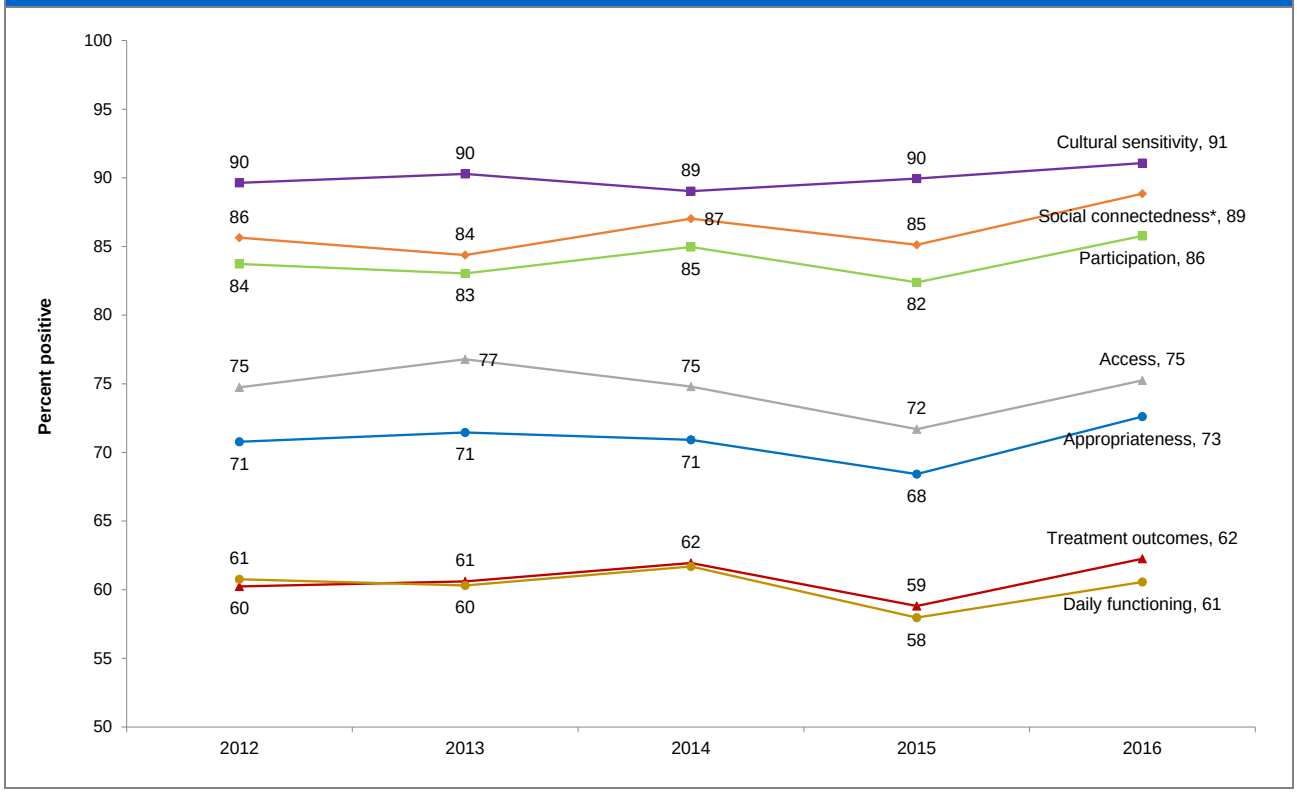
Figure 4. 2012–2016 Domain Satisfaction by Child or Young Person's Gender: Female.



*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

From 2012 to 2016, a significantly increasing percentage of caregivers of male children was satisfied with social connectedness. Satisfaction in most other domains also increased, though these changes were not statistically significant.

Figure 5. 2012–2016 Domain Satisfaction by Child's or Young Person's Gender: Male.



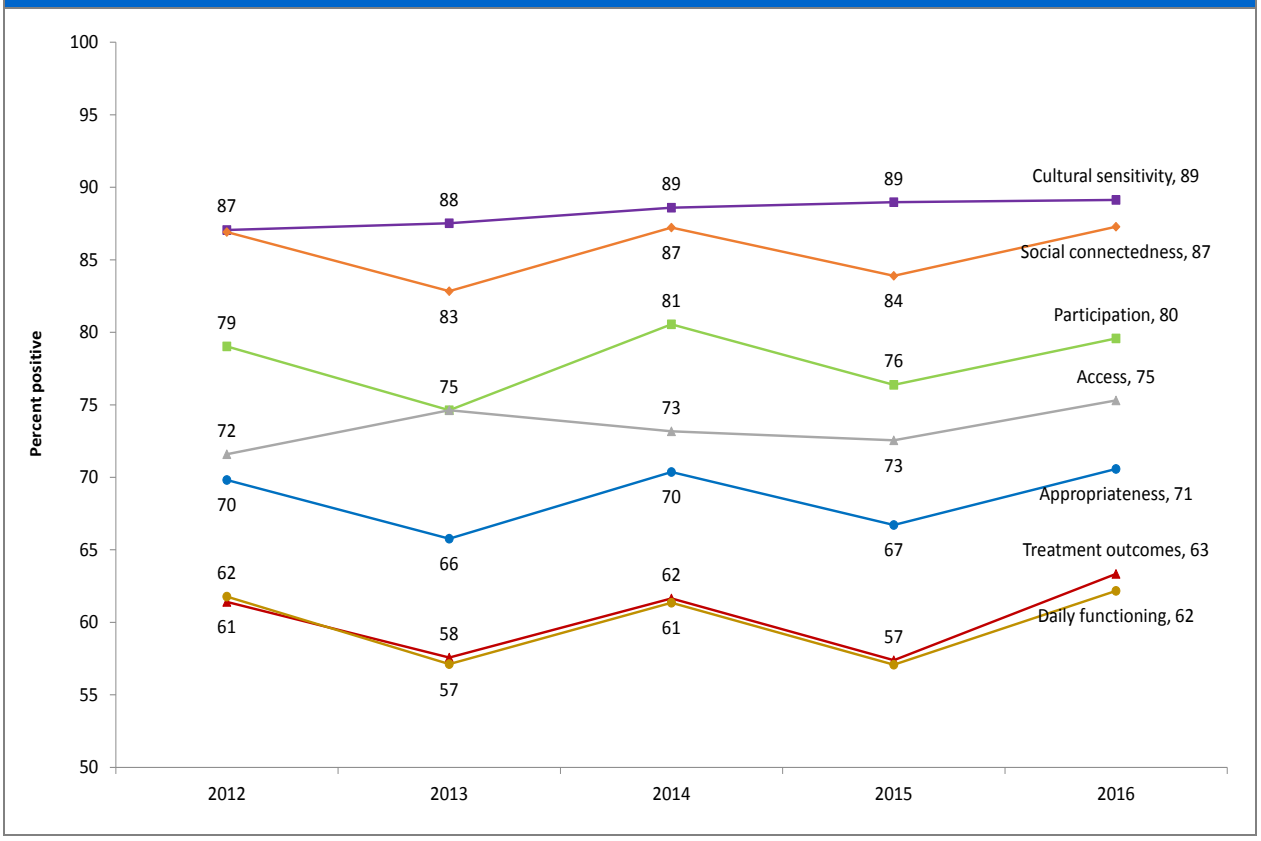
*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

Domain satisfaction by rural/urban residence

Caregivers were classified as rural or urban based on the ZIP code of their current residence, even though their children may have received mental health services in another ZIP code. Classifications came from the Oregon Office of Rural Health.

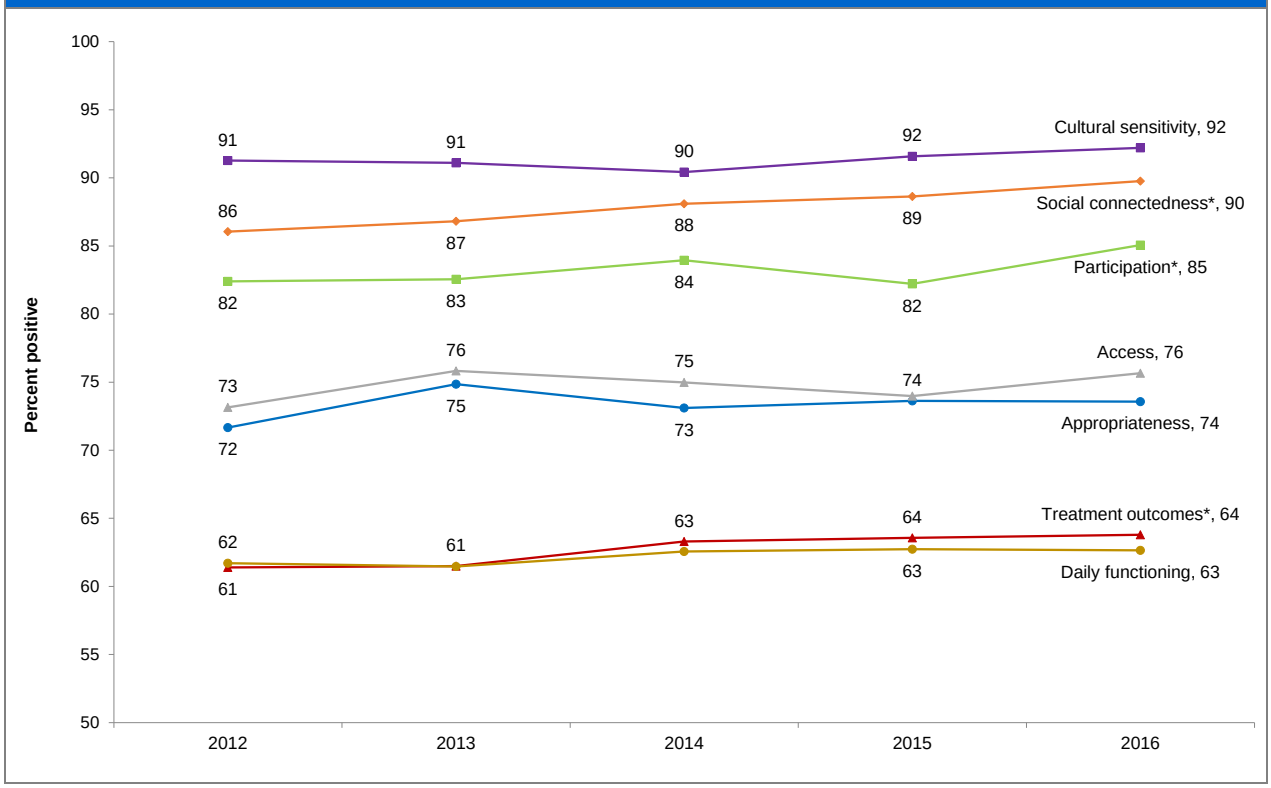
Figures 6 and 7 display the 2012–2016 results of respondent satisfaction by place of residence. As in previous years, more caregivers in urban areas were satisfied in every domain than caregivers in rural areas. There have not been any significant changes in satisfaction in the last five years among caregivers in rural areas. Among caregivers in urban areas, however, the percentage of satisfied respondents has significantly increased in the treatment outcomes, participation, and social connectedness domains.

Figure 6. 2012–2016 Domain Satisfaction by Residence: Rural.



There were no statistically significant trends.

Figure 7. 2012–2016 Domain Satisfaction by Residence: Urban.



*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

Domain satisfaction by child's or young person's race

Even though race information was self-reported this year, the results presented below are based on the state's MMIS data to allow comparison with the previous four years (self-reported race data were used for the first time in the 2015 survey analysis). Using race information provided on children's and youth's Medicaid enrollment form, we examined domain satisfaction according to identified race in 2016. There were no significant differences in the percentage of respondents indicating satisfaction between race groups on any domain.

We also examined changes over the last five years in reported satisfaction by race. There were fewer than 30 respondents indicating Asian, Native Hawaiian or Other Pacific Islander, or Unknown race in at least one year; therefore, those groups have been excluded from the figures below (Figures 8–14).

Key findings include:

- **American Indian or Alaskan Native**: Significantly fewer respondents have been satisfied in the Treatment Outcomes and Daily Functioning domains over the last five years.
- **White**: Significantly more respondents have reported satisfaction in the Treatment Outcomes, Participation, Social Connectedness, and Daily Functioning domains over the last five years.
- **Black or African American**: Significantly more respondents have reported satisfaction in the Social Connectedness and Access domains over the last five years.

In 2016, respondents were asked to identify their racial and ethnic identity in three separate questions: the first to identify ethnicity, the second to identify as many race categories as apply, and the third to identify a single race category. The second question, which provided the option to select more than one race category, is especially illuminating because respondents with more than one race identity have the lived experience of each race, and identifying respondents accurately is a critical component of improving the equity of services. As we gather additional years of survey data with self-reported race information we will use this self-report to examine results over time.

Figure 8. 2012–2016 Domain Satisfaction by Race: Appropriateness.

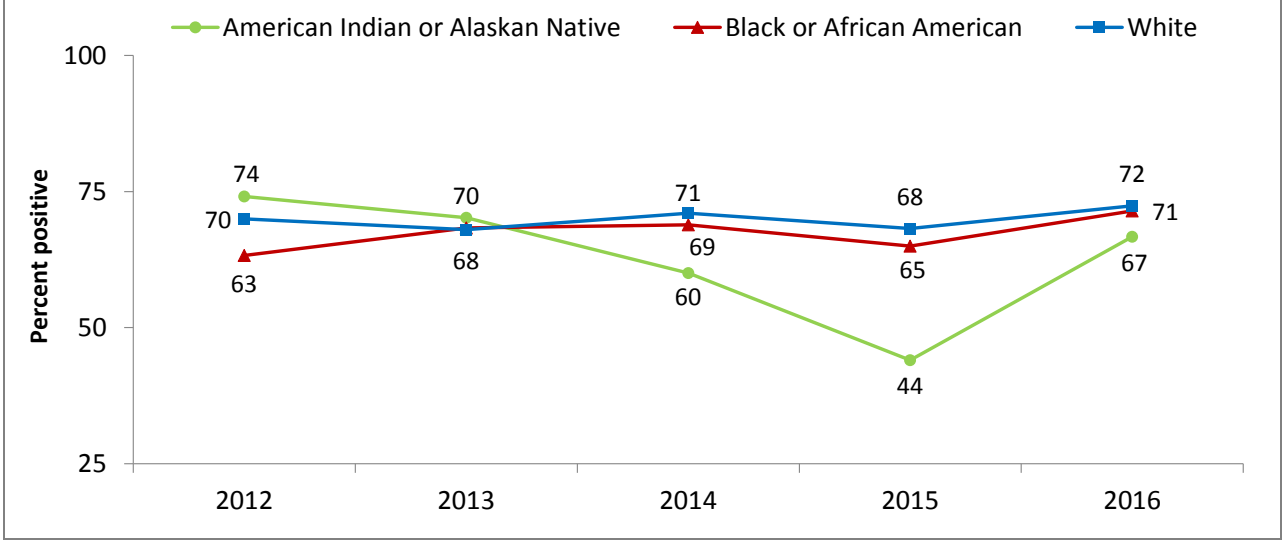
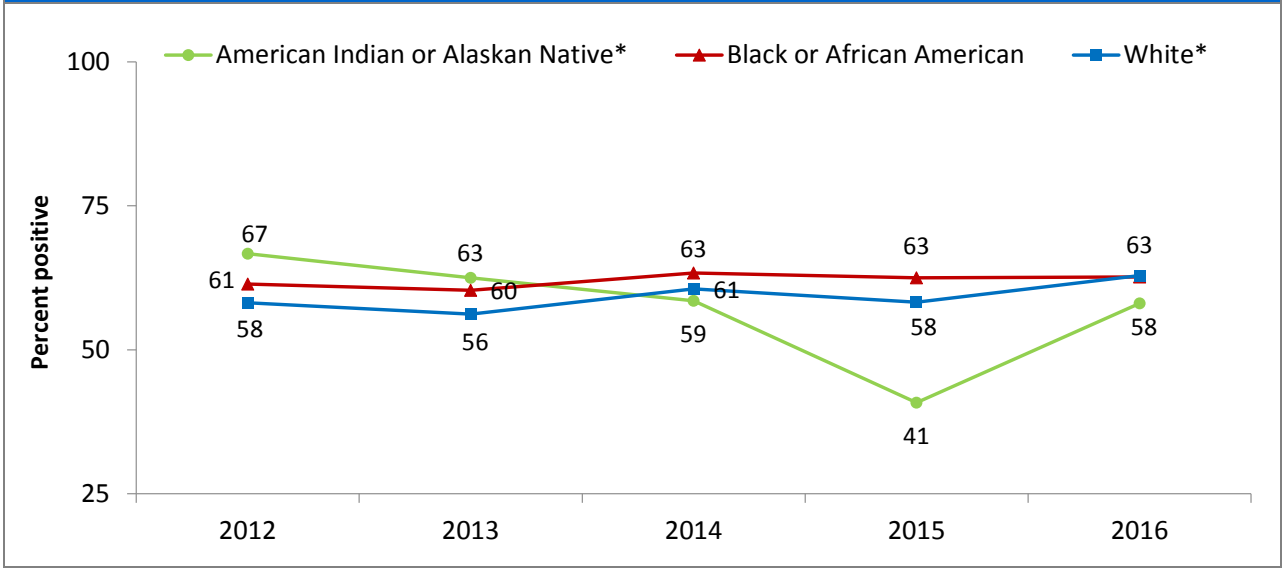
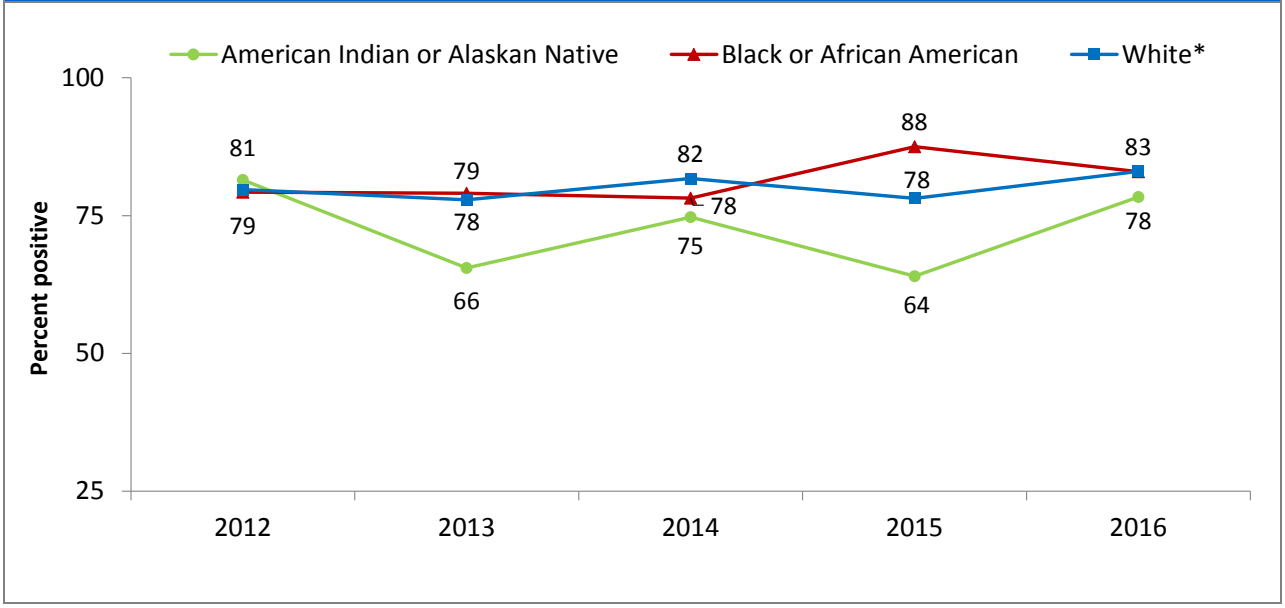


Figure 9. 2012–2016 Domain Satisfaction by Race: Treatment Outcomes.



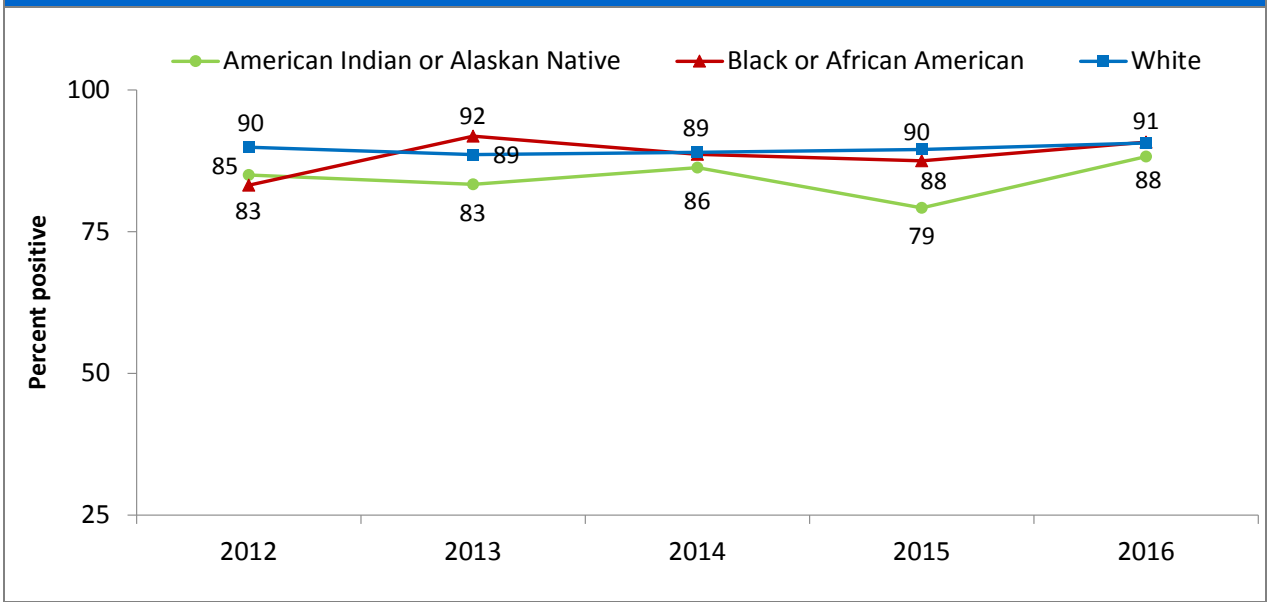
*Indicates a statistically significant upward or downward trend (p<.05) for that race group.

Figure 10. 2012–2016 Domain Satisfaction by Race: Participation.



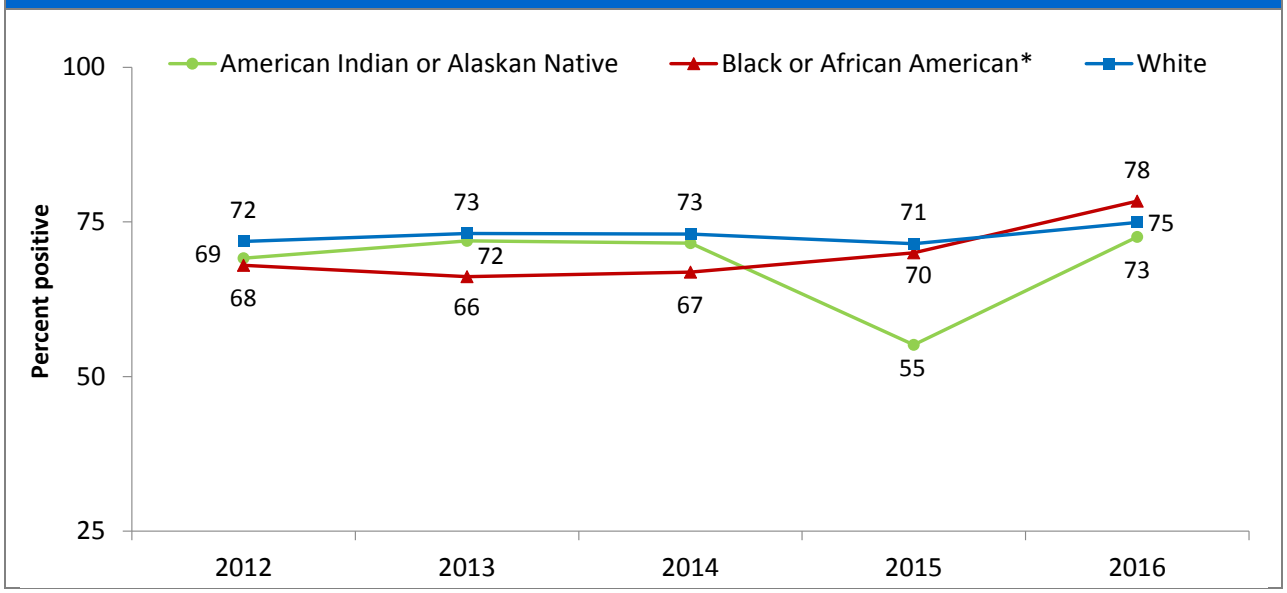
*Indicates a statistically significant upward or downward trend (p<.05) for that race group.

Figure 11. 2012–2016 Domain Satisfaction by Race: Cultural Sensitivity.



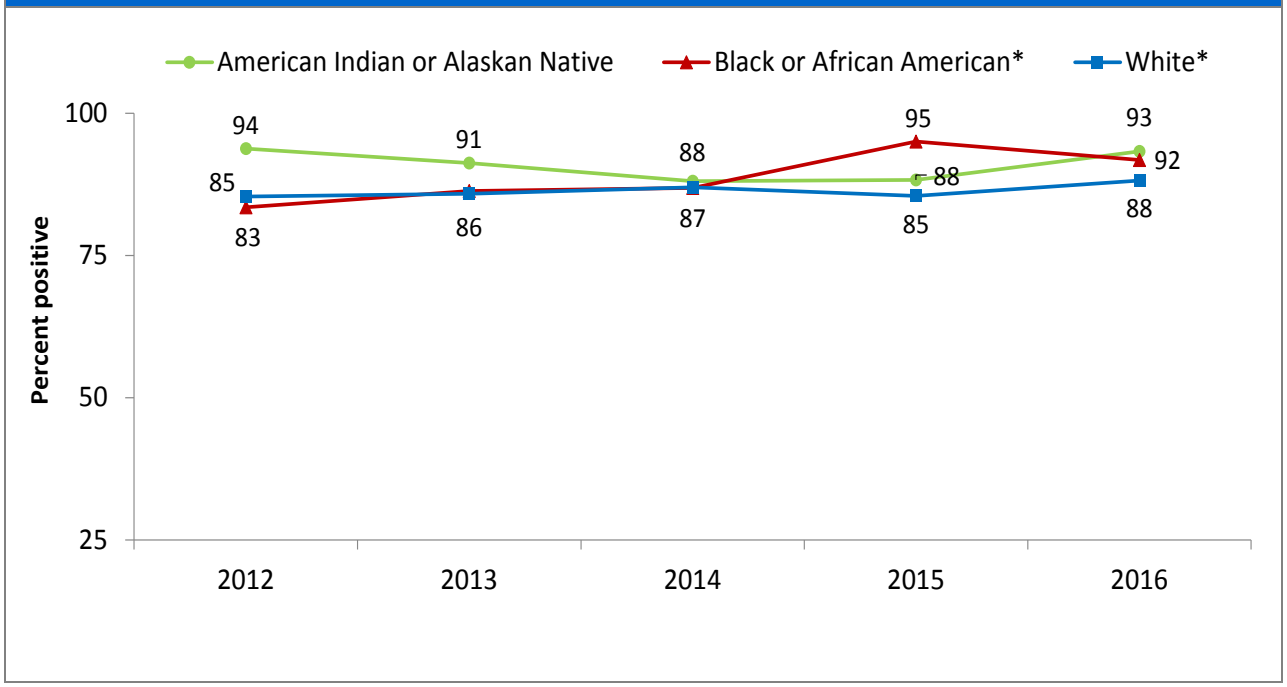
There were no statistically significant trends.

Figure 12. 2012–2016 Domain Satisfaction by Race: Access.



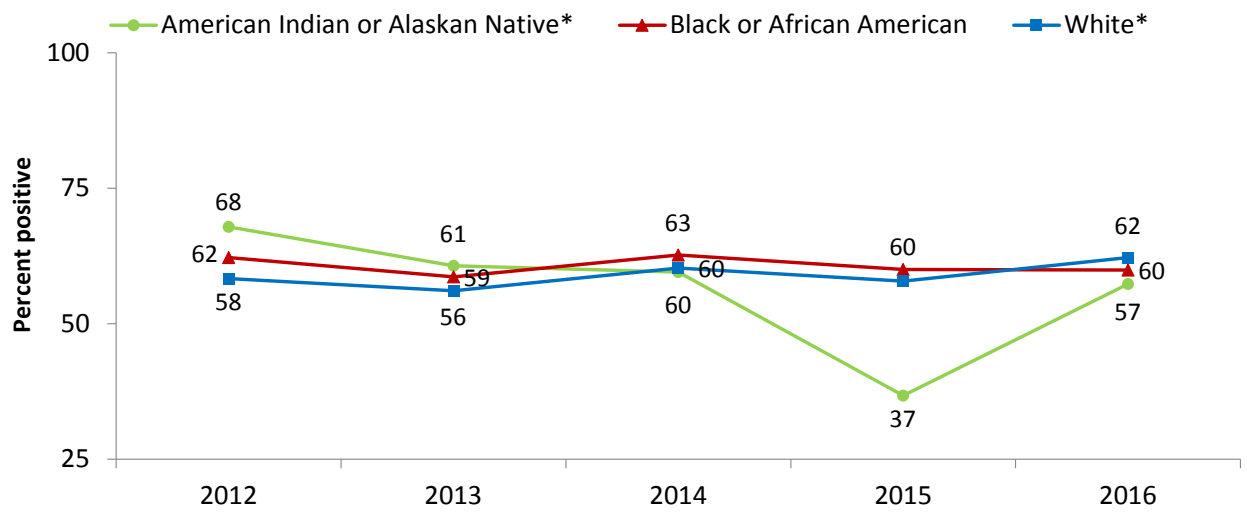
*Indicates a statistically significant upward or downward trend (*p*<.05) for that race group.

Figure 13. 2012–2016 Domain Satisfaction by Race: Social Connectedness.



*Indicates a statistically significant upward or downward trend (*p*<.05) for that race group.

Figure 14. 2012–2016 Domain Satisfaction by Race: Daily Functioning.



*Indicates a statistically significant upward or downward trend (p<.05) for that race group.

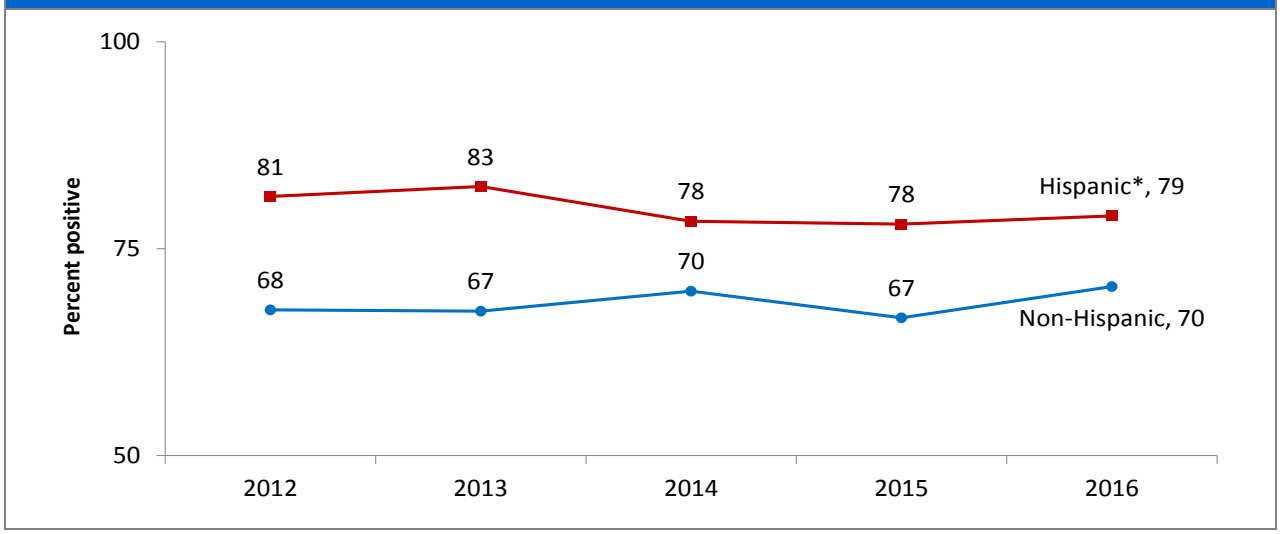
Domain satisfaction by ethnicity

Even though ethnicity information was self-reported this year, the results presented below are based on the state's MMIS data to allow comparison with the previous four years (self-reported race data were used for the first time in the 2015 survey analysis). Figures 15–21 display the percentage caregivers of Hispanic children and youth and caregivers of non-Hispanic children and youth who were satisfied in that domain for 2012 to 2016. Also included are those who did not select ethnicity or indicated their ethnicity as unknown.

Key findings include:

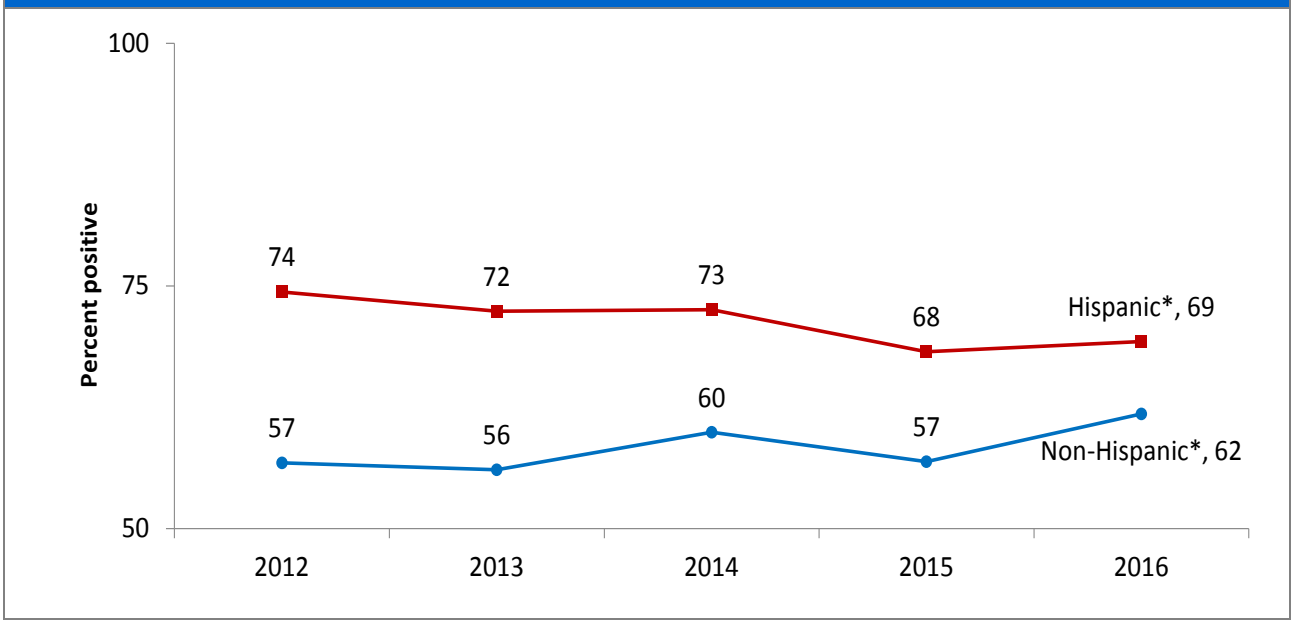
- Caregivers of Hispanic or Latino(a) children and youth were slightly more satisfied in most domains in 2016.
- Satisfaction among Hispanic respondents has decreased in several domains. Significantly fewer respondents with Hispanic or Latino(a) children and youth have been satisfied with appropriateness, treatment outcomes, access, and daily functioning over the last five years.
- Satisfaction among non-Hispanic respondents has increased in many domains. Significantly more respondents with non-Hispanic children and youth have been satisfied with treatment outcomes, participation, cultural sensitivity, access, social connectedness, and daily functioning over the last five years.

Figure 15. 2012–2016 Domain Satisfaction by Ethnicity: Appropriateness.



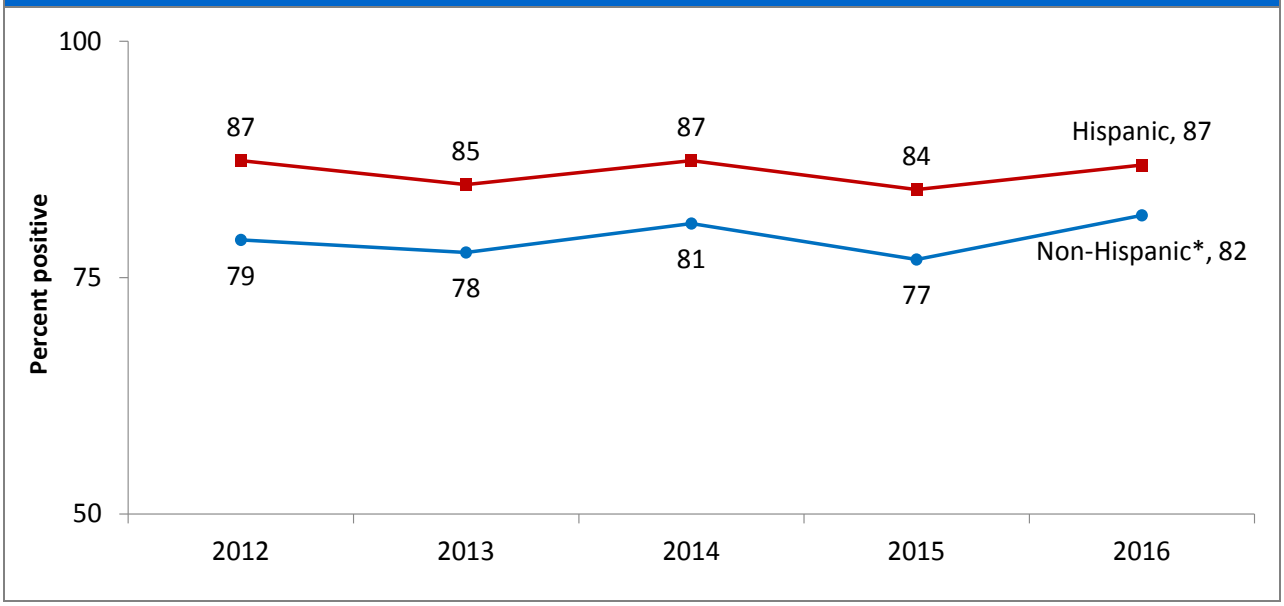
*Indicates a statistically significant upward or downward trend (*p*<.05) for that ethnic group.

Figure 16. 2012–2016 Domain Satisfaction by Ethnicity: Treatment Outcomes.



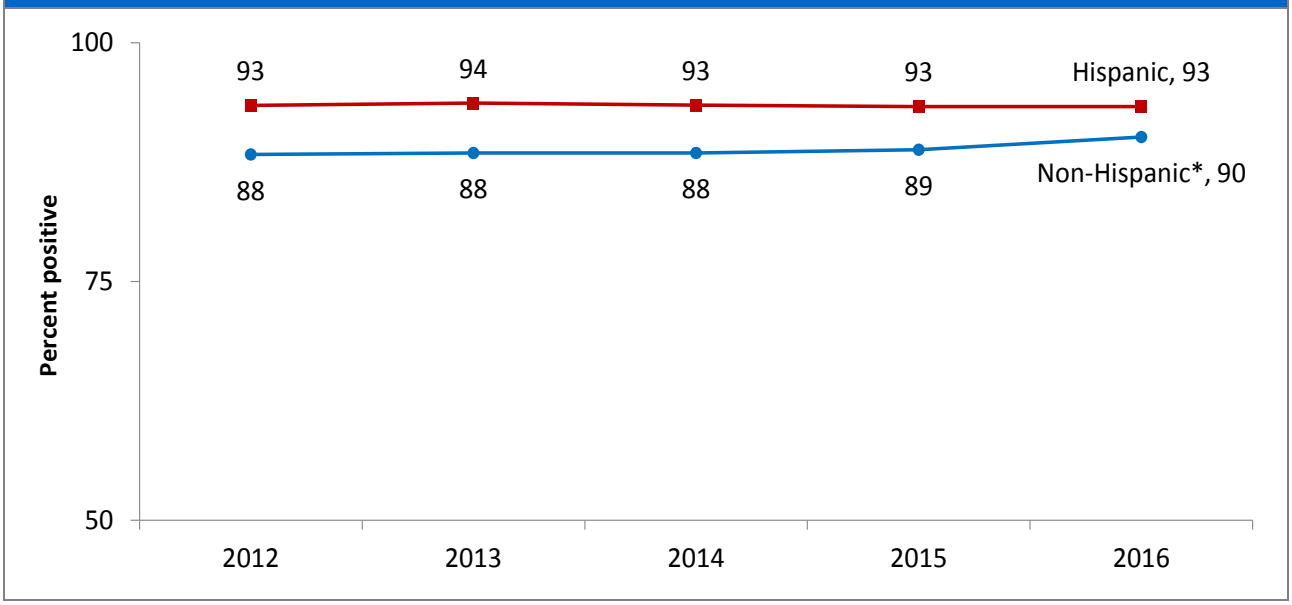
*Indicates a statistically significant upward or downward trend (*p*<.05) for that ethnic group.

Figure 17. 2012–2016 Domain Satisfaction by Ethnicity: Participation.



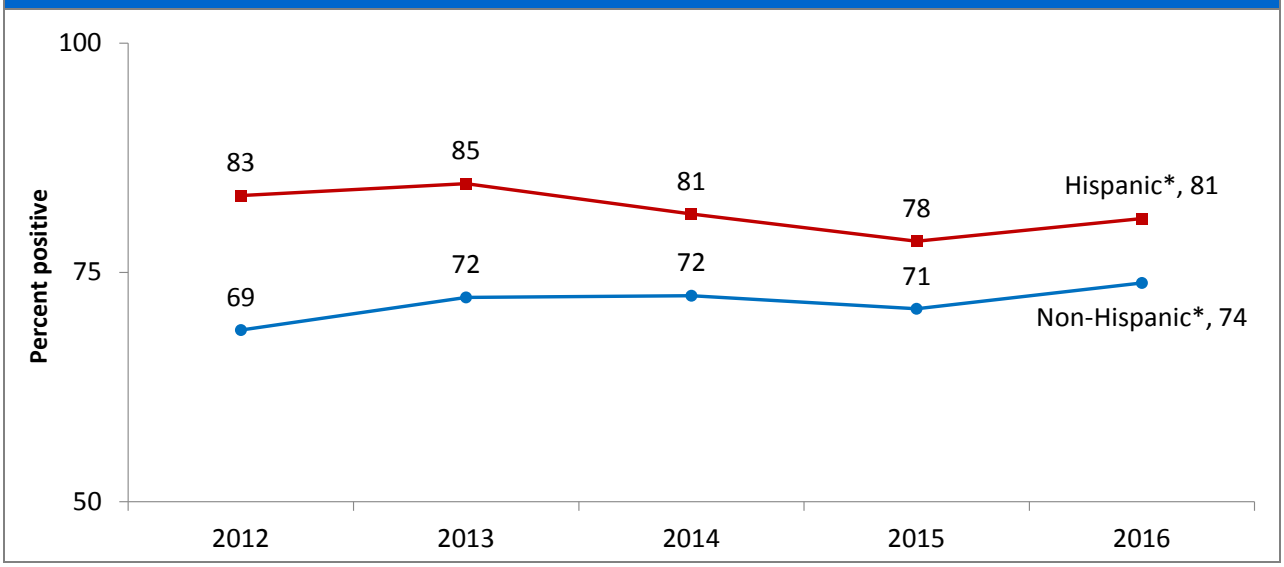
*Indicates a statistically significant upward or downward trend (p<.05) for that ethnic group.

Figure 18. 2012–2016 Domain Satisfaction by Ethnicity: Cultural Sensitivity.



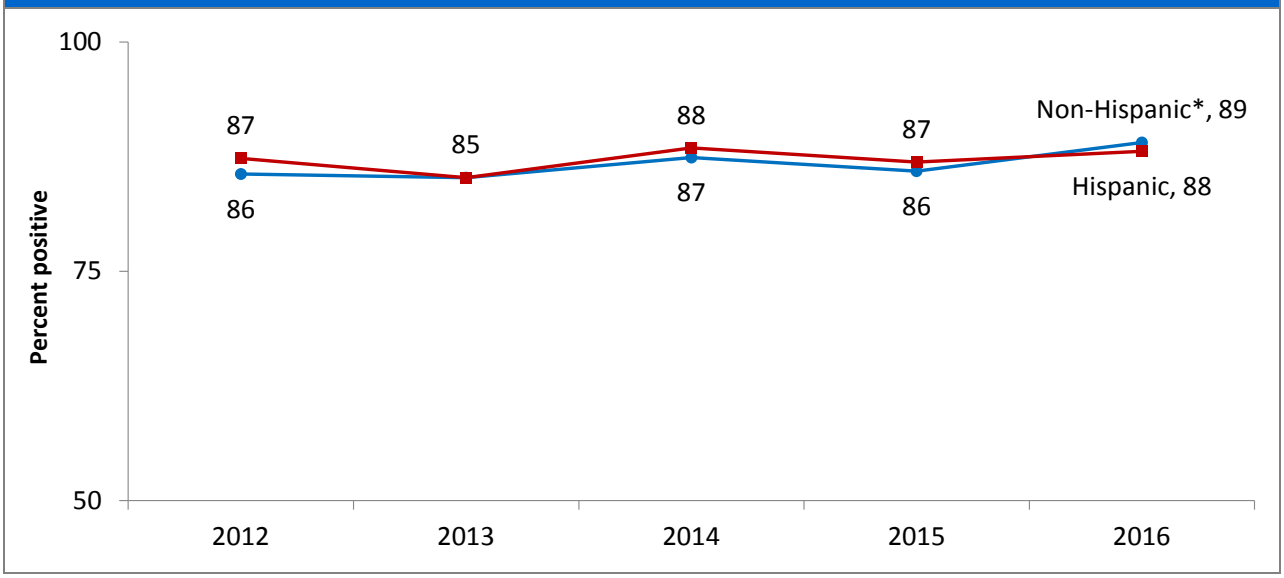
*Indicates a statistically significant upward or downward trend (p<.05) for that ethnic group.

Figure 19. 2012–2016 Domain Satisfaction by Ethnicity: Access.



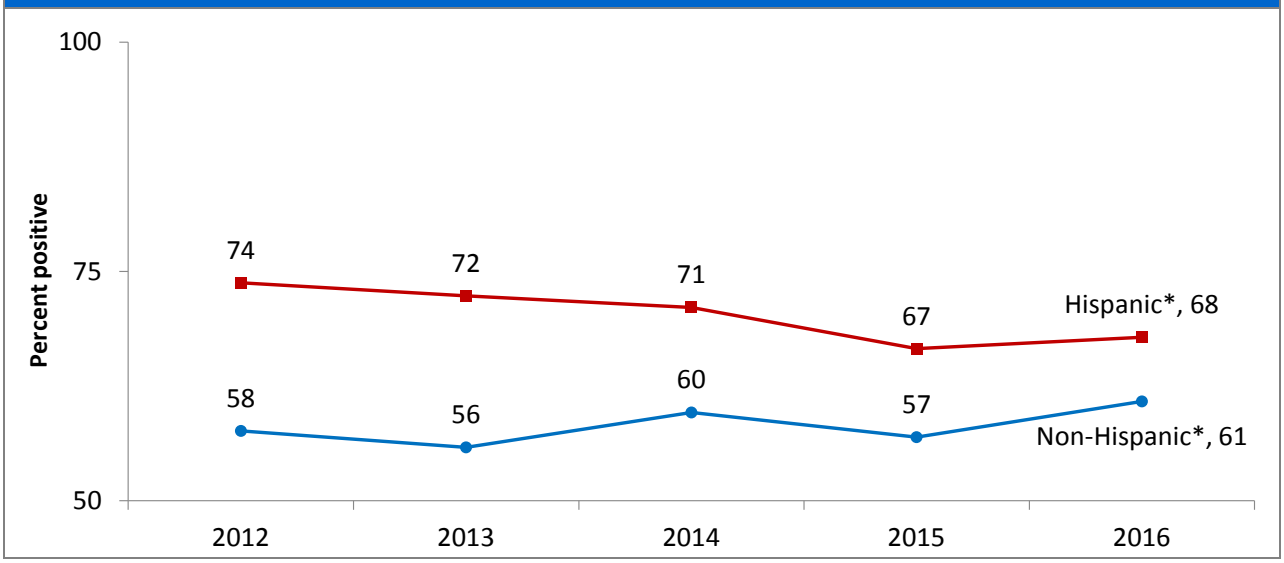
*Indicates a statistically significant upward or downward trend (*p*<.05) for that ethnic group.

Figure 20. 2012–2016 Domain Satisfaction by Ethnicity: Social Connectedness.



*Indicates a statistically significant upward or downward trend (*p*<.05) for that ethnic group.

Figure 21. 2012–2016 Domain Satisfaction by Ethnicity: Daily Functioning.



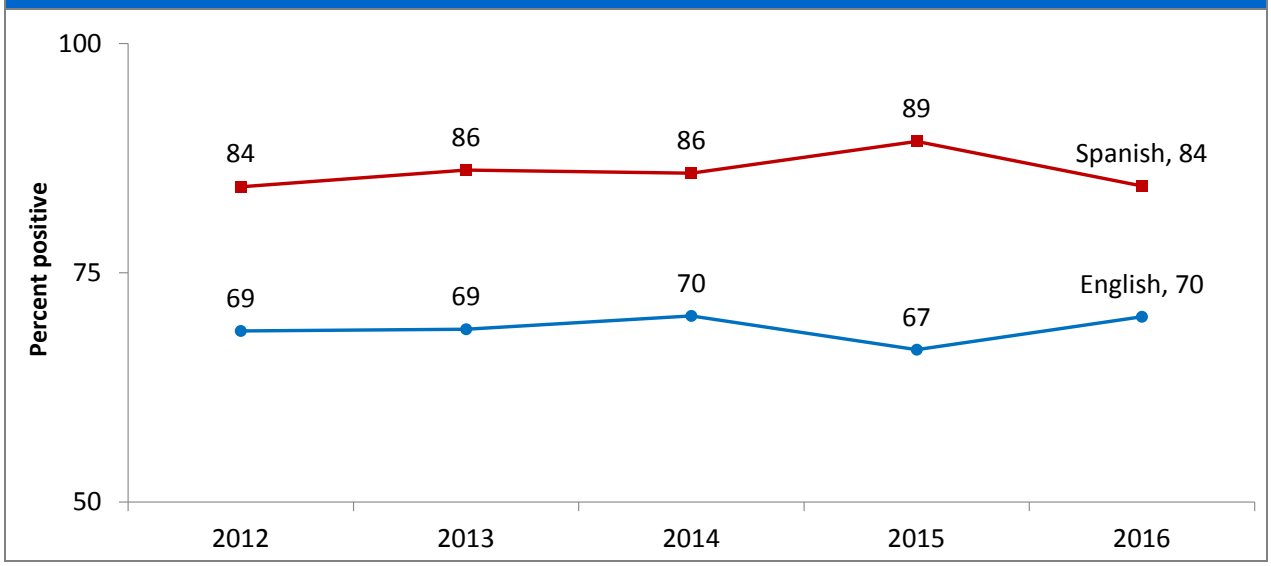
*Indicates a statistically significant upward or downward trend (p<.05) for that ethnic group.

Domain satisfaction by survey language

Spanish-speaking mental health recipients received a survey in Spanish. All others received a survey in English. (The English and Spanish versions of the survey are presented in Appendix B.) As shown in Figures 22–28, a larger percentage of Spanish-speaking respondents reported satisfaction in all domains except social connectedness in 2016, which is consistent with previous years.

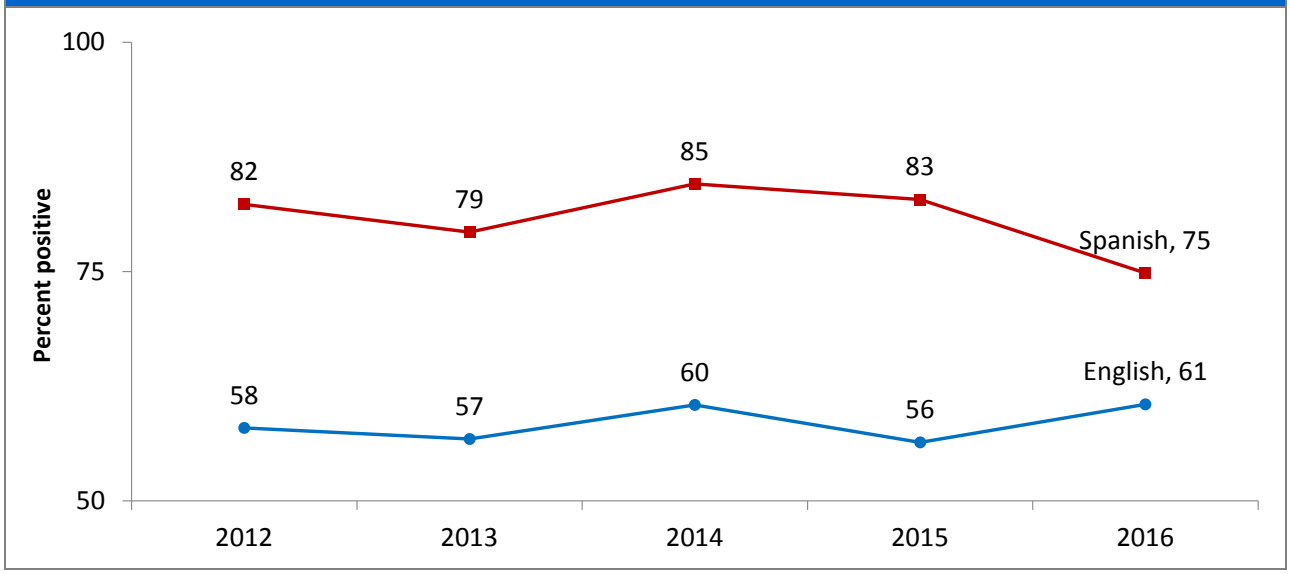
- Satisfaction among **English-speaking respondents** has increased significantly in the participation, access, and social connectedness domains over the last five years.
- Satisfaction with cultural sensitivity increased significantly among **Spanish-speaking respondents**, and declined significantly in the daily functioning domain over the last five years.

Figure 22. 2012–2016 Domain Satisfaction by Language: Appropriateness.



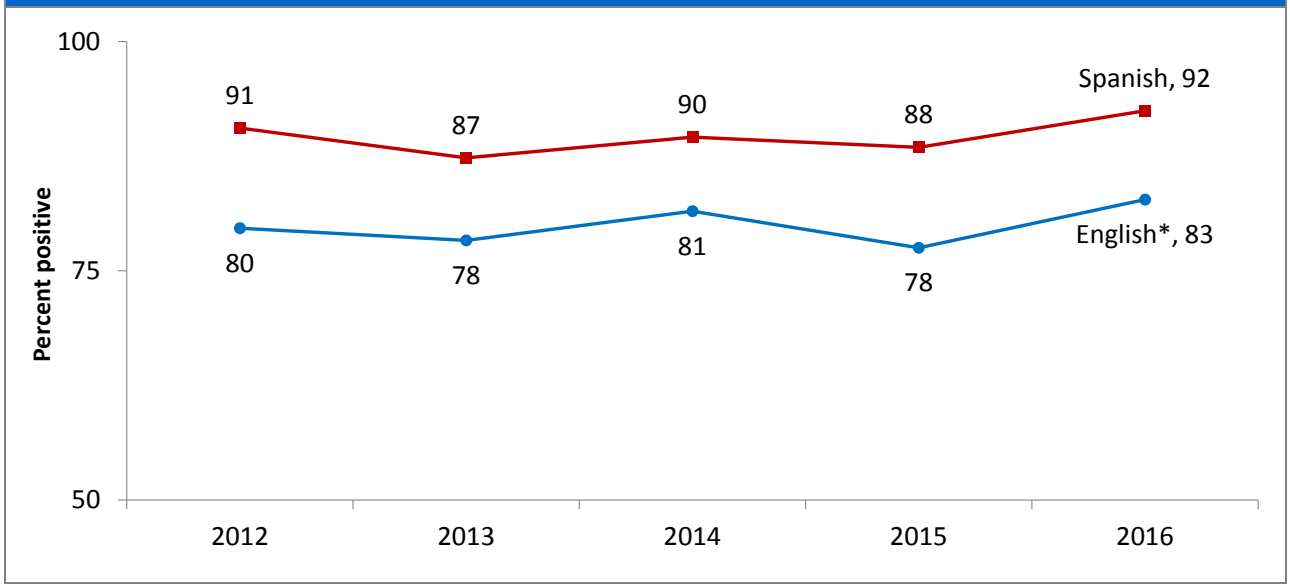
There were no statistically significant trends.

Figure 23. 2012–2016 Domain Satisfaction by Language: Treatment Outcomes.



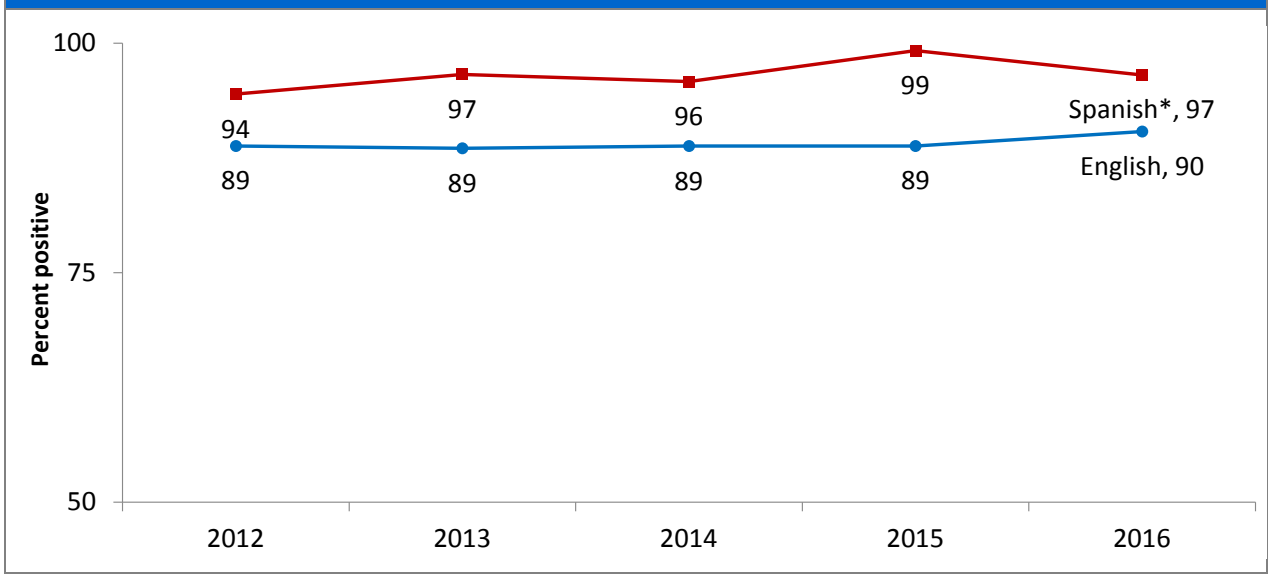
There were no statistically significant trends.

Figure 24. 2012–2016 Domain Satisfaction by Language: Participation.



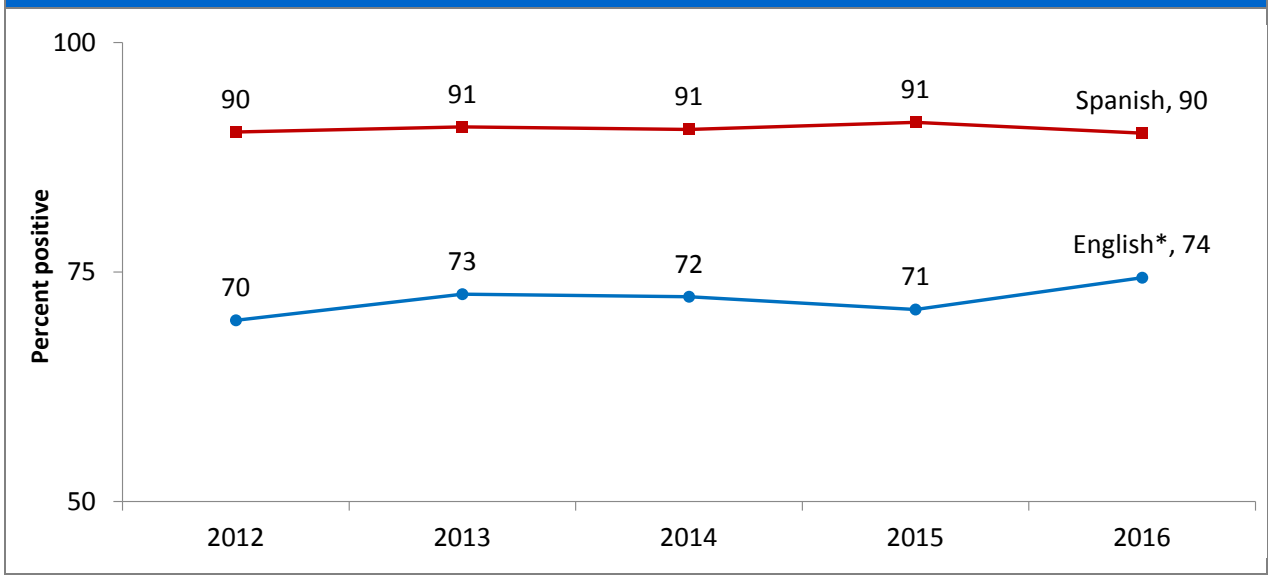
*Indicates a statistically significant upward or downward trend (p<.05) for that language group.

Figure 25. 2012–2016 Domain Satisfaction by Language: Cultural Sensitivity.



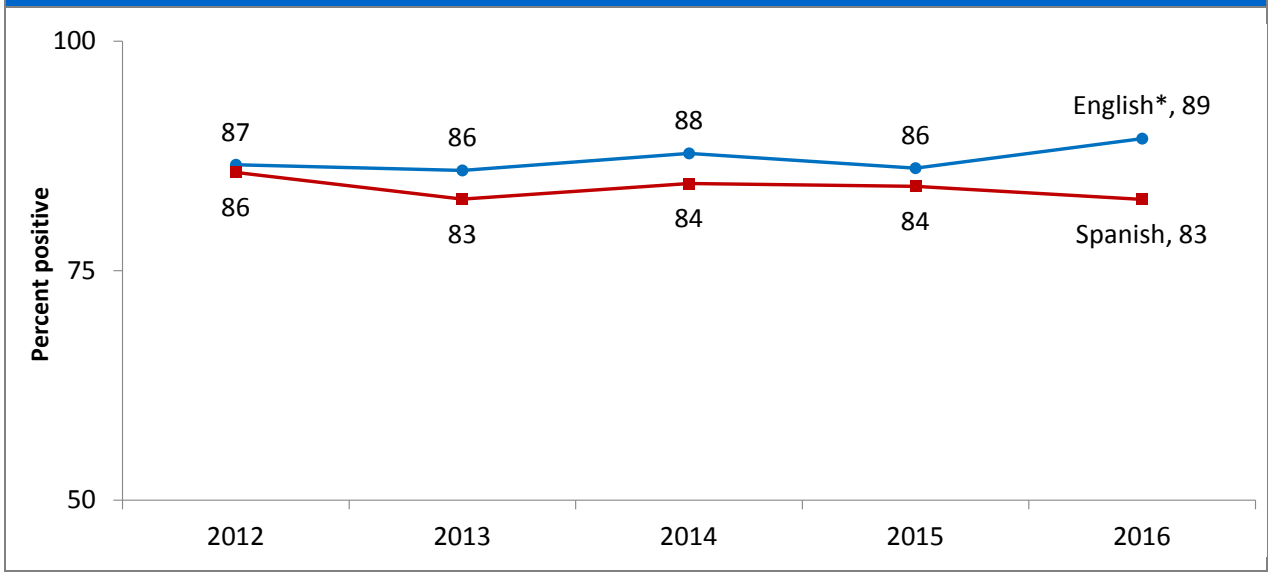
*Indicates a statistically significant upward or downward trend (*p*<.05) for that language group.

Figure 26. 2012–2016 Domain Satisfaction by Language: Access.



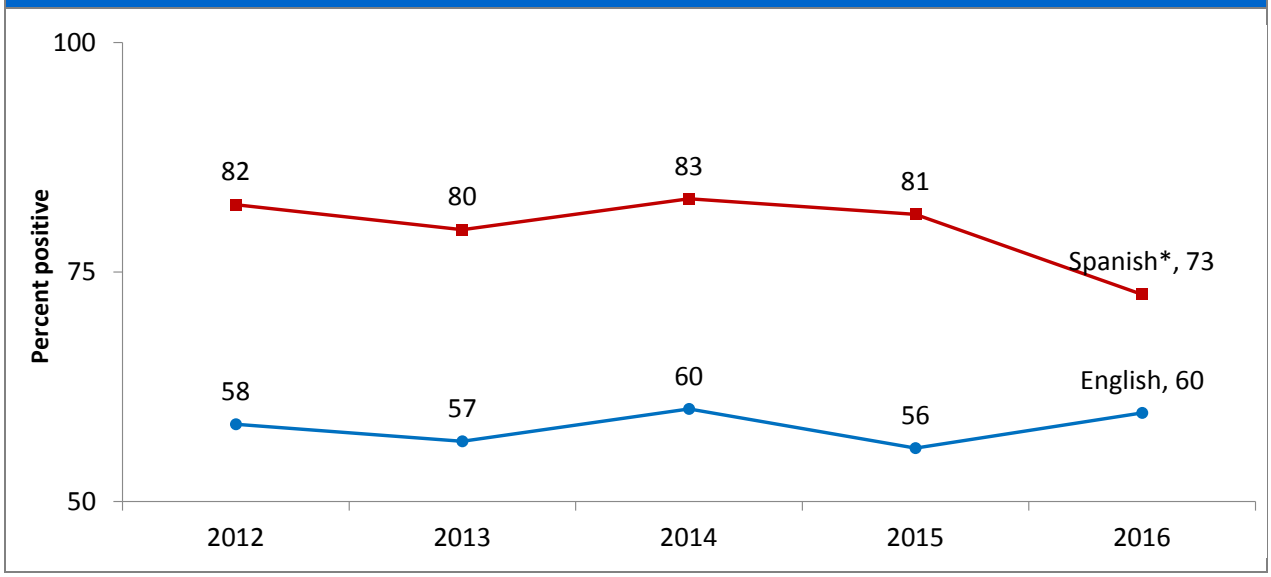
*Indicates a statistically significant upward or downward trend (*p*<.05) for that language group.

Figure 27. 2012–2016 Domain Satisfaction by Language: Social Connectedness.



*Indicates a statistically significant upward or downward trend (*p*<.05) for that language group.

Figure 28. 2012–2016 Domain Satisfaction by Language: Daily Functioning.



*Indicates a statistically significant upward or downward trend (*p*<.05) for that language group.

Analyses of State-Added Questions

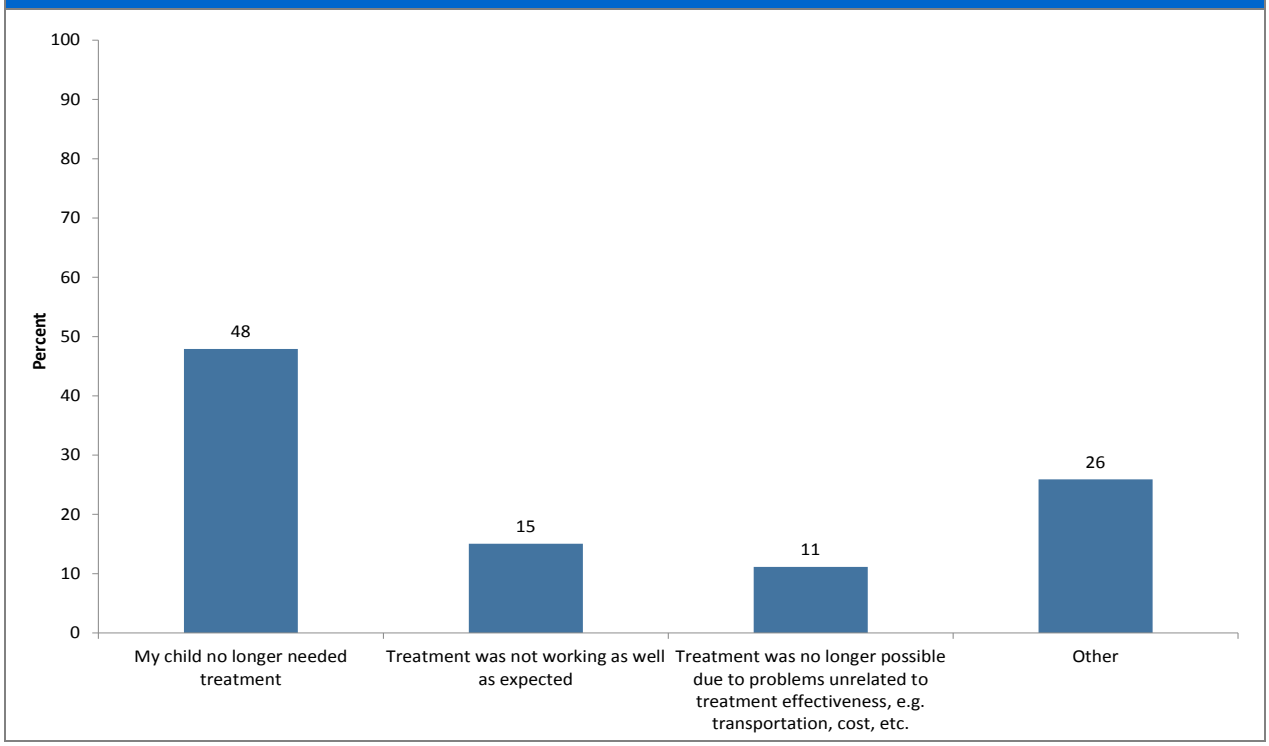
In addition to analyzing the data on YSS-F performance domains, HealthInsight Oregon analyzed responses to the survey questions related to service coordination, school attendance, arrest history, use of alcohol or drugs, service plans (treatment plans), primary health care providers and health status, psychotropic medication use, and history of trauma. The following tables and charts summarize these results.

Receiving services

At the time of survey completion, 1,857 (60%) of respondents indicated that their child was still receiving mental health services; 1,149 (37%) were not receiving mental health services; and 98 (3%) did not know.

Respondents whose child was no longer receiving mental health services were asked to indicate why they were not receiving services. Figure 29 presents these results.

Figure 29. Reasons Why Child or Young Person No Longer Receiving Services (n=1,149).



Respondents who selected "Other" were given open space to elaborate. A qualitative analysis indicated that access issues, having time to attend sessions and scheduling issues, and the child's or young person's refusal to attend were the most common reasons that service was discontinued. Payment issues, resolution of issues, summer break, insurance changes, and age were also cited as reasons for no longer receiving services.

Coordination of services

Many children and youth receiving mental health services and supports also receive services and supports from other agencies and providers including child welfare, the Oregon Youth Authority, juvenile justice, special education, services to persons with developmental disabilities, substance abuse treatment, and physical health care providers. In 2016, 1,816 (57%) respondents indicated that their child had received services and supports from other agencies. Of those, 881 (49%) received services from one additional agency; 549 (30%) received services from two additional agencies; and 386 (21%) received services from three or more additional agencies.

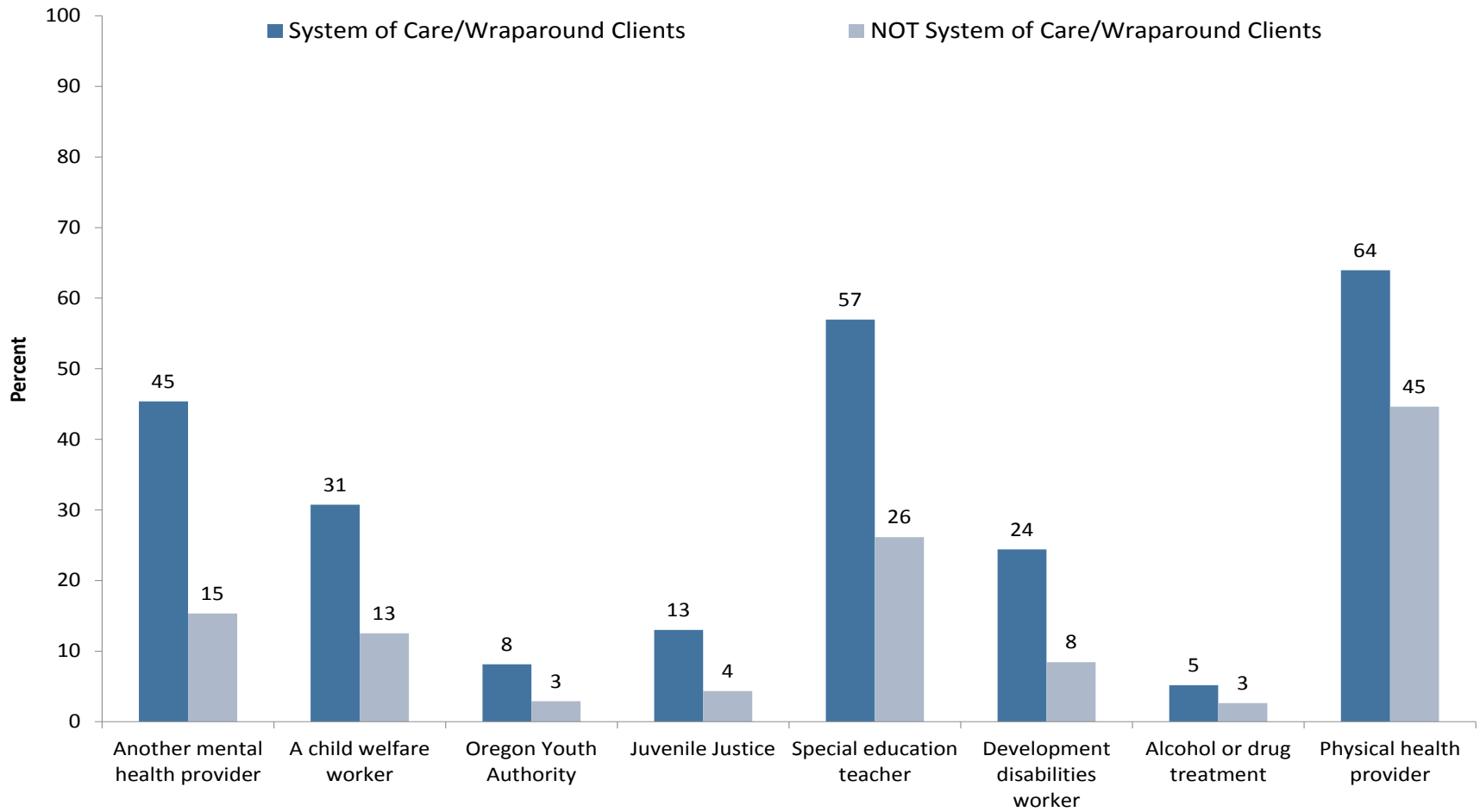
OHA's System of Care Wraparound Initiative uses coordinated, community-based services to provide individualized care for youth with complex behavioral health needs who are involved in multiple systems.[4] Of 3,060 respondents, 356 (12%) reported that their child was served under the system of care/wraparound process; 871 (29%) reported that their child was not served; and 1,833 (60%) did not know if their child was served. Figure 30 displays the percentages of caregivers who identified their children as receiving one or more of these services in 2016, according to whether that child or young person was served under the system of care/wraparound process.

As expected, caregivers of children and youth who were served under the system of care/wraparound process reported more involvement with multiple state agencies than caregivers whose children were not served under the wraparound process. Notably, more children and youth served under the system

[4] Oregon Health Authority. System of Care Wraparound Initiative, Oregon Health Plan. February 2016. Available at: https://www.oregon.gov/oha/amh/ChildMHProviderSWCIDocs/SOCWI%20-%20Guidance%20Document.pdf.

of care/wraparound process saw more than one mental health provider (45% vs. 15%), a child welfare worker (31% vs. 13%), a special education teacher (57% vs. 26%), a developmental disabilities worker (24% vs. 8%), and a physical health provider (64% vs. 45%).

Figure 30. Percentage of Caregivers whose Children Received Services from Specific State-Funded, Non-Mental Health Agencies/Systems, According to whether that Child Was Served by Wraparound, 2016.



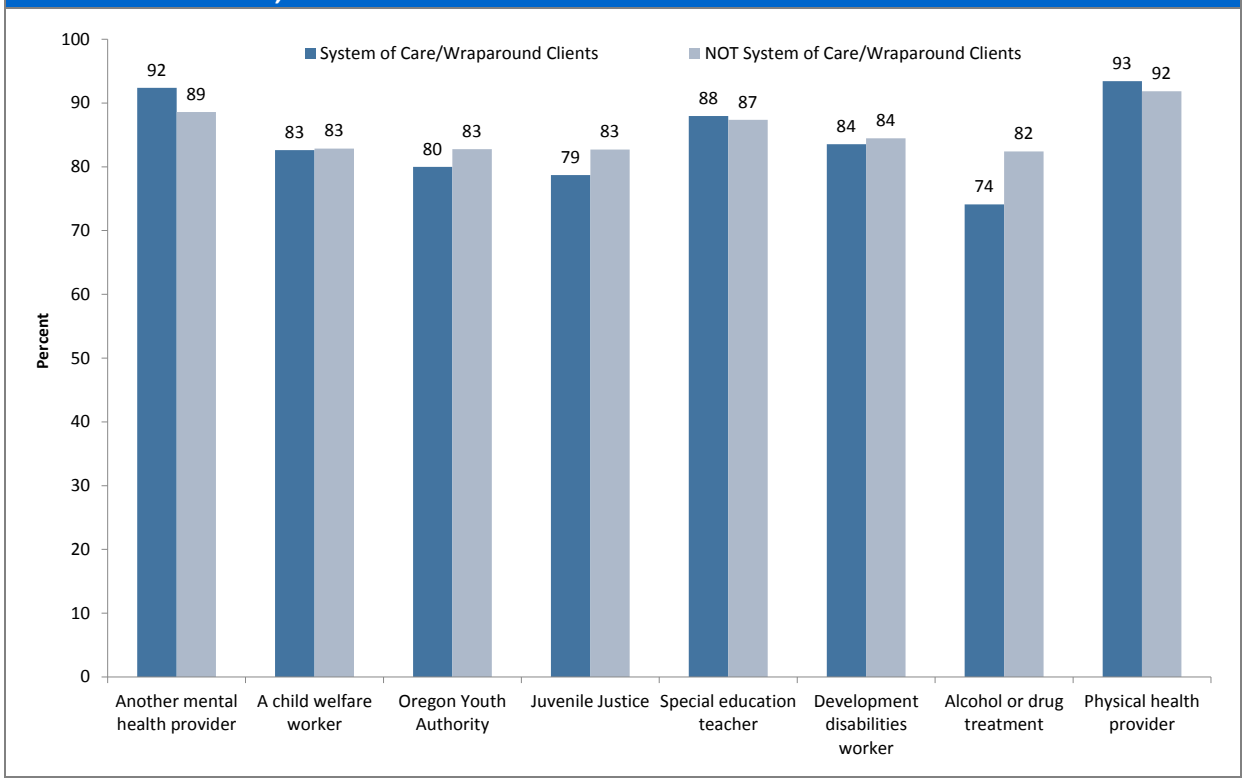
Relatively few respondents reported that the child or young person needed but did not receive services from specific service agencies, ranging from 0.41% (n=12) for a development disabilities worker to 1.61% (n=47) for juvenile justice.

Satisfaction with coordination between systems

The survey asked caregivers to indicate their satisfaction with the way their child's most recent mental health provider and other providers worked together to help their child.

Figure 31 shows the percentages of caregivers in 2016 who were either "strongly satisfied," "satisfied," or "somewhat satisfied" with the way their child's mental health services provider and other providers worked together. Caregivers of children and youth served and not served by wraparound were similarly satisfied with coordination of services in most areas.

Figure 31. Percent of Caregivers Satisfied with Coordination of Agency-Specific Services for Children and Youth, 2016.



A follow-up question asked dissatisfied respondents to elaborate on why they were dissatisfied with the willingness of the mental health provider and other providers to work together. A qualitative analysis indicated that lack of communication and unwillingness to reach out to others were common. In some cases, when the child or young person was receiving services from multiple providers, the caregiver was frustrated that the multiple providers didn't talk or share chart notes, resulting in inconsistency. Other times the caregiver was frustrated that the mental health provider didn't initiate contact with other service providers to help get the child or young person set up with services. Responses often tied in to dissatisfaction with the mental health provider.

Table 5 presents the percentage of respondents who were satisfied with the way the child's or young person's mental health services provider and other providers worked together according to CCO in 2016. (Note: The number of respondents by CCO is the maximum that responded to any one question; the actual number of responses varies according to service type. The survey did not ask respondents about satisfaction with the CCO, only service providers.)

Table 5. Percent (n) of Responders Satisfied with Coordination of Agency-Specific Services by CCO, 2016.

CCO**	Another mental health provider*	A child welfare worker*	Oregon Youth Authority*	Juvenile Justice*	Special education teacher	Development disabilities worker*	Alcohol or drug treatment*	Physical health provider
AllCare (n=71)	92	84	81	79	86	90	71	92
CHA (n=31)	79	78	73	75	93	86	79	90
CPCCO (n=43)	84	77	65	76	83	68	70	91
EOCCO (n=61)	85	67	69	69	74	65	68	84
FamilyCare (n=254)	94	92	91	91	92	94	93	95
Health Share (n=392)	88	83	82	81	89	85	78	91
IHN (n=121)	96	86	87	89	85	89	91	97
JCC (n=36)	67	77	76	75	73	60	76	84
PCS-CO (n=65)	98	80	83	86	85	89	82	95
PCS-CG (n=32)	97	100	89	89	93	88	100	100
TCHP (n=196)	89	83	88	88	86	81	86	91
WOAH (n=34)	94	92	91	90	93	86	89	94
WVCH (n=198)	88	79	81	79	89	85	79	91
YCCO (n=41)	84	71	80	75	81	78	76	93
FFS (n=149)	90	78	74	74	84	80	72	89

*Indicates statistically significant difference ($p<.05$) between CCOs.
**PHJC and UHA are not included in order to protect respondents' privacy because their sample size was less than 30.
Also, GOBHI is not included because GOBHI members were not explicitly sampled; therefore, the number of responses was too small to perform any MHO-specific analyses.

Caregivers' expectations about the results of children's and youth's mental health treatment

The 2016 survey asked family members about the expectations and hopes they held when their children began mental health treatment, and whether the treatment results met those expectations. As Figure 32 shows, the most frequent expectations were that the child or young person would:

- Feel better about himself/herself (74%)
- Become happier (71%)
- Become less anxious or fearful (70%)

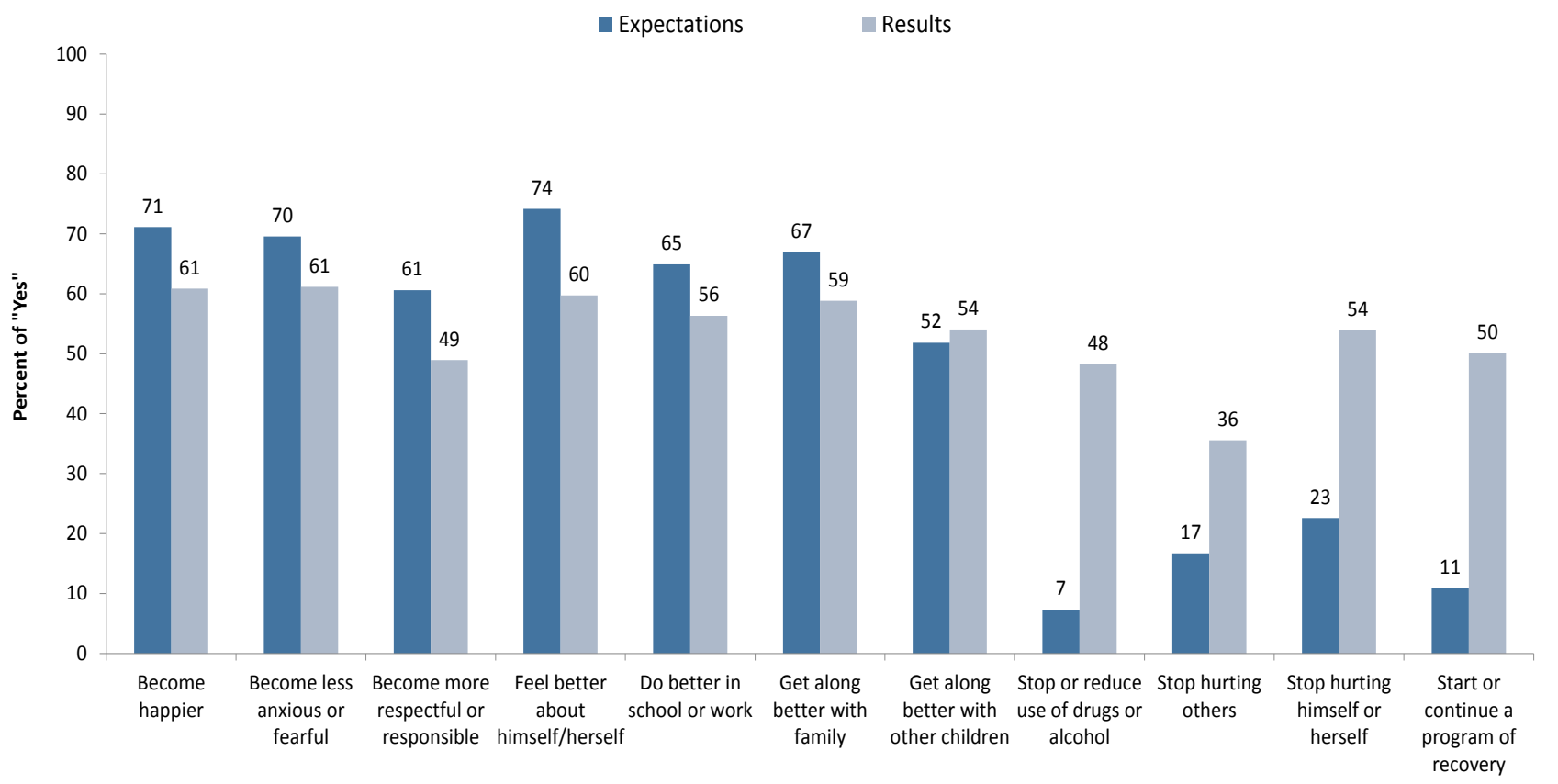
Among respondents with each expectation, we tabulated how many got the result they were expecting. The most frequently met expectations were that the child or young person:

- Became less anxious or fearful (61%)
- Became happier (61%)
- Felt better about himself/herself (60%)

The largest discrepancies between expectations and results were in the self-harm and substance use areas.

- Stop or reduce use of drugs or alcohol (7% expectation, 48% result)
- Start or continue a program of recovery (11% expectation, 50% result)
- Stop hurting himself or herself (23% expectation, 54% result)
- Stop hurting others (17% expectation, 36% result)

Figure 32. Expectations for the Child's or Young Person's Mental Health Treatment (N=3,212), and Results of Mental Health Services. "I expected my child would…"



Respondents could select all answer options that applied; therefore, all are included in the denominator.

Child's or young person's service plan

Service plans are individualized treatment plans completed before services begin that include the level of care to be provided, projected treatment timelines, personnel involved and treatment objectives. Plans should be created with participation from youth and their families and include "services and supports that will be used to meet the treatment objectives." (See Oregon Administrative Rule [OAR] 309-022-0140 for all required elements.)[5]

The survey asked whether the child's or young person's service plan supported the child's and caregiver's culture and language. A majority that responded to the question agreed or strongly agreed that the plans did (Table 6). Results were consistent with 2015 findings.

Table 6. Child's or Young Person's Individual Services and Supports Plan Supports the Following:

	Strongly Agree/ Agree	Strongly Agree/ Agree	Undecided	Undecided	Strongly Disagree/ Disagree	Strongly Disagree/ Disagree
Options	**2015**	**2016**	**2015**	**2016**	**2015**	**2016**
Considered and included my cultural values in my child's care	77	82	20	16	3	2
Communicated effectively in my primary language	93	95	5	4	2	2
Communicated effectively in my child's primary language	93	96	5	4	1	1
Made me feel welcome and comfortable when I spoke to them	89	91	7	6	4	3

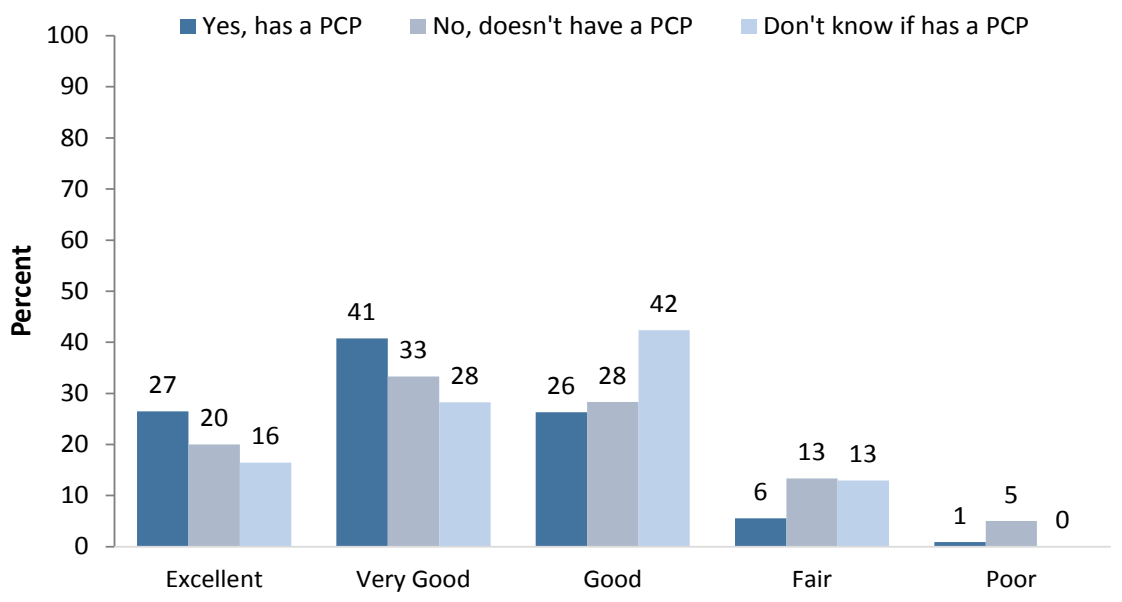
[5] Oregon Administrative Rules: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

Health status

Health status in childhood and adolescence is a major determinant of adult health status. The state has incentivized CCOs to provide annual wellness visits for adolescents and ensure all children and youth are up to date on vaccinations, among other childhood health initiatives.

Figure 33 shows that children and youth with excellent and very good health status are more likely to have a primary care health provider or other practitioner who provides check-ups, routine medical care and advice (PCP). Overall, 66% of caregivers reported that their child had excellent or very good health status; of these, 95% reported that their child had a primary health care provider. Among children and youth with good health status, 92% had a primary health care provider; as did 86% of those with fair health status, and 81% of those with poor health status.

Figure 33. Presence of a Primary Health Care Provider or Other Practitioner, According to Child's or Young Person's Health Status.



Psychotropic medications

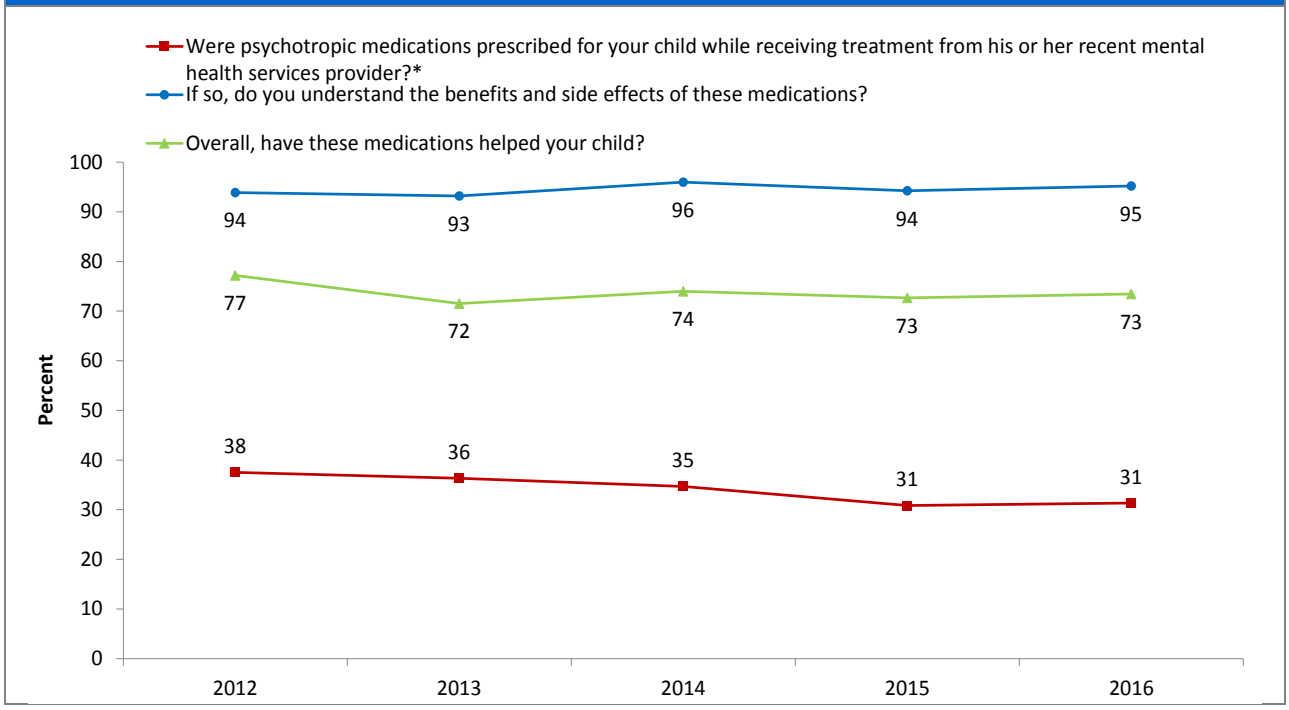
Oregon has taken a number of steps to address the use of psychotropic medications in children. For example, in 2012 OHA was awarded a technical assistance grant from the Center for Health Care Strategies which aimed to reduce the use of antipsychotic medications for unapproved indications and minimize polypharmacy use for children in foster care. Another initiative, the Oregon Psychiatric Access Line about Kids, provides free child psychiatric phone consultations to primary care providers in Oregon.[6,7]

Caregivers were asked three questions about psychotropic medications that were prescribed for their children or youth while they were receiving treatment from their current (or most recent) mental health services provider. As Figure 34 shows, the percentage of caregivers who reported that psychotropic medications were prescribed for the child or young person trended significantly downward over the last five years from 38% in 2012 to 31% in 2016. Of those whose child received psychotropic medications, the percentage who understood the benefits and side effects remained fairly consistent (94% to 95%), as has the percentage who thought the medications helped their child (77% to 73%).

[6] Presentation: Improving the Use of Psychotropic Medications in Children and Youth in Foster Care. December 2015 Update. Available at: http://www.oregon.gov/oha/pharmacy/CCOPharmacyDirectors/Presentation%20-Improving%20prescribing%20practices%20122015.pdf.

[7] OHSU School of Medicine, Department of Psychiatry. Oregon Psychiatric Access Line about Kids (OPAL-K). http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/index.cfm.

Figure 34. Psychotropic Medications Prescriptions, 2012–2016.



*Indicates a statistically significant upward or downward trend (p<.05) for that question.

School attendance

A common goal of mental health treatment is to improve functioning of the child or young person in order to improve school attendance and thereby school success. The YSS-F survey asked caregivers several questions about school attendance, suspensions, and expulsions.

There were 446 (15%) respondents who reported that their child did not attend a public or private school during the time they were served by their most recent mental health services provider and were excluded from these analyses.

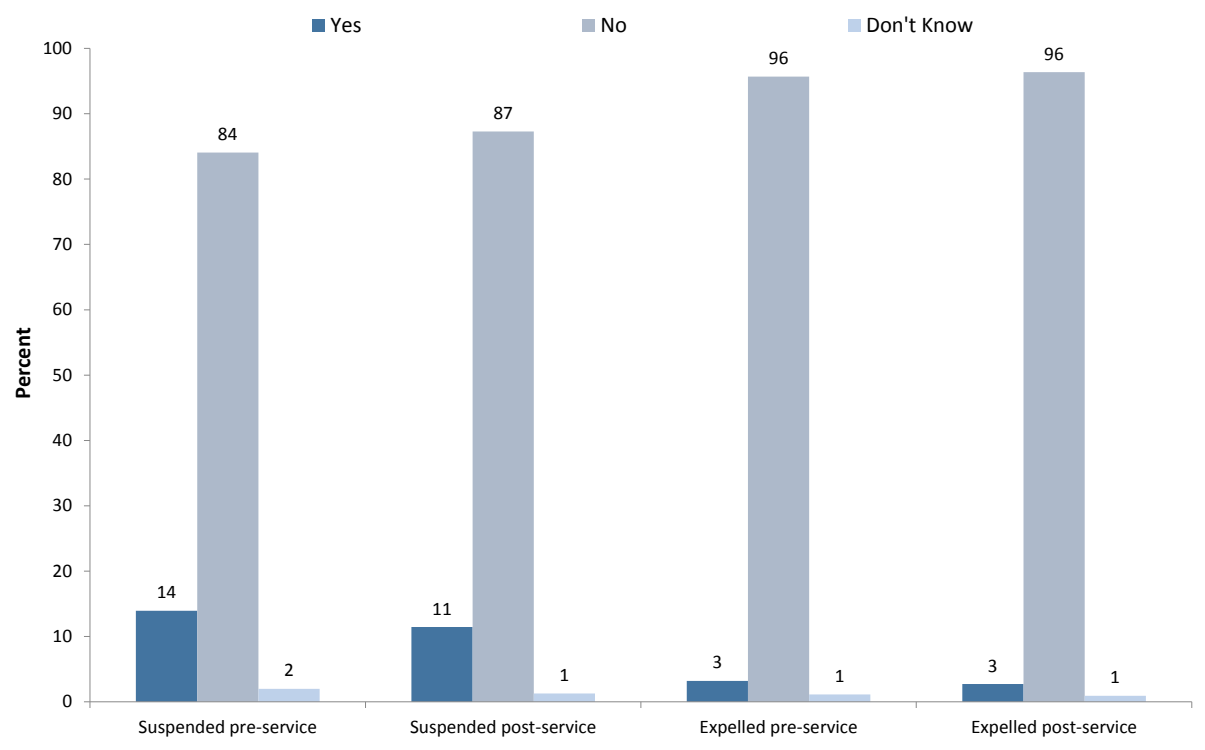
In the time since the child or young person started to receive mental health services, 40% of respondents indicated that the number of days their child had been in school was about the same; 24% reported an increase in school days; and 7% reported a decrease in school days. The remaining 30% of respondents said the question did not apply for the following reasons:

- Child had no problem with attendance before starting school (86%)

- Other (8%)
- Child is too young to be in school (0.7%)
- Child is home schooled (3%)
- Child dropped out of school (2%)
- Child was expelled from school (0.4%)

As Figure 35 shows, the percentage of respondents who indicated that their child was suspended before or after receiving mental health services declined from 14% to 11%. The percentage of respondents who indicated that the child or young person was expelled before or after receiving mental health services remained stable at 3%.

Figure 35. School Suspensions or Expulsions Pre- and Post-Service Initiation.



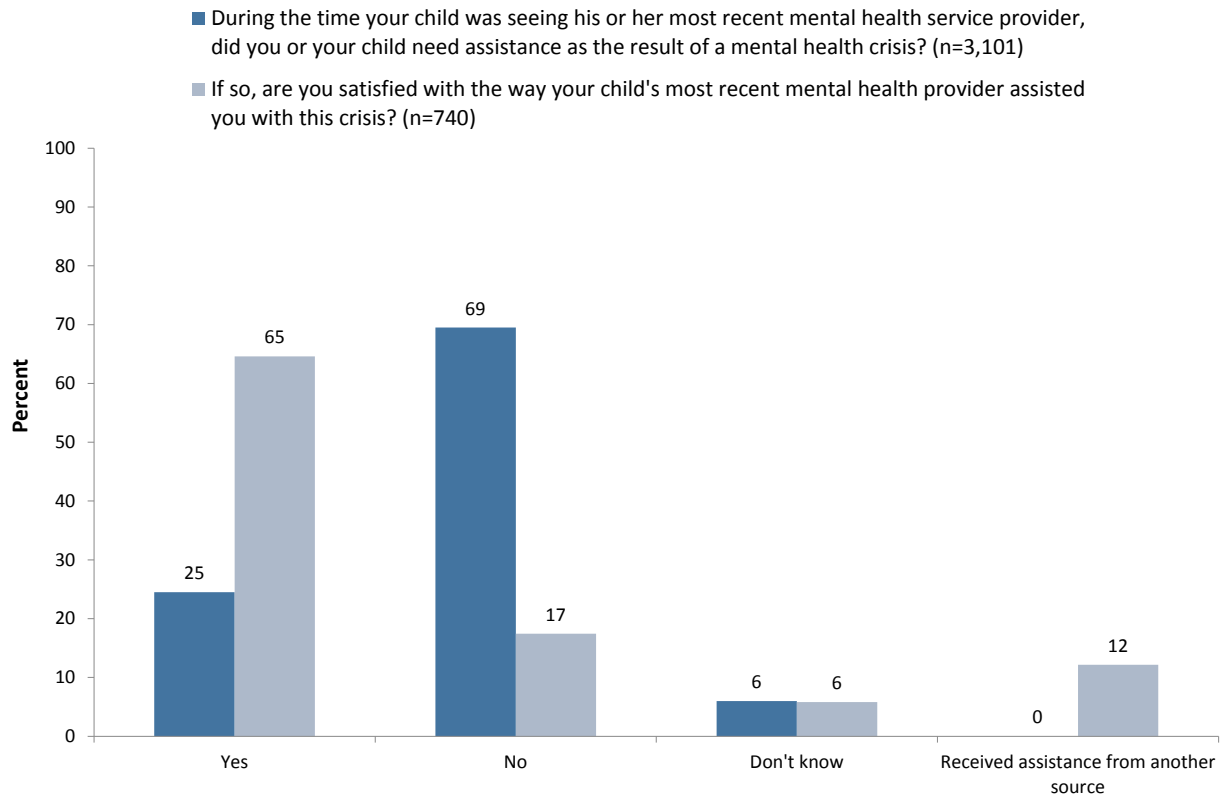
Mental health crisis

A mental health crisis is an unfortunate, but not uncommon experience of children and youth with a mental health diagnosis. State law dictates that service plans, required for each member, must include "proactive safety and crisis planning."[8]

Figure 36 shows that during the time the child or young person was seeing his or her most recent mental health services provider, 25% needed assistance as the result of a mental health crisis. Of these, 65% of caregivers were satisfied with the way the mental health provider assisted them. Over the last four years, the percent of caregivers reporting that their child had a mental health crisis has shown a significant downward trend from 26% to 25%, while the percent of caregivers who were satisfied with the mental health provider's response has also shown a significant downward trend from 68% to 65%.

[8] OAR 309-022-0140(3)(e), Service Planning and Coordination. Available at: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

Figure 36. Mental Health Crisis and Provider Assistance.



Youth's arrest history

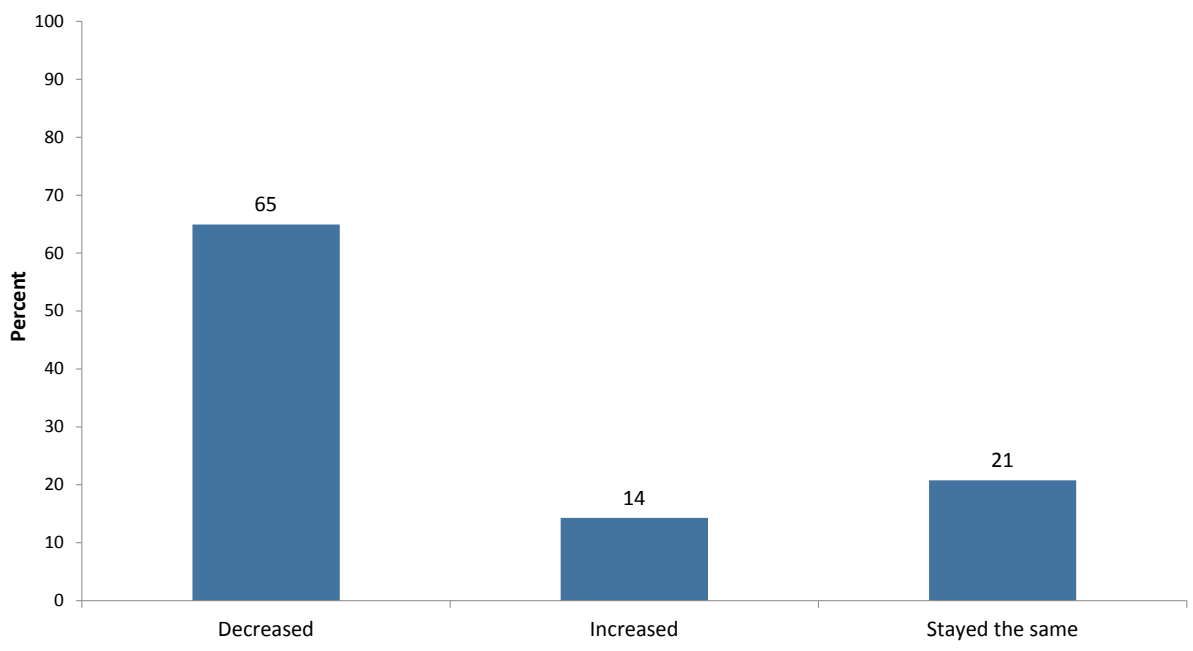
Improved management of a young person's behavioral health symptoms should lead to a reduction in arrests and other encounters with police.

- 13% of respondents indicated that their child has ever had an encounter with the police, including being arrested, hassled by police, or taken by the police to a shelter or crisis program
- 2% were uncertain
- 85% reported that their child had never had an encounter with police

Of respondents whose children or youth had ever encountered the police, 21% reported that encounters with the police had stayed the same after their child began receiving mental health services; 65% reported a decrease in encounters; and 14% reported an increase in encounters (Figure 37).

Among respondents whose child had ever encountered the police, 27% reported that their child was arrested before starting treatment and 15% reported an arrest after starting treatment.

Figure 37. Youth's Encounters with Police since Receiving Mental Health Treatment, Ages 14–18. "Since your child began to receive mental health services from this provider, have his or her encounters with the police…"

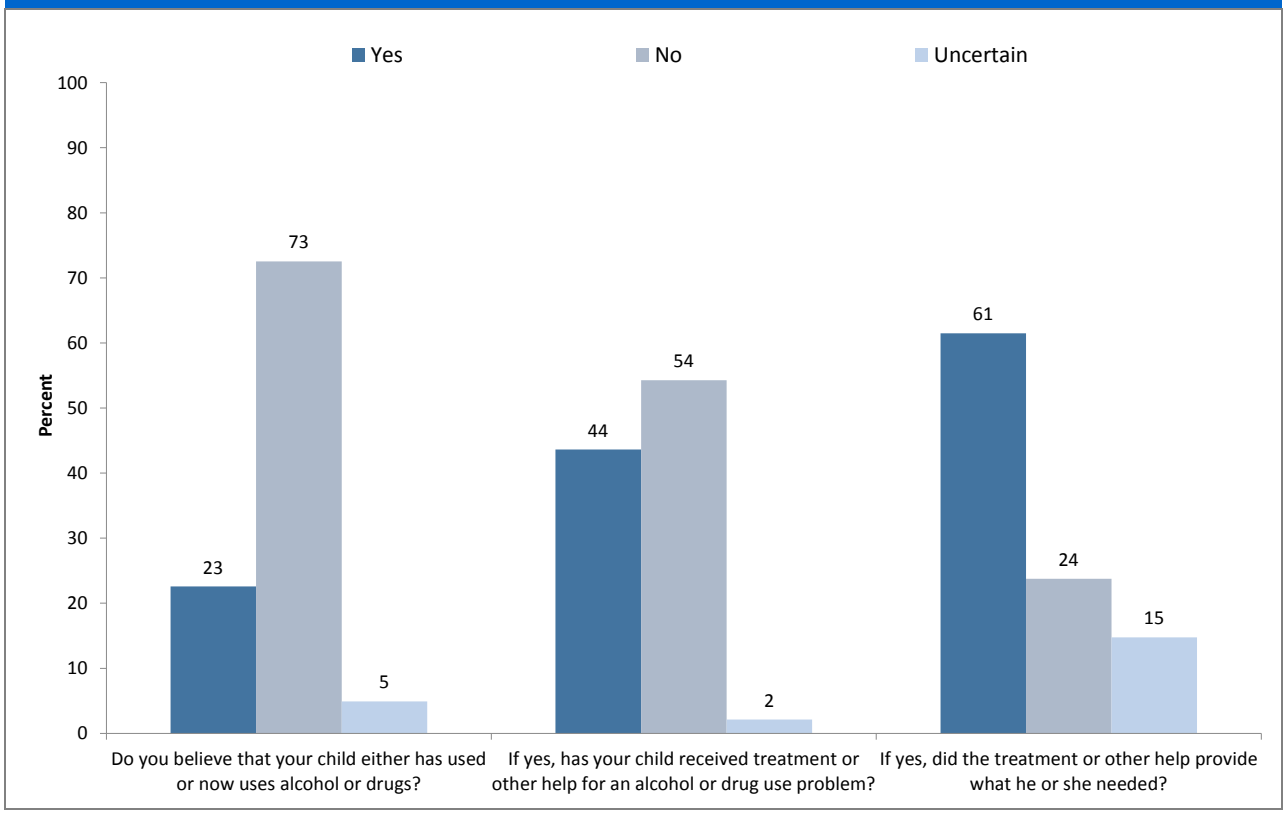


Alcohol and drug use

For some youth, mental illness and substance use disorder occur simultaneously. These co-morbidities can be complex to address, but must be addressed together to increase the odds of improvement for the young person and their family.

As shown in Figure 38 below, 23% of caregivers of youth ages 13–17 believed that their child either has used or now uses alcohol or drugs. While similar to 2015, this is an increase from 19% in 2014 when this question was modified to its current form. Of these, fewer than half (44%) reported that their child had received treatment or other help, and of those who did receive help, 61% thought the treatment or other help provided what the young person needed. The survey did not allow respondents to elaborate on what other help youth may have received.

Figure 38. Status Substance Abuse Treatment for Youth Ages 13–17.

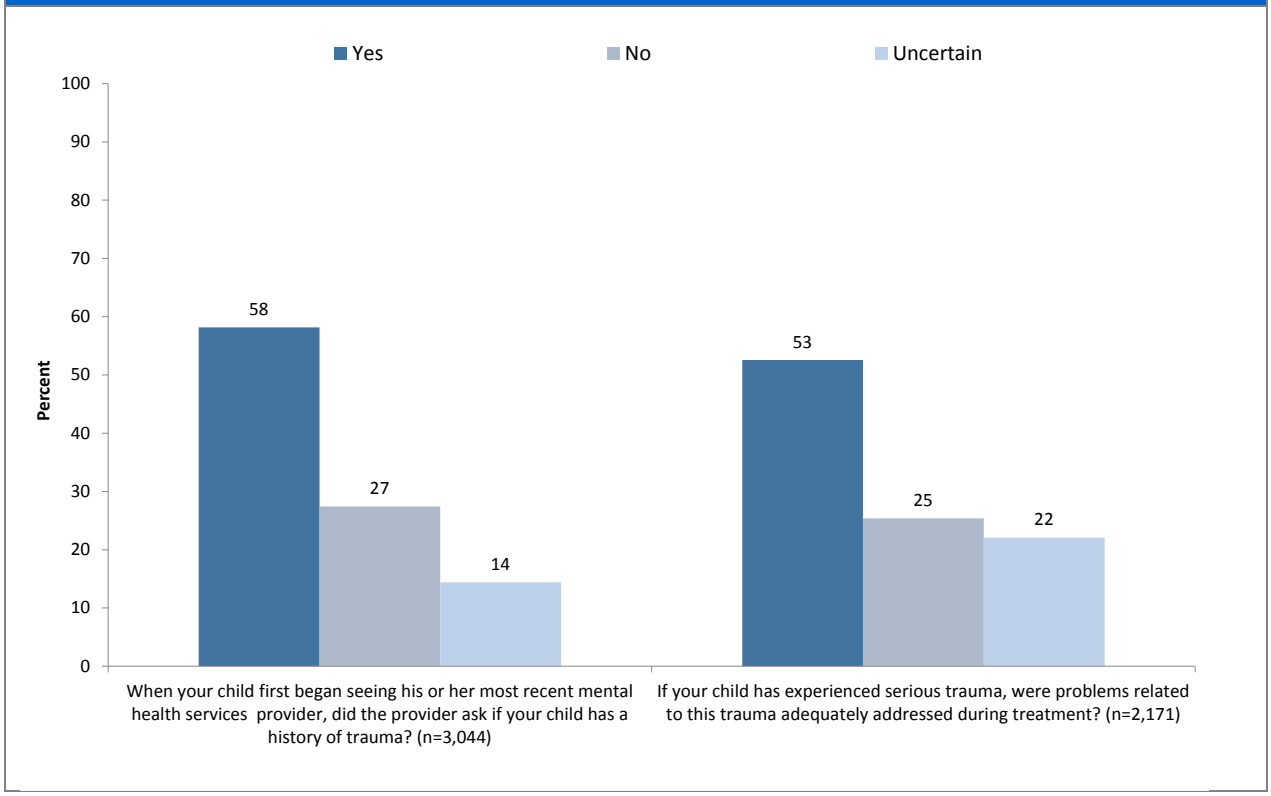


History of trauma

For many children and youth, a history of trauma is interwoven with their mental illness. The YSS-F survey defined trauma as: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Providers must screen for trauma and include trauma-informed services in behavior support plans.[9] As Figure 39 shows, 58% of respondents said their child was asked if they had a history of trauma. If the child or young person had experienced serious trauma, 53% of respondents felt the problems related to this trauma were adequately addressed during treatment.

Figure 39. Provider Asking About Trauma; Trauma Addressed in Treatment.



[9] OARs 309-022-0135 and 309-022-0165. Available at: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

Housing stability

Housing instability, especially for children and youth, can cause stress and, therefore, an aggravation of mental health symptoms. Caregivers were asked how many times in the last three years their child had changed residence (for example, moved from one house to another house, or moved from home to residential treatment). More than half (58.8%) reported at least one move in the last 3 years. The average number of moves was 2.3 (standard deviation 1.6), with a maximum of 16 moves.

2016 YOUTH SERVICES SURVEY RESULTS

The YSS measures young people's perceptions of the mental health services they receive in five performance domains:

- **Access to Services**: service location, frequency and availability of appointments, and responsiveness of staff
- **Appropriateness of Services**: general satisfaction, someone for child to talk to, had providers that stuck with them, received the right services, and received the right quantity of services
- **Cultural Sensitivity:** staff respect of client, family, cultural/ethnic background, and religious/spiritual beliefs
- **Participation in Treatment:** client's participation in determining treatment goals and comfort asking questions
- **Treatment Outcomes:** client's ability to deal with problems and crisis, control life, relationships with family, functioning in social situations and school or work, housing, and reduction in symptoms

Like the YSS-F, the YSS includes a cluster of questions designed to assess young people's perceptions of different aspects of access, appropriateness, cultural sensitivity, participation, and outcomes. For example, responses to two statements measure the perception of access to services:

- "The location of services was convenient."
- "Services were available at times that were convenient for me."

These questions are similar to those used in the YSS-F to evaluate access.

Each question uses a 5-point Likert scale, with responses ranging from "Strongly Agree" (5) to "Strongly Disagree" (1). Domain scores are calculated with the same methodology as used for the YSS-F. The comparable approach of the two surveys makes it possible to compare the responses of young respondents with those of their caregivers, both for individual questions and for overall domain scores.

In order to gain more insight into the population's satisfaction with mental health services, HSD added survey items. The YSS includes additional questions about:

- current and past living arrangements
- utilization of physical health care services

- school absenteeism
- what has been helpful about the services the young person responding has received and what would improve services

As designed by the MHSIP, the YSS instrument contains 38 questions. Oregon's HSD modified the YSS instrument slightly, removing questions about the respondent's Medicaid status (not necessary because the survey was sent only to Medicaid enrollees) and adding a "Not applicable" option for the first 21 questions.

According to the MHSIP, the YSS is appropriate for young people ages 13 to 18. Using the sample provided for the YSS-F, HSD identified young people who were at least 14 years of age during the period they were in treatment, and assigned these respondents to the same categories (outpatient, psychiatric residential, and psychiatric day treatment) as used in the YSS-F. No sample size criteria were applied for the YSS; rather the YSS sample is pulled directly from the YSS-F sample. YSS results by CCO are not presented in this report because more than half of the CCOs had fewer than 30 respondents, the threshold below which results are suppressed to maintain the respondents' confidentiality.

The YSS questionnaire was fielded in English and Spanish, according to the young person's primary language on file in MMIS. Both survey versions are presented in Appendix A.

Survey Response

HealthInsight Oregon mailed an introductory letter to 5,714 young people in May 2016. Three quarters (75%) of the YSS surveys were completed online in 2016, an increase in online submissions over previous years. Respondents were incentivized with a $10 gift card for completing the survey online. As of September 15, the day when data entry ended, 1,025 surveys had been received from among 4,672 sent to valid addresses, for an overall response rate of 22%. Mental health recipients who refused or opted out of the survey were excluded from the denominator for response rate calculations.

Table 7 shows the response rate by treatment setting. The outpatient group had the highest response rate at 23% while the psychiatric residential and psychiatric day groups were notably lower at 13%. Due to low population numbers in the

psychiatric day treatment and psychiatric residential groups, domain scores are not broken down by treatment setting except where noted.

Table 7. YSS Response Rate by Treatment Setting.

Setting	Number of responses	Number of surveys sent	Response rate (%)
Outpatient	980	4,317	23
Psychiatric Day	8	61	13
Psychiatric Residential	37	294	13
Total	**1,025**	**4,672**	**22**

Note: surveys sent exclude opt-outs and bad addresses.

As shown in Table 8, response rates were notably higher for female than for male respondents and for white vs. non-white respondents.

Table 8. YSS Response Rate by Demographic Characteristics.

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
Gender	Female	661	2,712	24
	Male	364	1,960	19
Age group	13–15	541	2,320	23
	16–18	484	2,352	21
Race	Non-white	151	731	21
	White (Caucasian)	654	2,914	22
	Race unknown	220	1,027	21
Location of residence	Rural	380	1,756	22
	Urban	633	2,870	22
	Unknown	12	46	26
Language	English	579	2,791	21

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
	Spanish	68	384	18
	Other	378	1,497	25

Note: surveys sent exclude opt-outs and bad addresses. All demographic information presented above comes from the state's Medicaid enrollment data.

Table 9 shows the response rate by the young person's CCO. EOCCO had the highest response rate at 26%, followed by FamilyCare, JCC and PSCS-CO (25% each). Several other CCOs following closely with response rates of 20% to 23%.

Table 9. YSS Response Rate by CCO.

CCO	Number of responses	Number of surveys sent	Response rate (%)
AllCare	36	162	22
CHA	16	89	18
CPCCO	18	91	20
EOCCO	42	161	26
FamilyCare	131	522	25
Health Share	222	1,090	20
IHN	50	256	20
JCC	28	110	25
PSCS-CO	60	239	25
PSCS-CG	9	70	13
PHJC	13	71	18
TCHP	120	507	24
UHA	15	72	21
WOAH	12	76	16
WVCH	139	591	24
YCCO	21	116	18
GOBHI MHO*	2	9	22
FFS	91	440	21

CCO	Number of responses	Number of surveys sent	Response rate (%)
Total	**1,025**	**4,672**	**22**

*GOBHI was not sampled as a CCO.

Surveys sent exclude opt-outs and bad addresses.

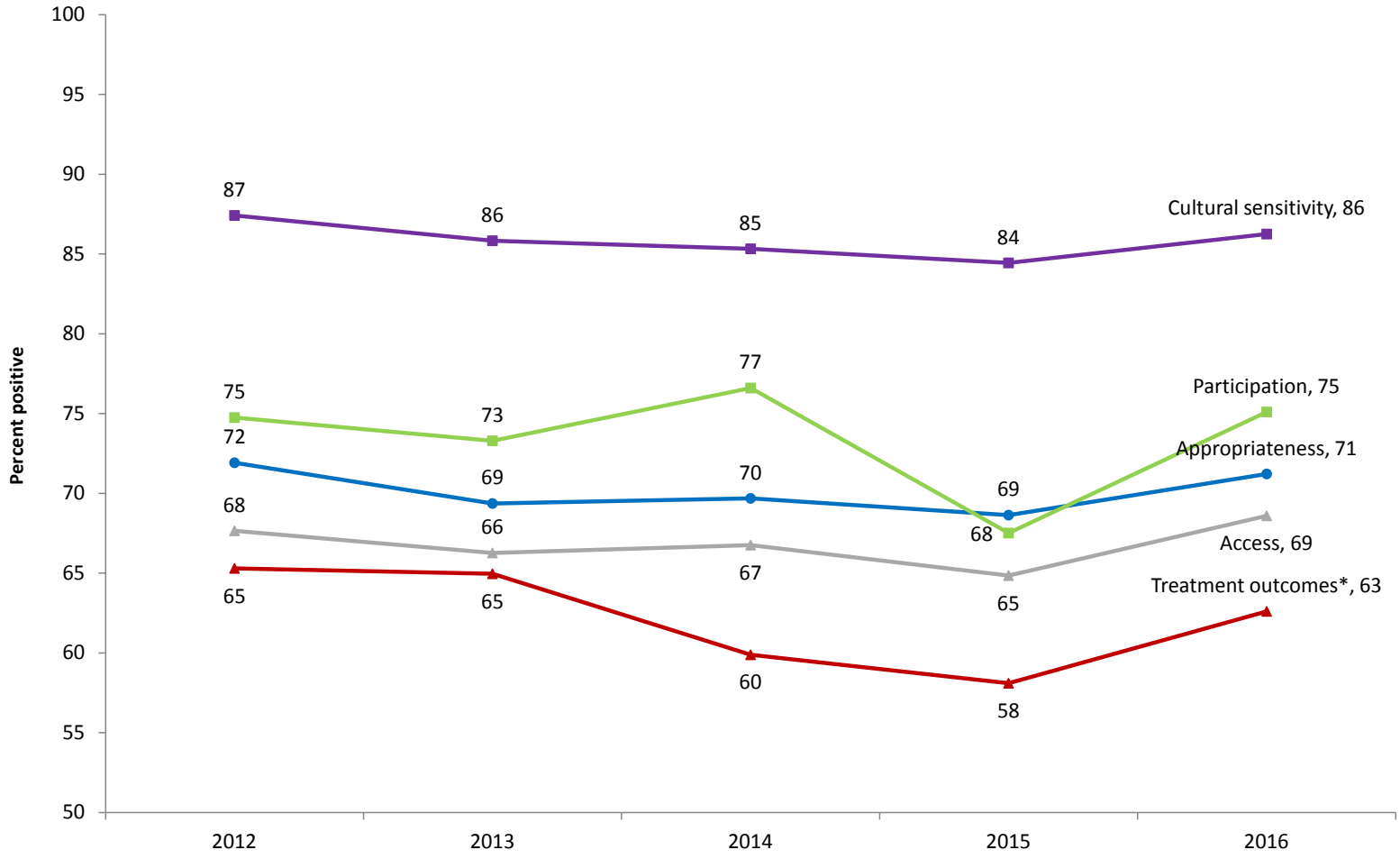
Domain Satisfaction

Figure 40 shows the percentage of respondents that were satisfied in each domain. Over the last five years, the percentage of respondents who were satisfied with their treatment outcomes has trended significantly downward. While satisfaction in other domains has varied year to year, none showed a significant upward or downward trend.

Domain satisfaction according to CCO assignment is not presented in this report due to the low number of respondents (< 30) in 9 of the CCOs. OHA is considering methods to increase the sample and response rate among youth.

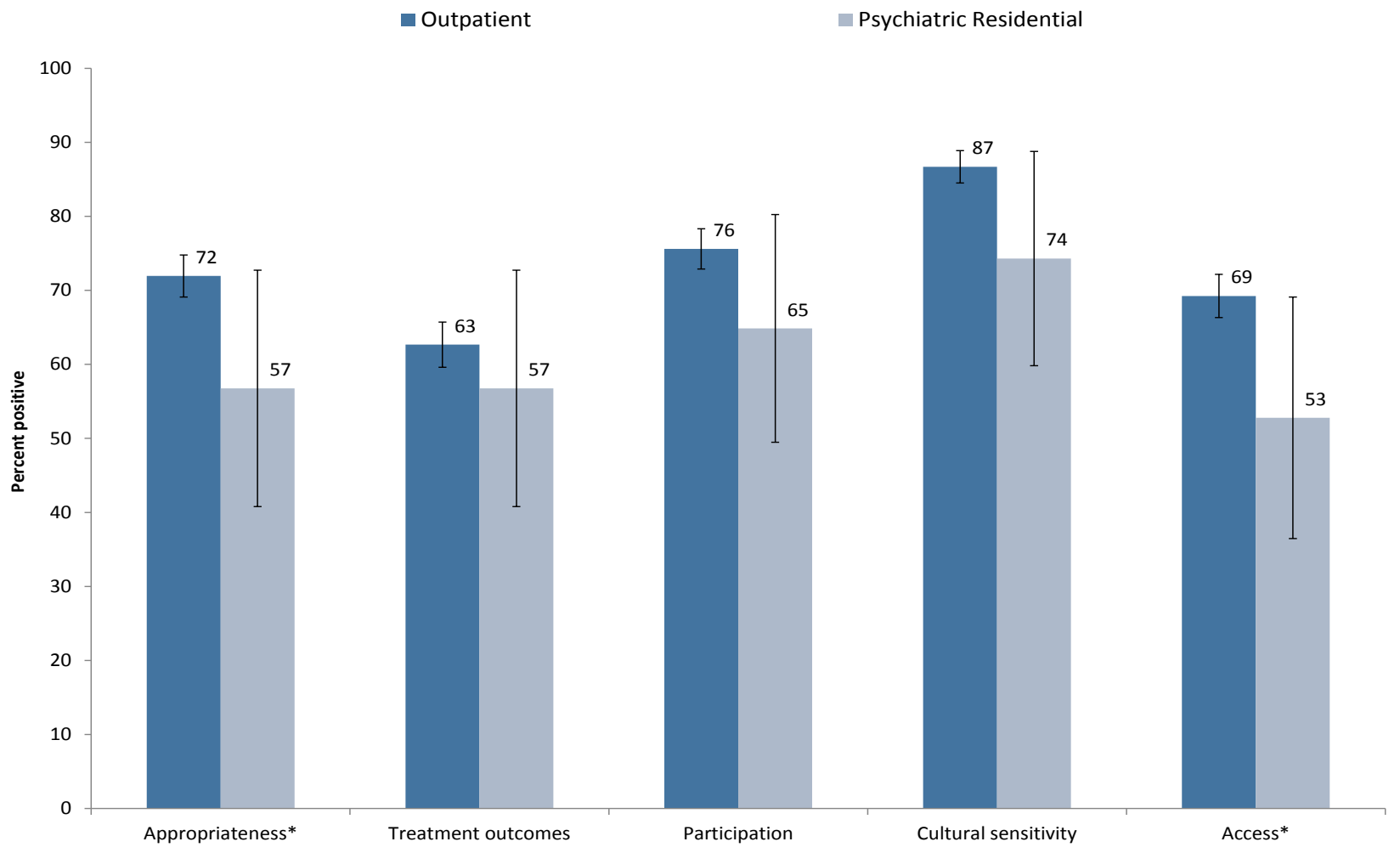
Figure 41 shows domain satisfaction by treatment setting. The outpatient group was more satisfied than the psychiatric residential group in all domains, and significantly more so in the access and appropriateness domains.

Figure 40. 2012–2016 Comparison of YSS Domain Satisfaction.



*Indicates statistically significant upward or downward trend (*p*<.05) over time for that domain.

Figure 41. Domain Satisfaction by Treatment Setting with 95% Confidence Intervals.



*Indicates a statistically significant difference (p<.05) between the two groups.

Table 10 shows 2016 YSS domain scores by demographic characteristics. Spanish speakers were significantly more satisfied than all other language speakers in the appropriateness, treatment and access domains. Domain satisfaction was similar between all other demographic groups.

Domain satisfaction according to the young person's specific race is rolled up to non-white, white, and unknown due to the small number of respondents in all race groups except white and unknown.

Table 10. YSS Domain Scores by Demographic Characteristics.

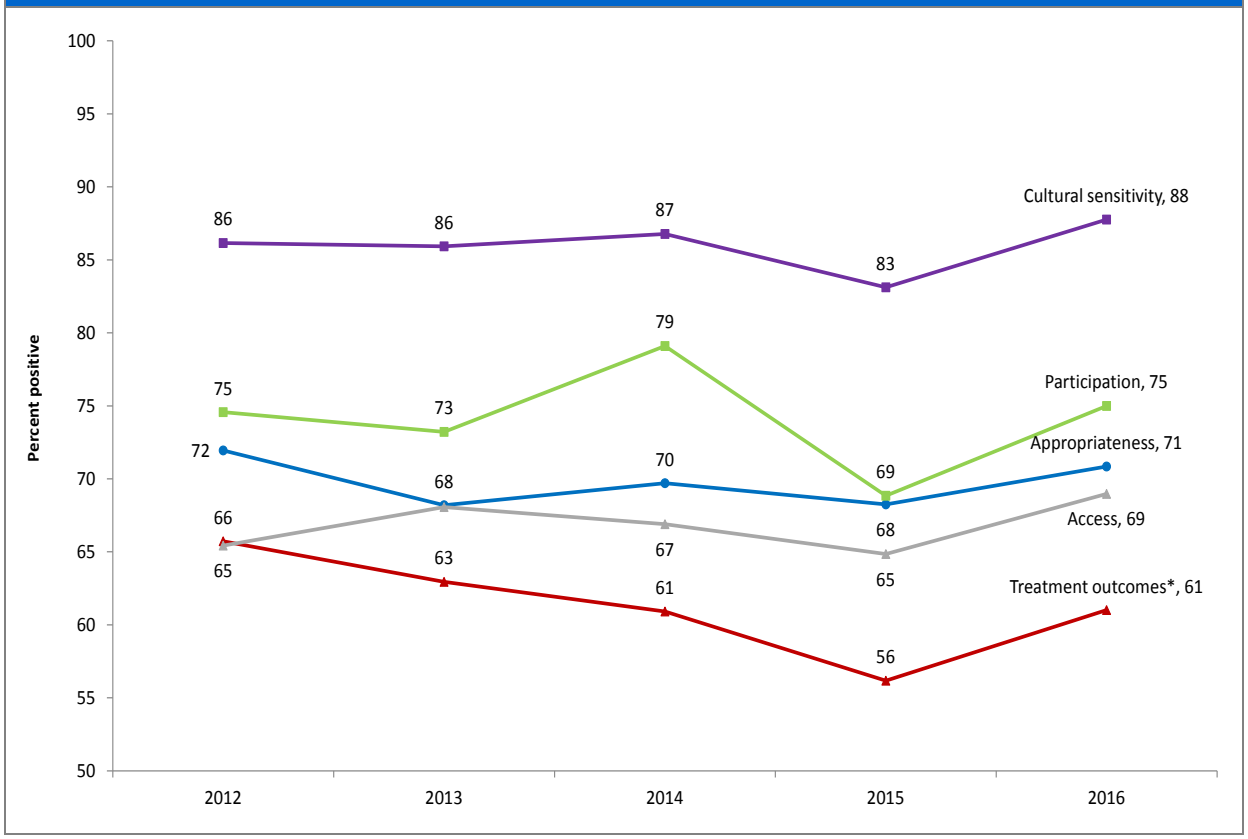
Categories	Characteristics	Appropriateness	Treatment outcomes	Participation	Cultural Sensitivity	Access
Gender	Female	71	61	75	88	69
	Male	72	66	75	83	68
Age Group	13–15	71	63	74	85	66
	16–17	72	62	76	88	71
Race	Non-white	68	56	73	85	64
	White (Caucasian)	71	63	76	86	70
	Race unknown	73	66	75	87	68
Location of Residence	Rural	70	62	76	84	70
	Urban	72	63	75	87	67
Survey Language	English	73*	61*	75	85	67*
	Spanish	82*	82*	82	94	82*
	Other	67*	62*	74	87	68*

*Indicates a statistically significant difference (p<.05) between group domain scores.

Domain Satisfaction by Gender

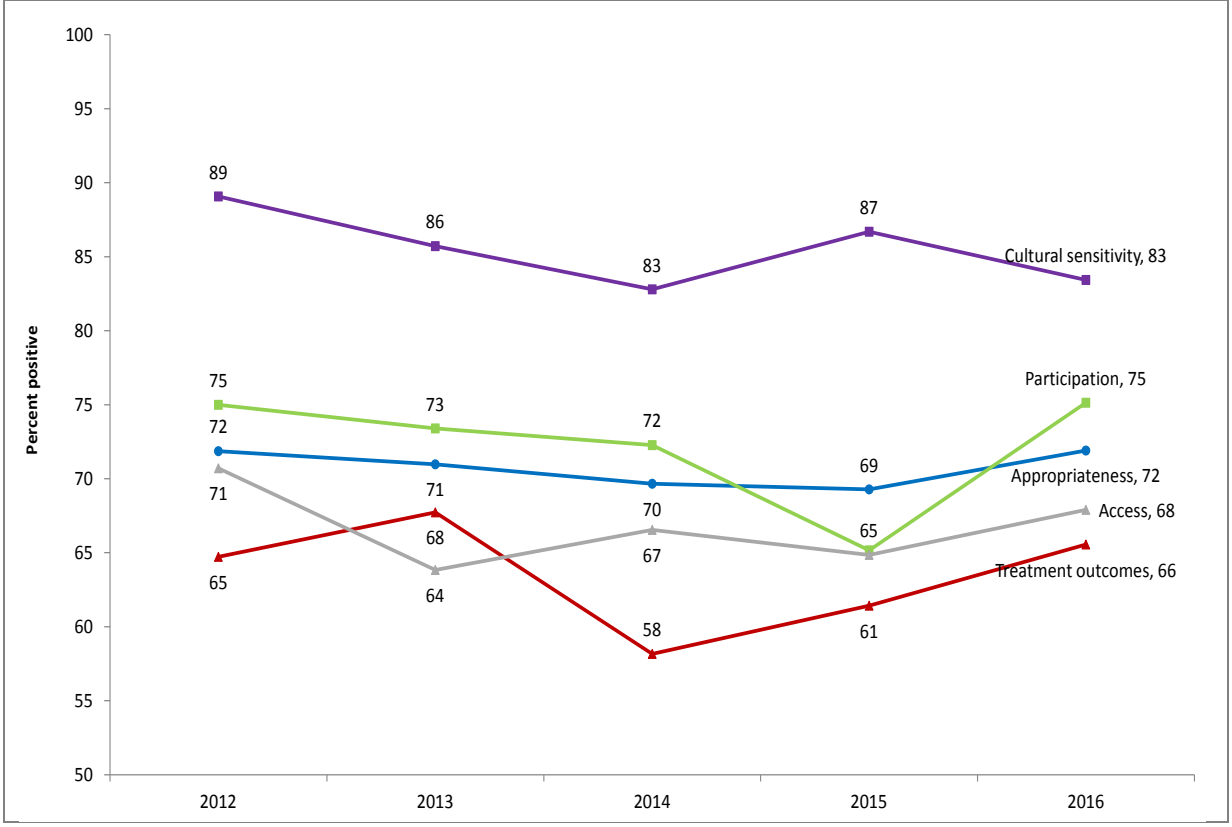
Figures 42 and 43 show satisfaction in each domain by gender for the past five years. Girls have shown a significant downward trend in satisfaction with treatment outcomes over time, and are generally less satisfied with treatment outcomes than boys.

Figure 42. 2012–2016 YSS Domain Satisfaction by Youth's Gender: Female.



*Indicates a statistically significant upward or downward trend (p<.05) for that domain.

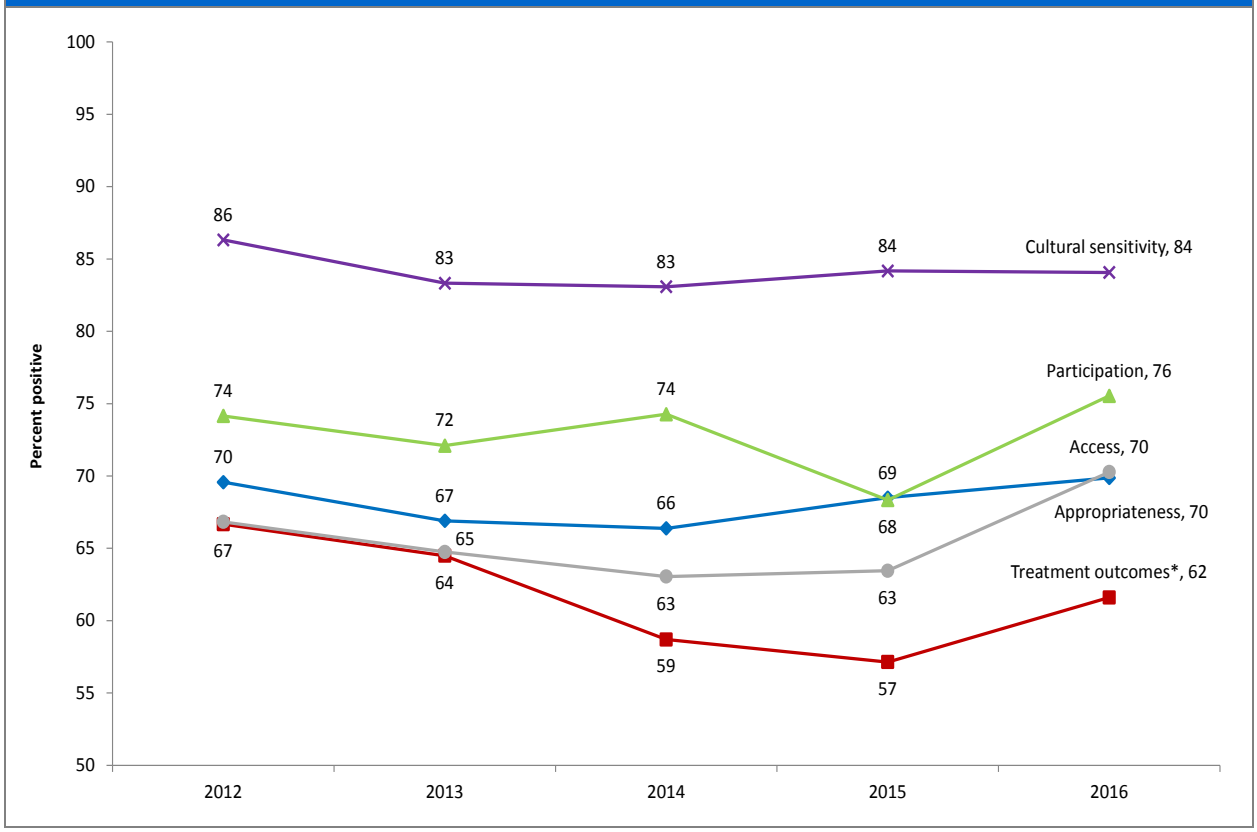
Figure 43. 2012–2016 YSS Domain Satisfaction by Youth's Gender: Male.



Domain Satisfaction by Residence

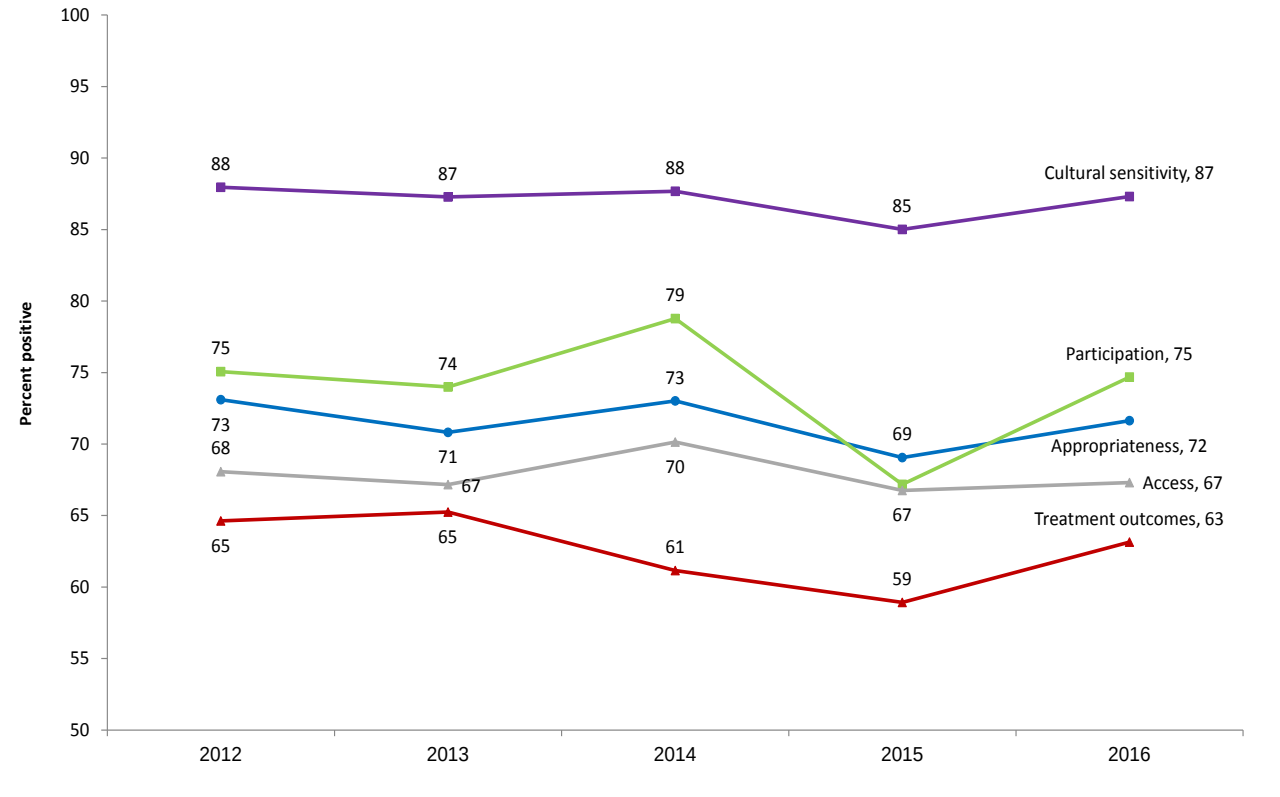
Figure 44 and 45 shows rural and urban respondents' satisfaction in each domain for the past five years. Rural respondents have shown a significantly decreasing trend in satisfaction with treatment outcomes over time, while urban respondents' satisfaction has remained consistent or varied up and down without a notable trend.

Figure 44. 2012–2016 YSS Domain Satisfaction by Residence: Rural.



*Indicates statistically significant upward or downward trend over time for that domain.

Figure 45. 2012–2016 YSS Domain Satisfaction by Residence: Urban.



Domain Satisfaction by Ethnicity

Figures 46–50 show satisfaction in each domain by ethnicity for the past five years. Hispanic or non-Hispanic identification comes from Medicaid enrollment data. Consistently, more Hispanic respondents reported satisfaction in all domains over time. Non-Hispanic respondents have shown a significant downward trend in satisfaction with treatment outcomes.

A similar result appeared when comparing English and Spanish language speakers' domain satisfaction over time. More Spanish-speaking youth were satisfied in all domains consistently over time. Satisfaction with treatment outcomes among English-speaking respondents has trended downward significantly.

Figure 46. 2012–2016 Domain Satisfaction by Ethnicity: Appropriateness.

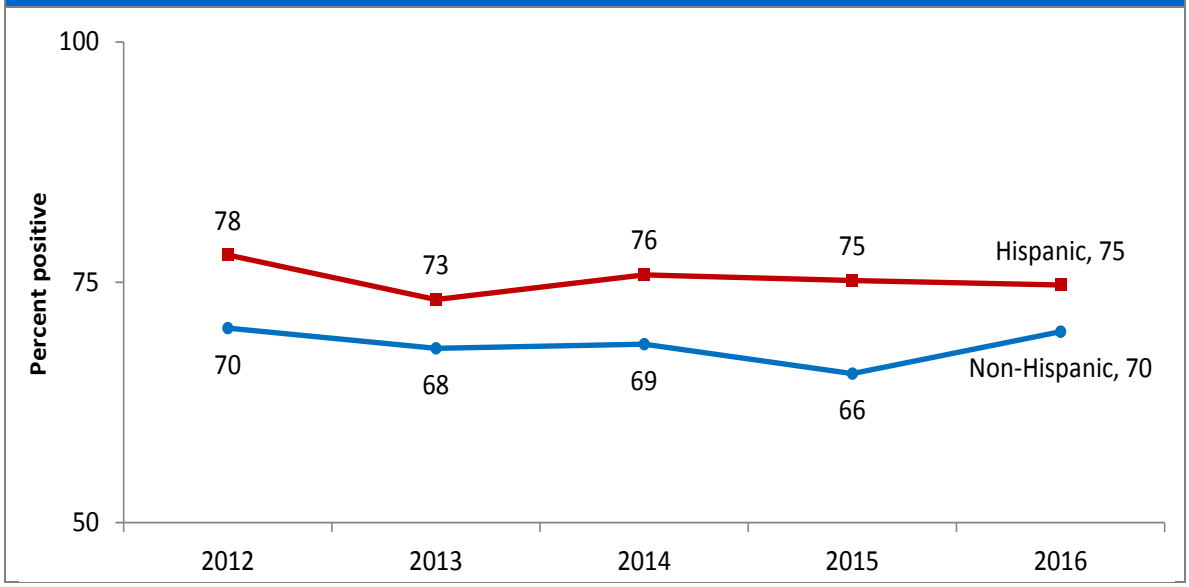
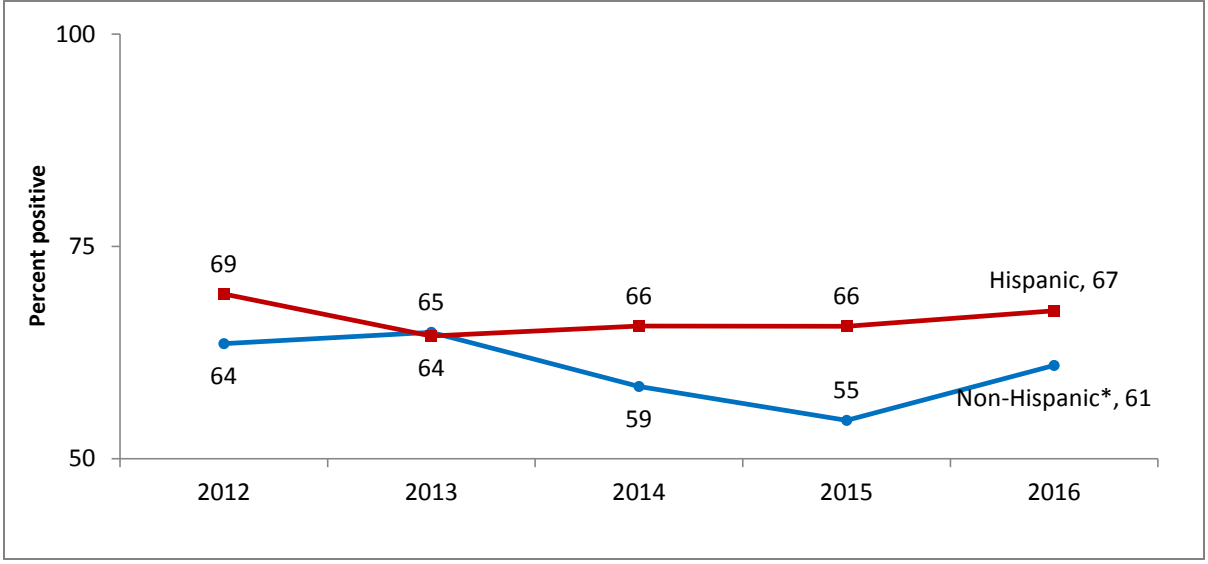


Figure 47. 2012–2016 Domain Satisfaction by Ethnicity: Treatment Outcomes.



*Indicates a statistically significant upward or downward trend (p<.05) for that ethnic group.

Figure 48. 2012–2016 Domain Satisfaction by Ethnicity: Participation.

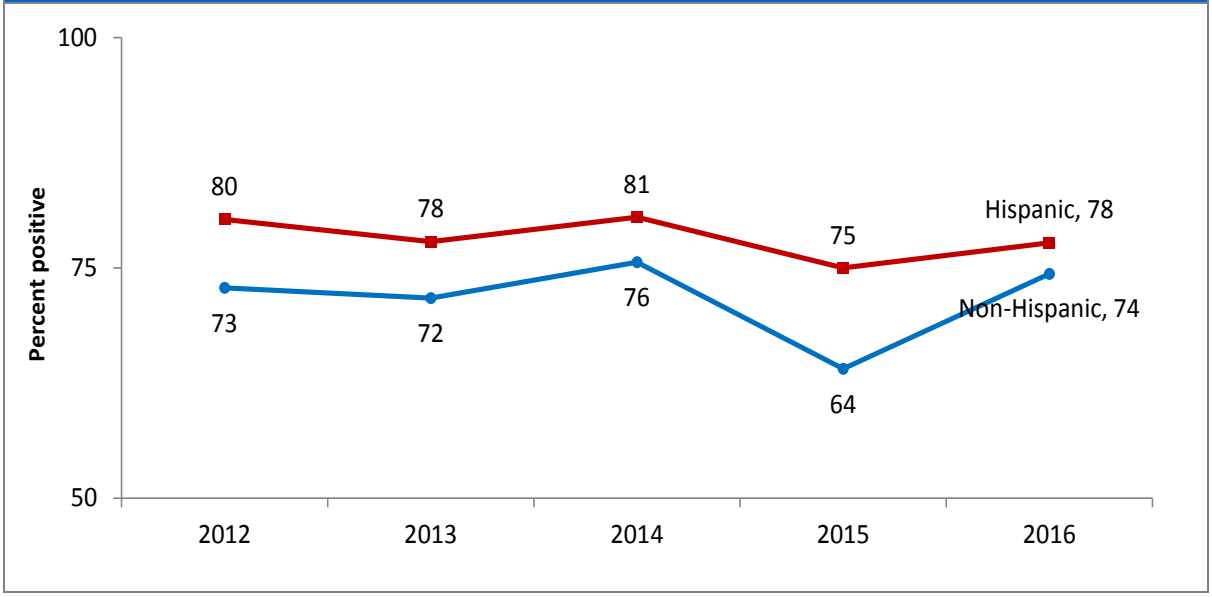


Figure 49. 2012–2016 Domain Satisfaction by Ethnicity: Cultural Sensitivity

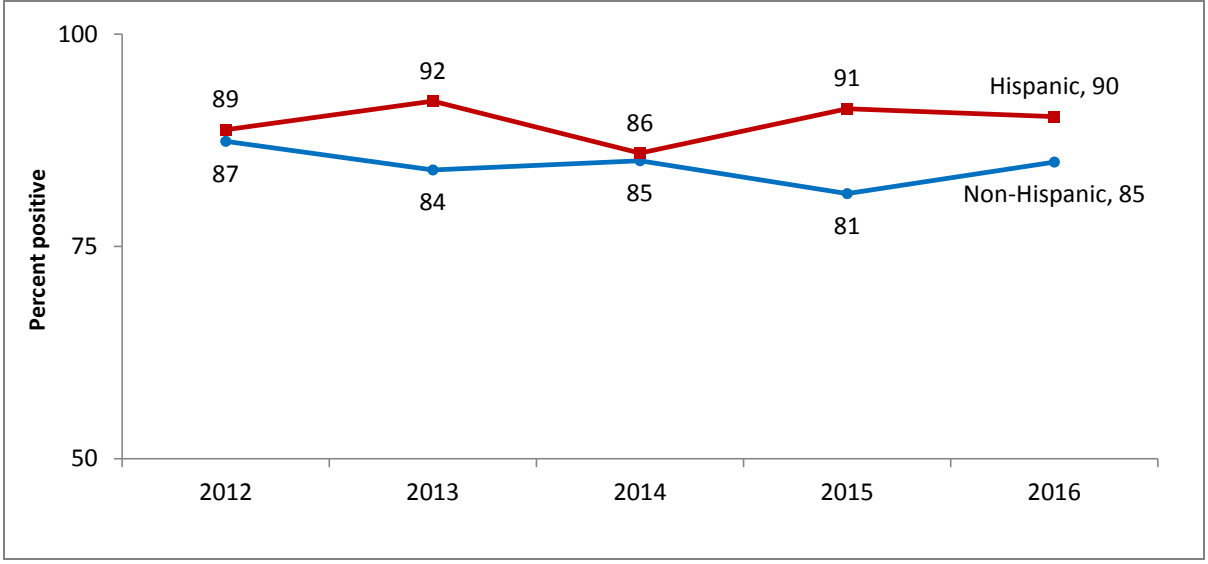
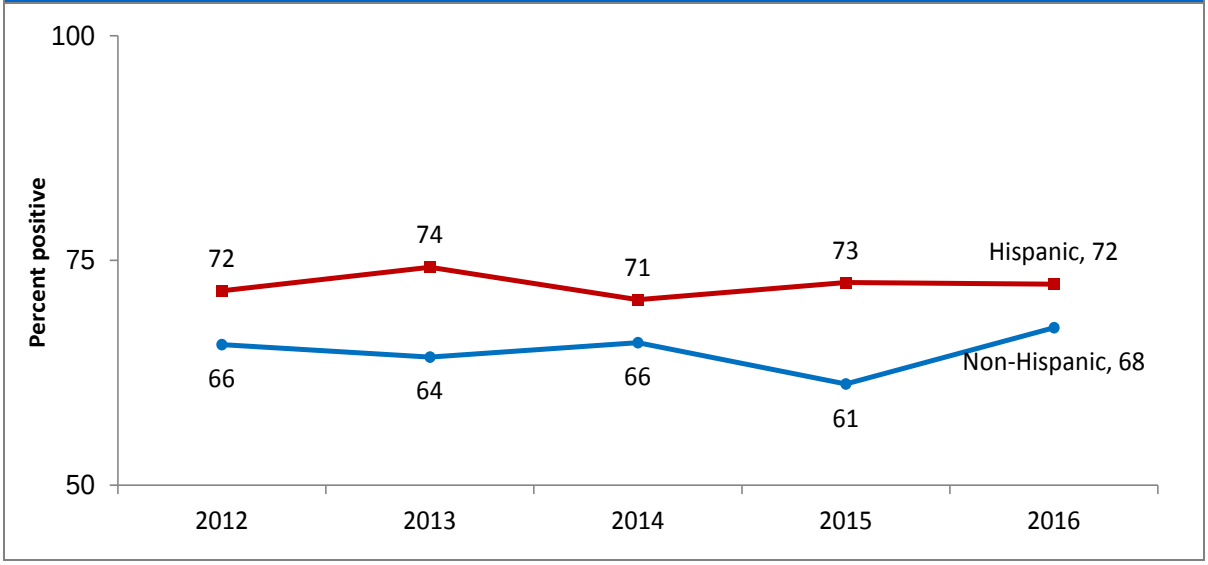


Figure 50. 2012–2016 Domain Satisfaction by Ethnicity: Access.



Analyses of Additional Questions

For youth receiving mental health services, many factors compound to influence satisfaction and improvement including living situation, school absences, utilization of health care services, medication for emotional/behavioral problems, and arrest history. The YSS survey asks about these areas.

Open-ended questions

Two open-ended questions asked youth to describe the most helpful thing about the services they received over the last six months, and what would improve services. Handling issues better, having someone to listen and share their feelings with, and feeling supported were most commonly cited as the most helpful things about services. Others mentioned getting help, being respected, and having a good therapist as the most helpful things. More services and better schedules or therapist availability were most commonly cited as things that would improve services. More caring or understanding therapists, more therapist variety, increased punctuality by therapists, and general comfort (e.g., comfortable chairs, having things to fidget with) were also mentioned as things that would improve services.

Living situation during past six months

Stable and safe housing is instrumental in helping youth address their mental health symptoms. Currently 82% of respondents lived with one or both parents.

Another question asked about different places the young respondent might have lived in the previous six months (the respondent could choose more than one place). Table 11 shows that the percentage of respondents who lived with one or both parents or another family member has increased in the last 5 years, while the percentage who lived in a foster home decreased. The percentage of youth encountering all other living situations has remained relatively stable.

OHA's System of Care Wraparound Initiative emphasizes family involvement in youth mental health treatment decisions. Key outcome measures include reducing the number of youth in substitute care and increasing the percentage of youth served in their home community.[10]

[10] Oregon Health Authority. System of Care Wraparound Initiative, Oregon Health Plan. February 2016. Available at: https://www.oregon.gov/oha/amh/ChildMHProviderSWCIDocs/SOCWI%20-%20Guidance%20Document.pdf.

Table 11. Living Arrangements in the Previous Six Months, Five-Year Comparison.

Living situation	2012	2013	2014	2015	2016
With one or both parents	70	74	74	80	81
With another family member	13	20	17	17	17
Foster home	13	12	11	7	7
Therapeutic foster home	3	3	2	1	1
Crisis shelter	1	1	1	<1	1
Homeless shelter	1	1	1	1	2
Group home	2	3	2	2	3
Residential treatment center	5	7	5	4	5
Hospital	2	3	3	2	3
Local jail or detention facility	3	3	3	1	2
State correctional facility	<1	0	0	<1	1
Runaway/homeless/on the streets	4	3	2	3	3
Other	6	5	5	4	5

*Percentages may not add to 100 because respondents could choose more than one living arrangement.

Utilization of physical health care services

The American Academy of Pediatrics (AAP) recommends an annual well-visit for all children from birth through age 21.[11] The AAP identifies the following priority topics for adolescent well care visits:

- Physical growth and development
- Social and academic competence
- Emotional well-being
- Risk reduction (tobacco, alcohol and other drugs, pregnancy, sexually transmitted infections)
- Violence and injury prevention

[11] Bright Futures/American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. January 2016. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

Scheduling these visits, especially for adolescents, can be challenging but is critical for their health and well-being. Some youth will visit a medical doctor for an illness or injury. Any encounter with a medical doctor, regardless of the reason for the visit, could be a good time to address the priority areas identified by the AAP.

In 2014, data collected by the CCOs for incentive measure reporting requirements showed that 32% of Medicaid enrollees ages 12–21 received a well-care visit.[12] But as shown in Table 12, 78% of adolescent respondents—all of whom received this survey because they received mental health services paid for by Medicaid in Oregon—reported visiting a doctor for any reason in the last year. If both of these metrics are representative of the adolescent Medicaid population, there may be an opportunity for an additional 46% of adolescent Medicaid members to receive well-care services when they visit the doctor for an illness or injury.

Table 12. Utilization of Physical Healthcare Services in the Past Year. "In the last year, did you see a medical doctor (or nurse) for a health checkup or because you were sick?"

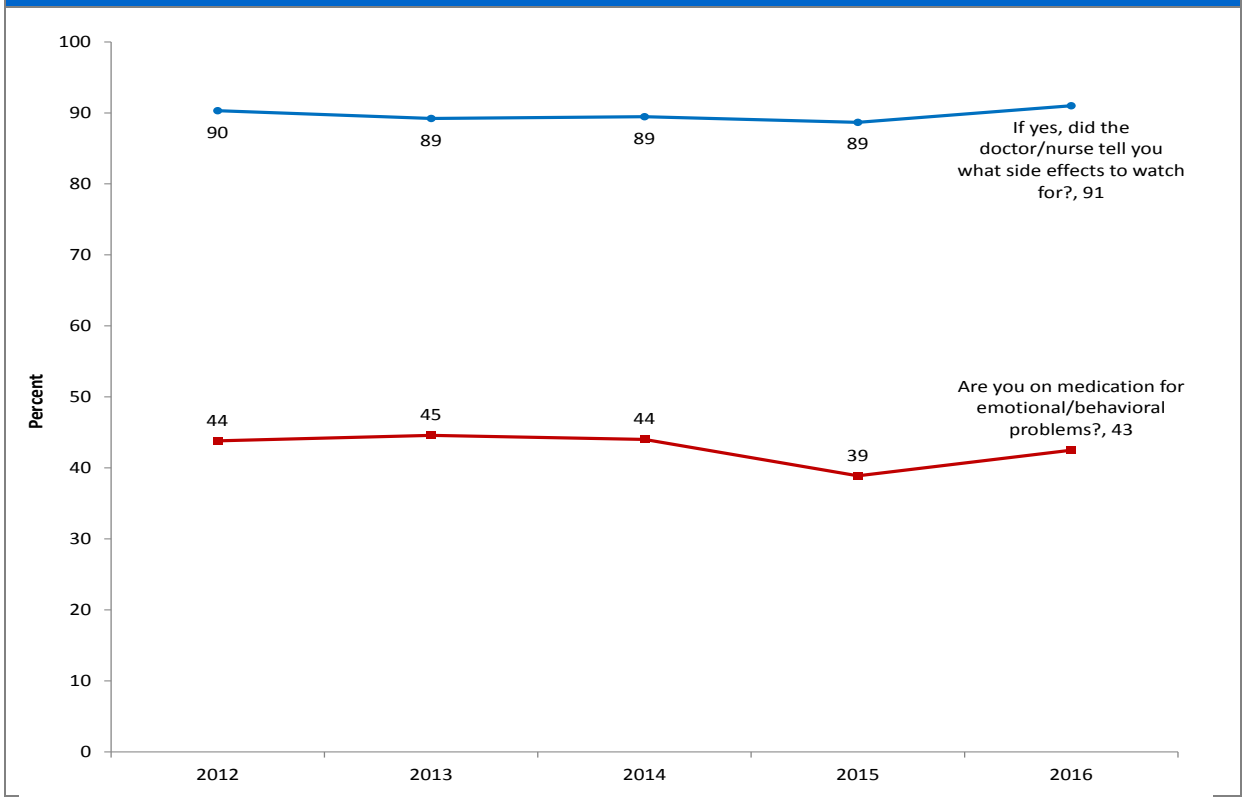
Responses	2015		2016	
	Number (n=796)	% of respondents	Number (n=1,012)	% of respondents
Yes, in a clinic or office	568	71	724	72
Yes, but only in a hospital emergency room	47	6	57	6
No	125	16	146	14
Do not remember	56	7	85	8

[12] Oregon Health Authority. Adolescent Well Care Visits Guidance Document. November 2015. Available at: http://www.oregon.gov/oha/analytics/CCOData/Adolescent%20Well%20Care%20Visits%20Guidance%20Document%20-%20Nov%202015.pdf.

Medication

While medication for emotional and behavioral health issues can be very effective, it is not always the solution (see page 52). Figure 51 shows that 43% of respondents are current taking medication for their emotional/behavioral problems, and 91% were told about possible side effects. These percentages have not shown any significant upward or downward trends over the last five years.

Figure 51. Current Use of Medications for Emotional/Behavioral Problems, 2012–2016 Comparison.



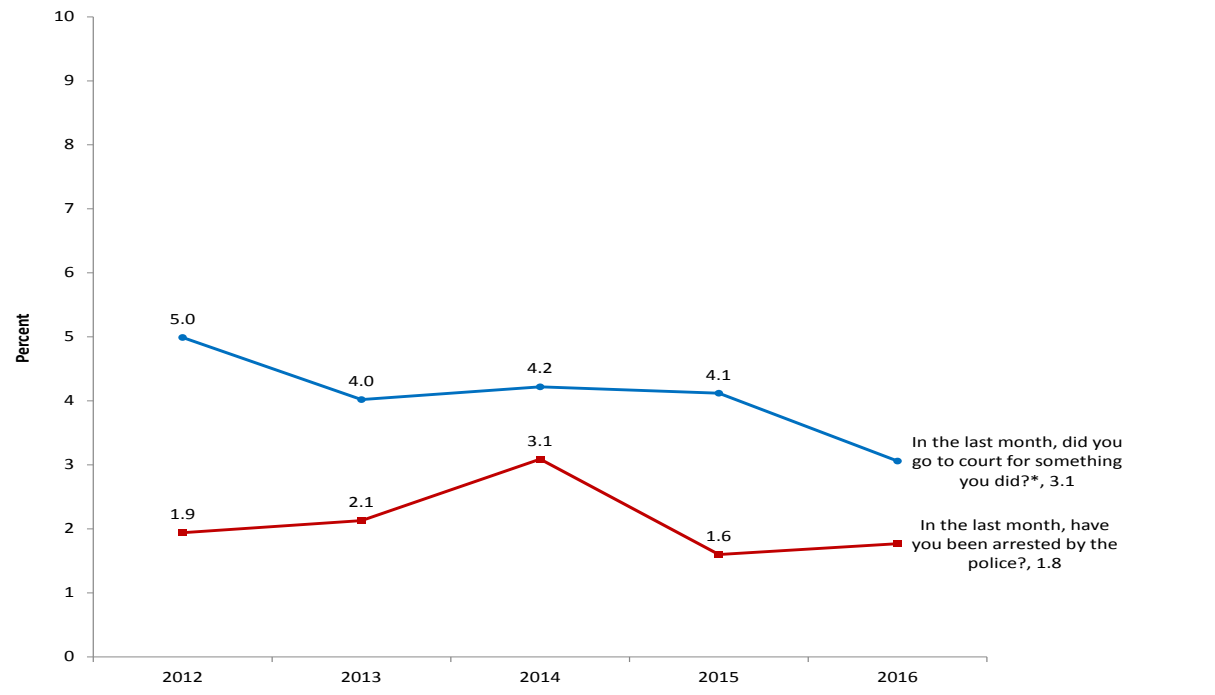
Arrest history

Youth involved in the criminal justice system have poor outcomes related to reintegration into society and recidivism. According to a 2016 report by the Oregon State Court Juvenile Justice Mental Health Task Force, "it is estimated that 70 percent of youth in the juvenile justice system meet the criteria for at least

one mental health disorder."[13] The report recommends screening and diverting youth with mental health conditions into "more appropriate evidence based trauma interventions." One initiative related to this recommendation, the Criminal Justice Feeder System Project, attempts to identify high risk youth and provide opportunities to intervene before they become involved in the criminal justice system.

Figure 52 shows that in the last five years, a significantly decreasing percentage of youth respondents went to court for something they did while the percentage of youth that were arrested by the police has remained stable with a notable increase in 2014.

Figure 52. Arrest History, 2012–2016 Comparison.



*Indicates statistically significant upward or downward trend over time for that question.

[13] State of Oregon Judicial Department. Oregon State Court Juvenile Justice Mental Health Task Force, Report and Recommendations. January 2016. Available at: http://www.oregonyouthdevelopmentcouncil.org/wp-content/uploads/2016/06/Oregon-Chief-Justice-Task-Force-on-Juvenile-Justice-and-Mental-Health-Report-2016.pdf.

School absences

School attendance is often negatively affected by a young person's mental illness. The survey asked, "How often were you absent from school during the last month?" Respondents could select all answers that applied; therefore, all were included in the denominator. Fifty-eight percent of respondents said they were absent from school for two or more days, with 12.6% of respondents reporting more than 10 days of absences in the last month.

This question does not control for summer break, and with survey administration occurring between April and September, it is likely that many of the respondents reporting a high number of absences were out of school for the summer.

COMPARISON OF YOUTH AND CAREGIVER RESPONSES

Because the YSS sample is pulled directly from the YSS-F sample, both the caregiver and young person could respond to their respective surveys, providing two perspectives on the same episode of care. In 2016, there were 486 pairs of respondents who answered at least one question.

Table 13 shows the result of this analysis. Significantly more caregivers were satisfied than their adolescent children on the following questions:

- Services were available at the times that were convenient for me (81% vs. 72%).
- I helped to choose my services (77% vs. 65%).
- Staff spoke with me in a way that I understood (92% vs. 86%).
- I felt I had someone to talk to when I was troubled (83% vs. 76%).

Significantly more adolescents were satisfied than their adult caregivers on the following question:

- I helped to choose my treatment goals (79% vs. 70%).

Table 13. Youth and Caregiver Perceptions of Treatment Services (Percent who Strongly Agree/Agree with each Statement), 2016 (n=486).

Domain	Question	YSS	YSS-F
Access to services			
8	The location of the services was convenient.	76	80
9	Services were available at times that were convenient for me.*	72	81
Treatment Outcomes			
16	I am better at handling daily life.	74	70
17	I get along better with family members.	67	67
18	I get along better with friends and other people.	72	70
19	I am doing better in school and/or work.	64	64
20	I am better able to cope when things go wrong.	65	67
21	I am satisfied with my family life right now.	65	69

Domain	Question	YSS	YSS-F
Participation in treatment			
2	I helped to choose my services.*	65	77
3	I helped to choose my treatment goals.*	79	70
6	I participated in my own treatment.	85	83
Cultural sensitivity			
12	Staff treated me with respect.	89	91
13	Staff respected my family's religious/spiritual beliefs.	87	87
14	Staff spoke with me in a way that I understood.*	86	92
15	Staff was sensitive to my cultural/ethnic background.	85	86
Appropriateness of services			
1	I am satisfied with the services I received.	82	80
4	The people helping me stuck with me no matter what.	78	78
5	I felt I had someone to talk to when I was troubled.*	76	83
7	I received services that were right for me.	74	76
10	I got the help I wanted.	70	73
11	I got as much help as I needed.	65	67

*Indicates a statistically significant difference ($p<.05$) between YSS and YSS-F scores.

Youth and their caregivers also reported differences of opinion in domain scores. Table 14 shows that caregivers were significantly more satisfied than their adolescent children with access, participation and cultural sensitivity in 2016. Domain scores for youth and their caregivers increased in all domains between 2015 and 2016.

Table 14. YSS-F and YSS Domain Scores, 2012–2016.

	YSS-F						YSS					
Domain	**2012**	**2013**	**2014**	**2015**	**2016**	**Change**	**2012**	**2013**	**2014**	**2015**	**2016**	**Change**
Access*	73	75	74	73	75	+2	68	66	67	65	69	+4
Participation*	81	80	82	79	83	+4	75	73	77	68	75	+7
Appropriateness	71	72	72	70	72	+2	72	69	70	69	71	+2
Cultural sensitivity*	90	90	89	90	91	+1	87	86	85	84	86	+2
Treatment outcomes	61	60	63	60	64	+4	65	65	60	58	63	+5

*Indicates a statistically significant difference ($p<.05$) between YSS and YSS-F domain score in 2016.

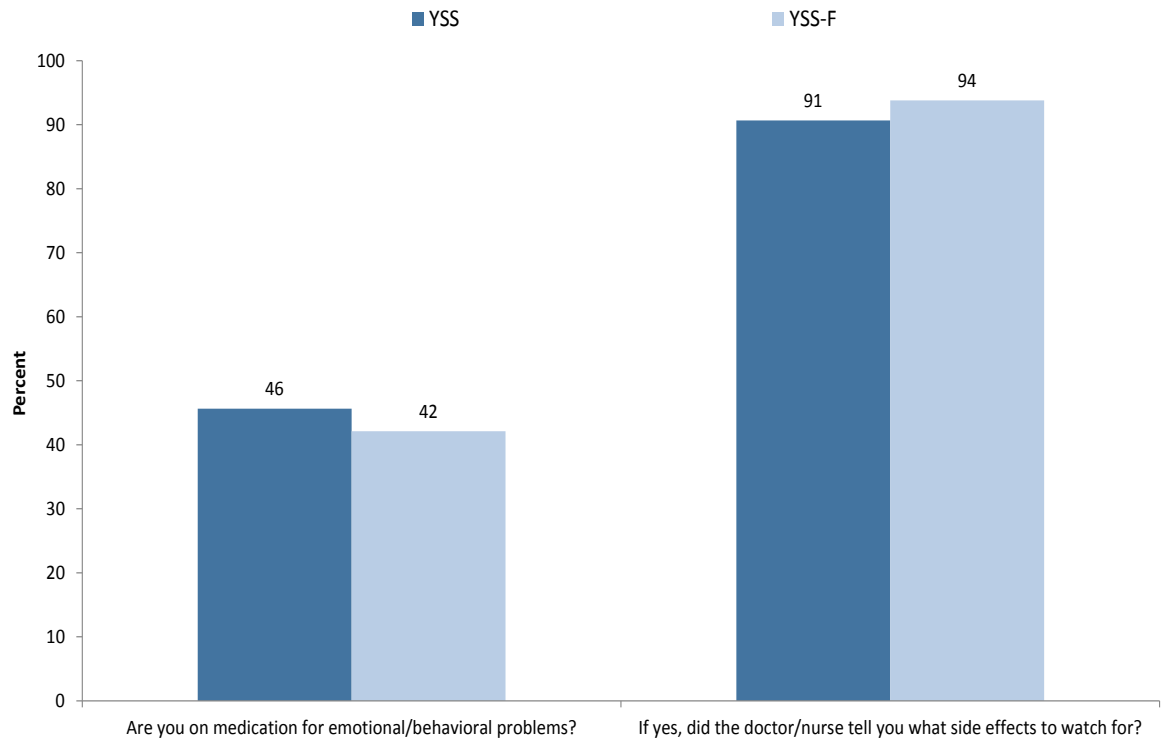
Note: The social connectedness and daily functioning domains are not included in this table since it only applies to the YSS-F survey.

Medication

As shown in Figure 53, among the paired adolescent/caregiver respondents, more adolescents reported taking a medication for their emotional/behavioral problems than their caregivers, suggesting that caregivers were not always aware of the medications their child was taking.

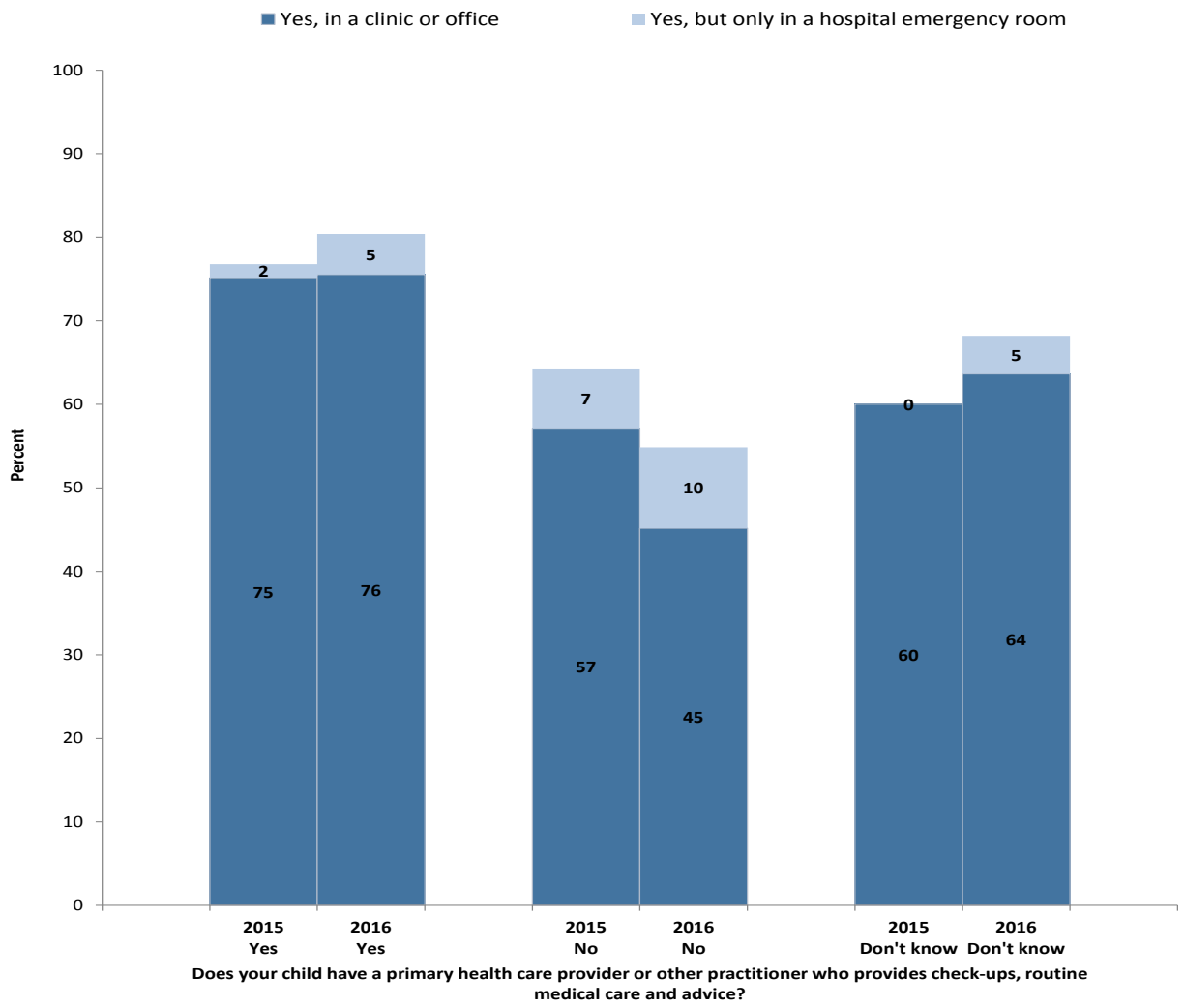
More caregivers were told what side effects to watch out for than their adolescent children. The questions in the two surveys were slightly different: "Were psychotropic medications prescribed for your child while receiving treatment from his or her recent mental health services provider?" (YSS-F) and, "Are you on medication for emotional/behavioral problems?" (YSS). The past-tense inclusion in the YSS-F question with the present-tense in the YSS question may have the effect of under-estimating the difference between the two.

Figure 53. Medication Use as Reported by Youth and Caregivers.



Among respondent pairs, if the caregiver indicated that the young person had a primary care provider (a question only asked of caregivers), the young person was more likely to have seen a provider in a clinic or office (a question only asked of adolescents) than youth whose caregivers indicated that they did not have a primary care provider (Figure 54). The proportion of youth who only saw a provider in a hospital emergency room was higher for those without a primary care provider (10%) than those with a primary care provider (5%).

Figure 54. In the last year, did you see a medical doctor (or nurse) for a health check-up or because you were sick? (YSS-F and YSS respondent pairs): 2015 and 2016 comparison.



DISCUSSION AND RECOMMENDATIONS

Overall Survey Results

In 2016, 3,212 responses from caregivers of 13,794 children and youth for an overall response rate of 23%. For the first time this year, more respondents filled out the survey online than by mail.

A total of 1,025 young people submitted surveys in 2016, for an overall response rate of 22%. Most of these surveys (75%) were completed online.

In the YSS-F, satisfaction has remained relatively stable across domains for the past five years, with a slight increase in satisfaction in all domains in 2016. Over the past five years, satisfaction among YSS respondents has varied in domains year to year, with a significant downward trend in treatment outcomes.

As in previous years, young people were less satisfied in all domains when compared to their caregivers, with significant differences in the access, participation, and cultural sensitivity domains.

Survey Limitations

While a client survey has many benefits (e.g., ease of administration, first-hand experience reports, and client involvement), there are limitations as well. As in any survey, social desirability may bias some results. This is especially true in questions on sensitive topics such as alcohol and drug use. These surveys also rely on a respondent's memory of events that occurred sometime in the past year.

While the MHSIP domain portions of the survey have remained untouched, additional questions are added and/or removed each year by HSD. Some of these questions have not been validated, and it is unknown what effect, if any, they have on the validity of the preceding MHSIP items.

The length of the survey may deter some potential respondents. Totaling seven printed pages with 53 questions and many sub-questions, the YSS-F may take significant time to complete. Caregivers may have different perceptions of their child's treatment than the child has for a number of reasons. If the caregiver has different treatment expectations, different opinions on presenting issues, or limited information (e.g., caregivers may not know about the young person's

school attendance or alcohol or substance use), their report about the child's or young person's treatment may not reflect the episode of care the way the therapist or young person would report. The YSS is only three pages with 37 questions, but could still be daunting. Mental or cognitive challenges may have impacted the respondents' ability to understand and respond accurately to some questions. Youth may view services through a different lens than adults, but this is a benefit rather than a detriment to the survey. It is important to hear and consider the young person's voice.

Finally, the survey results combine data from surveys completed on paper and returned by mail, and surveys completed online. There are potential differences in the way respondents answer the same questions in the two modes. Also, there may be differences in age, disability, treatment setting, or living situation between online and paper respondents that would affect the way they answered the questions. Web respondents may feel more anonymous, and therefore likely to answer more honestly than paper survey respondents. These differences were not the focus of this survey or analysis, but may be interesting to study in the future.

Highlights and Recommendations

Responses by race and ethnicity

Race and ethnicity data are missing for many Medicaid enrollees in the state's dataset because neither of these fields are required in MMIS. The surveys asked respondents to self-identify their race and ethnicity, which enabled comparisons between the state dataset and the self-reported data. This analysis found that the state ethnicity data overestimates the number of non-Hispanic enrollees and the number of white enrollees.

Obtaining accurate race and ethnicity data is a key component of addressing health equity in Oregon, and the state should continue efforts to do so.

- **HealthInsight Oregon encourages OHA-HSD to work with the CCOs to gather and update these data at points of contact to obtain the most accurate race and ethnicity data. OHA-HSD could provide policy direction and technical assistance to CCOs to follow best practices in gathering these data to improve quality of care and reduce disparities.**

Urban vs. rural respondents

As in previous years, more urban YSS-F respondents were satisfied than rural respondents in most domains. Over the past five years, the percentage of satisfied respondents in urban areas has significantly increased in treatment outcomes, participation, and social connectedness, while there has been no significant changes among rural respondents.

Satisfaction with treatment outcomes among rural YSS respondents has trended significantly downward over the past five years. Satisfaction among urban YSS respondents in all domains has remained consistent over time or varied up and down without significant trends.

- **OHA-HSD, CCOs, and providers should continue to explore opportunities for the use of technology (e.g., telehealth) for screening, assessment, treatment, and care coordination in rural areas.**

Health status

Children and youth with excellent and very good health were more likely to have a primary care provider or other practitioner who provides regular care (check-ups, routine medical care and advice).

- **OHA-HSD should work with CCOs to continue to focus on initiatives to ensure adolescents receive well visits.**

Substance abuse treatment (youth 13–18)

Of caregivers who reported that their adolescent child had or currently uses alcohol or drugs, fewer than half reported the young person had received treatment or other help. Of those who did receive help, 61% thought the treatment or other help provided what the young person needed.

- **OHA-HSD should work with CCOs to increase treatment for alcohol and drug use. CCOs should ensure that appropriate referrals, care coordination and follow-up occur after substance abuse screening.**

Trauma screening

Only 58% of caregivers indicated that their child was asked if they had a history of trauma. Of caregivers with children or youth who had experienced serious trauma, 53% felt it had been adequately addressed during treatment.

- **OHA-HSD should work with CCOs and continue efforts to increase trauma screening and provision of trauma-informed care for Oregon's youth.**

Mental health crisis

While the percentage of youth experiencing mental health crisis has trended significantly downward over the past five years, so has the caregivers' satisfaction with the mental health provider's response.

- **OHA-HSD should work with CCOs on improving services provided to children and youth in mental health crises.**

Lower satisfaction with treatment outcomes in YSS

Satisfaction with treatment outcomes has trended significantly downward over the past five years. This was especially true for female respondents compared to male respondents.

- **OHA-HSD should work with CCOs to further investigate adolescents' lower satisfaction, particularly girls, and determine steps to increase satisfaction.**

Provider visits

Most (77%) YSS respondents saw a doctor in the last year. These visits are a good opportunity to provide well-care services; however, CCO incentive measure reporting showed that only 32% of Medicaid enrollees ages 12–21 received a well-care visit. Having a primary care provider also appears to prevent emergency department visits, as the proportion of youth who only saw a provider in a hospital emergency room doubled from 5% to 10% between those with and without a primary care provider.

- **OHA-HSD should continue working with the CCOs to increase regular adolescent wellness visits.**

Service convenience, choices, and communication

Youth were not as satisfied as their caregivers regarding the convenience of services, being able to choose services, having someone to talk to, and being spoken to by staff in a way they understood.

- **OHA-HSD should encourage CCOs to ensure they have an adequate number of providers in their panels who have expertise in treating adolescents.**

Medication

Over the past five years, the percentage of caregivers reporting that their child was prescribed psychotropic medications has trended significantly downward.

Among the paired adolescent/caregiver respondents, more youth reported taking medication than their caregivers, suggesting that caregivers were not always aware of what medications their child was taking. (Note: the questions were worded differently between the surveys, which may have contributed to the differences.)

Also, more caregivers reported being informed about medication side effects than the adolescents.

- **OHA-HSD should continue to work with CCOs in focusing on communicating with youth about medication side effects.**
- **Providers should be sure that adolescents are informed about and understand the side effects of their medications because the caregivers may or may not be part of that conversation/oversight.**

APPENDIX A: SURVEY DATA SECURITY AND QUALITY ASSURANCE PROCEDURES

HealthInsight Oregon stored the electronic data for this survey in REDCap software on a secure server. Only essential team members had access to the raw data to perform data entry. Exported data files were also saved on the secure server, where access was limited. HealthInsight Oregon kept the original paper copies of the surveys in a secure location.

Data entry staff members were trained on entering the survey data, and other authorized staff checked every tenth survey to ensure consistent and correct data entry. HealthInsight Oregon maintained data quality on two tiers. First, built-in data checks in the REDCap software ensured that only valid field values could be entered, and enforced the use of custom codes to note missing or out-of-range data. For example, the application checked to make sure that the field corresponding to Question 1 was coded with 1–5 (Strongly Disagree to Strongly Agree), or 9 for NA, or 0 for missing or invalid response on the paper copy.

Second, SAS recheck programs written by the data analyst scanned each field of each survey response and checked for missing and out-of-range data or logic check problems.

HealthInsight Oregon used tabulations and univariate analysis to examine demographic variables and other frequencies; cross-tabulations to examine the relationship between and among different categorical variables; chi-square analyses to identify statistically significant differences between groups; and Cochrane-Armitage tests of trend to identify changes over time.

APPENDIX B: SURVEY FORMS IN ENGLISH AND SPANISH

Please contact HealthInsight Oregon for a copy of the survey forms.

Oregon Statewide Performance Improvement Project (PIP) on Opioid Safety: Results and Interpretation

Nicole O'Kane, PharmD

Sara Hallvik, MPH

HealthInsight OREGON

Agenda

1. Introductions
2. Presentation of results
3. Small group discussion
4. Small group report out
5. Large group discussion
6. Wrap up

Session Objectives

At the end of the session, participants will have a better understanding of:

1. the limitations and considerations when interpreting Statewide PIP results
2. the conclusions regarding the Statewide and CCO-level PIP baseline and current measurement results
3. next steps for this PIP

Reducing Prescribing of High Morphine Equivalent Doses

- CCOs are working within their communities to address the opioid epidemic and decrease opioid-related harms
- Measures selected for performance monitoring:
  - Percentage of OHP enrollees aged 12 years and older with opioid prescriptions for ≥ 120 mg and for ≥ 90 mg Morphine Equivalent Dose (MED) per day

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Denominator Definition

- Denominator: Any OHP enrollee, age 12+ as of the last day of the measurement year, who meets continuous enrollment criteria, with at least one OHA-paid prescription for an opioid filled in the measurement year. Inclusive of dual eligible population.

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Denominator Exclusions

- Neoplasm-related pain, end-of-life care, palliative care or hospice care in the measurement year or in the year prior to the measurement year
- Any opioid prescription not paid for by OHA (e.g., cough suppressant)

Numerator Definition

- Numerator: Enrollees in the denominator with one or more days with an MED ≥ 120 mg or ≥ 90 mg

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Supplemental Measures

- Enrollees in the denominator on ≥ 120 mg or ≥ 90 mg MED for 30 consecutive days or more

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Study Time Periods

- Baseline measurement: January 1, 2014 – December 31, 2014
- First remeasurement: January 1, 2016 – December 31, 2016
- Second remeasurement: January 1, 2017 – December 31, 2017

Limitations and Considerations

- Narrowly-focused metrics
- Many state and national interventions
- Some interventions preceded baseline
- OHA back pain guideline implemented during PIP (July 2016)

Limitations and Considerations (continued)

- Non-contiguous measurement periods
- Cash payments not captured
- Statewide average does not reflect wide range among CCOs
- Members tapered off high doses still appear in measurement year period

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Statewide PIP Results

Denominators

Age	CY 2014	CY 2015	12/1/2015 – 11/30/2016
12-17	6,453	5,672	4,545
18 +	106,375	117,004	97,255
Total	112,768	122,676	101,800

120 mg MED Numerator

Age	CY 2014	CY 2015	12/1/2015 – 11/30/2016
12-17	142 (2.2%)	101 (1.8%)	77 (1.7%)
18 +	11,803 (11.1%)	12,059 (10.3%)	9,441 (9.7%)
Total	11,945 (10.6%)	12,160 (9.9%)	9,518 (9.3%)

$\rho \leq .001$

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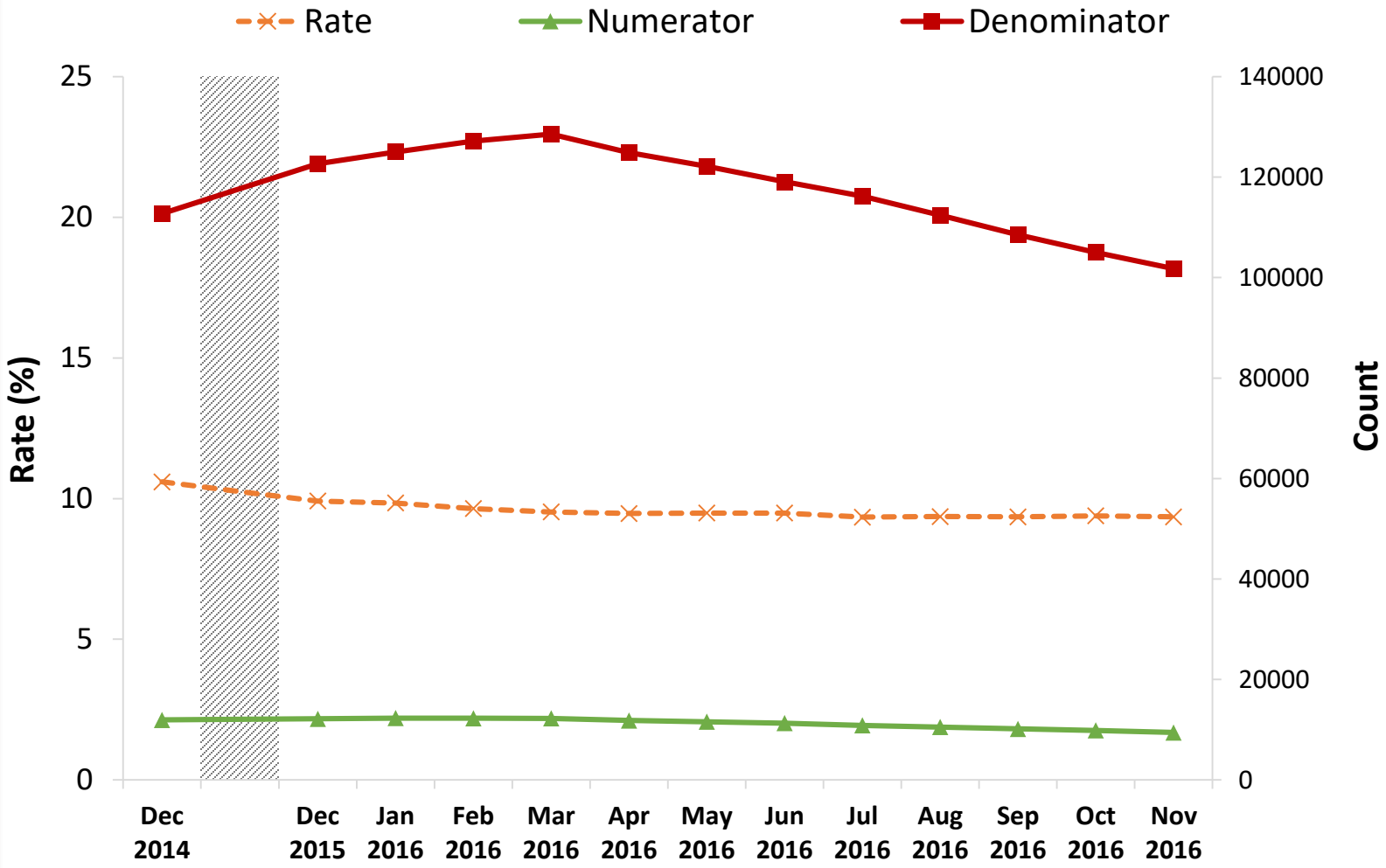
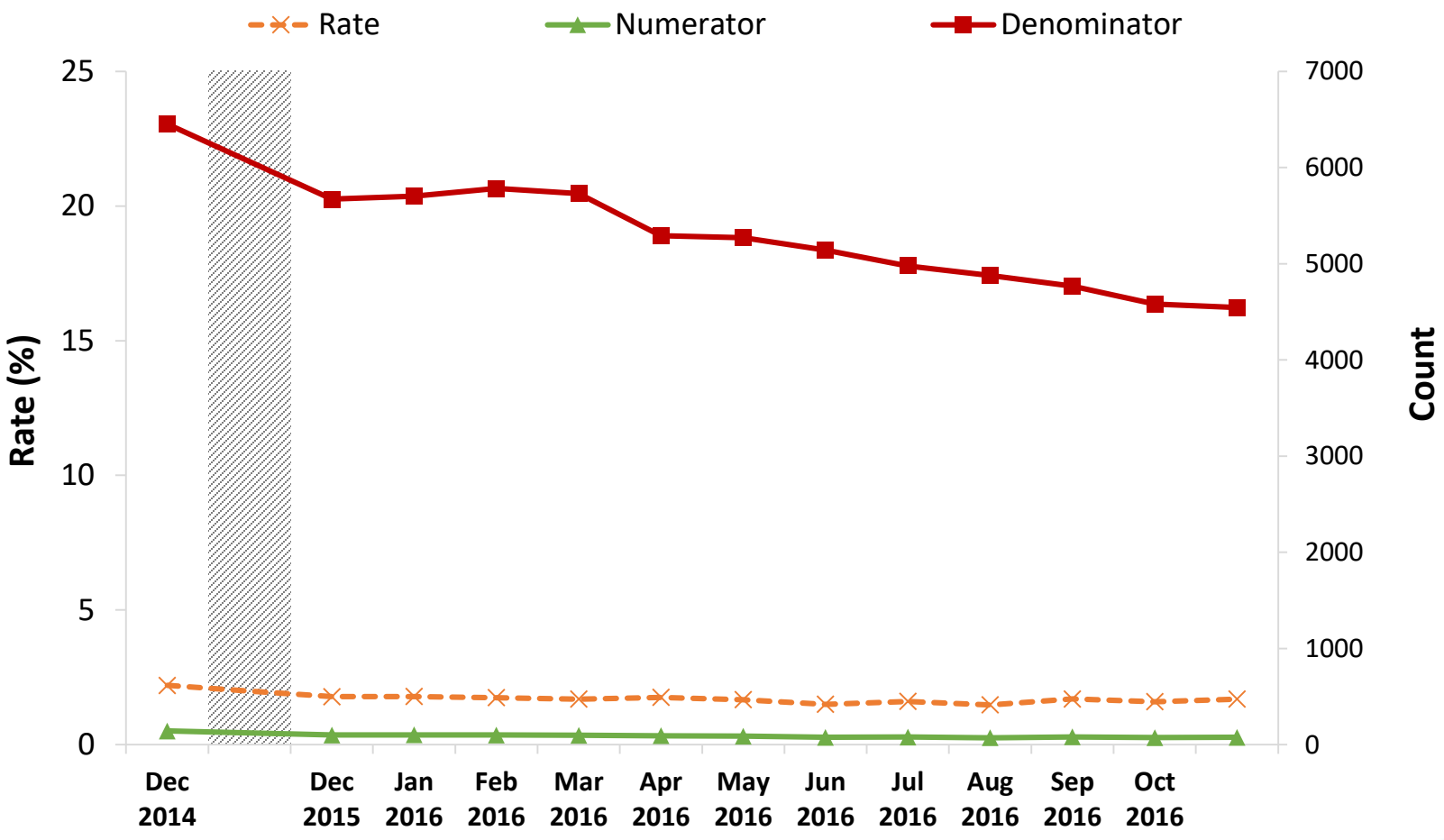
Any day >=120 mg MED, Total

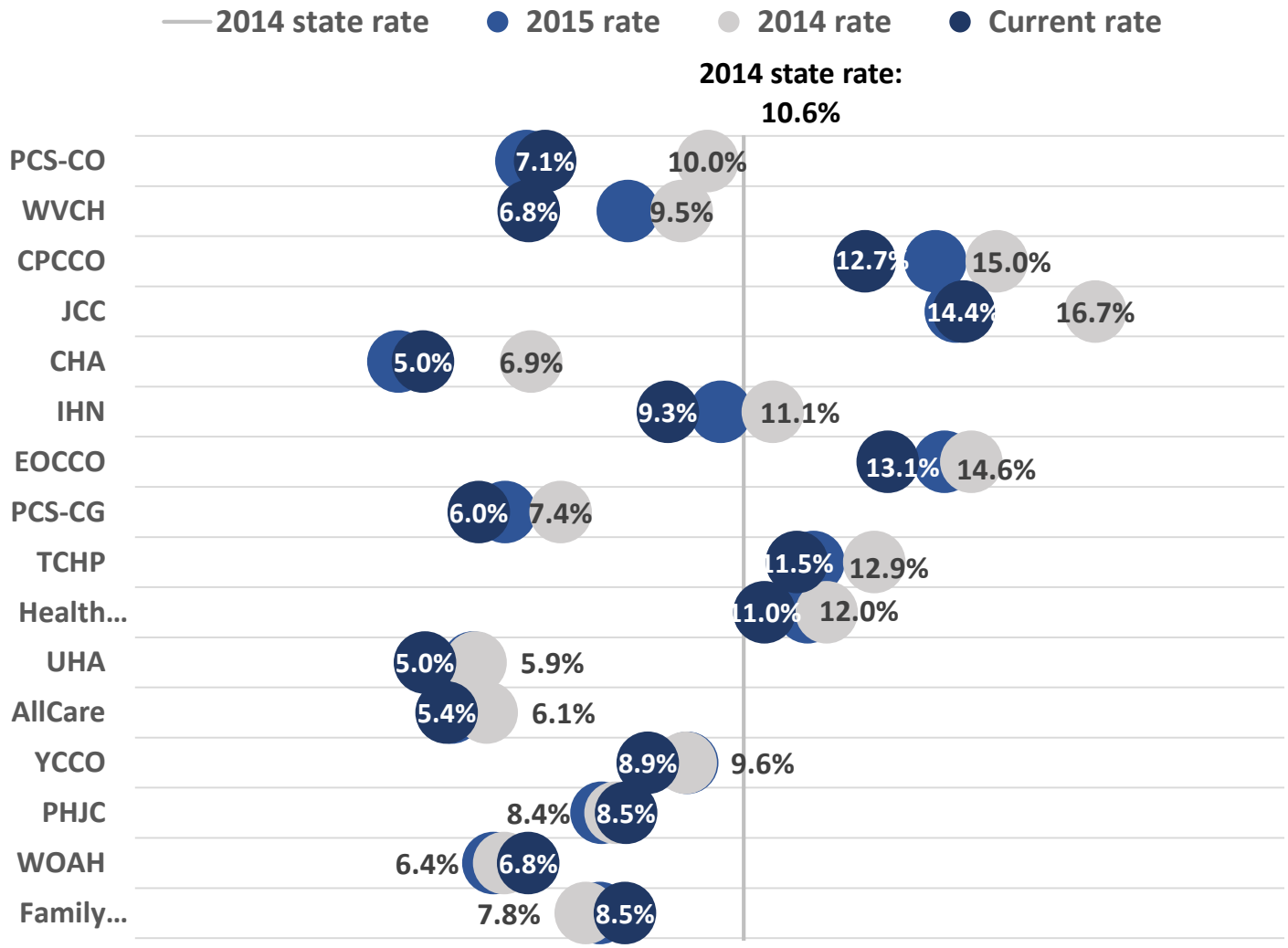


Any day >=120 mg MED, ages 12-17



HealthInsight OREGON

Any day >= 120 mg MED, total



Lower is better

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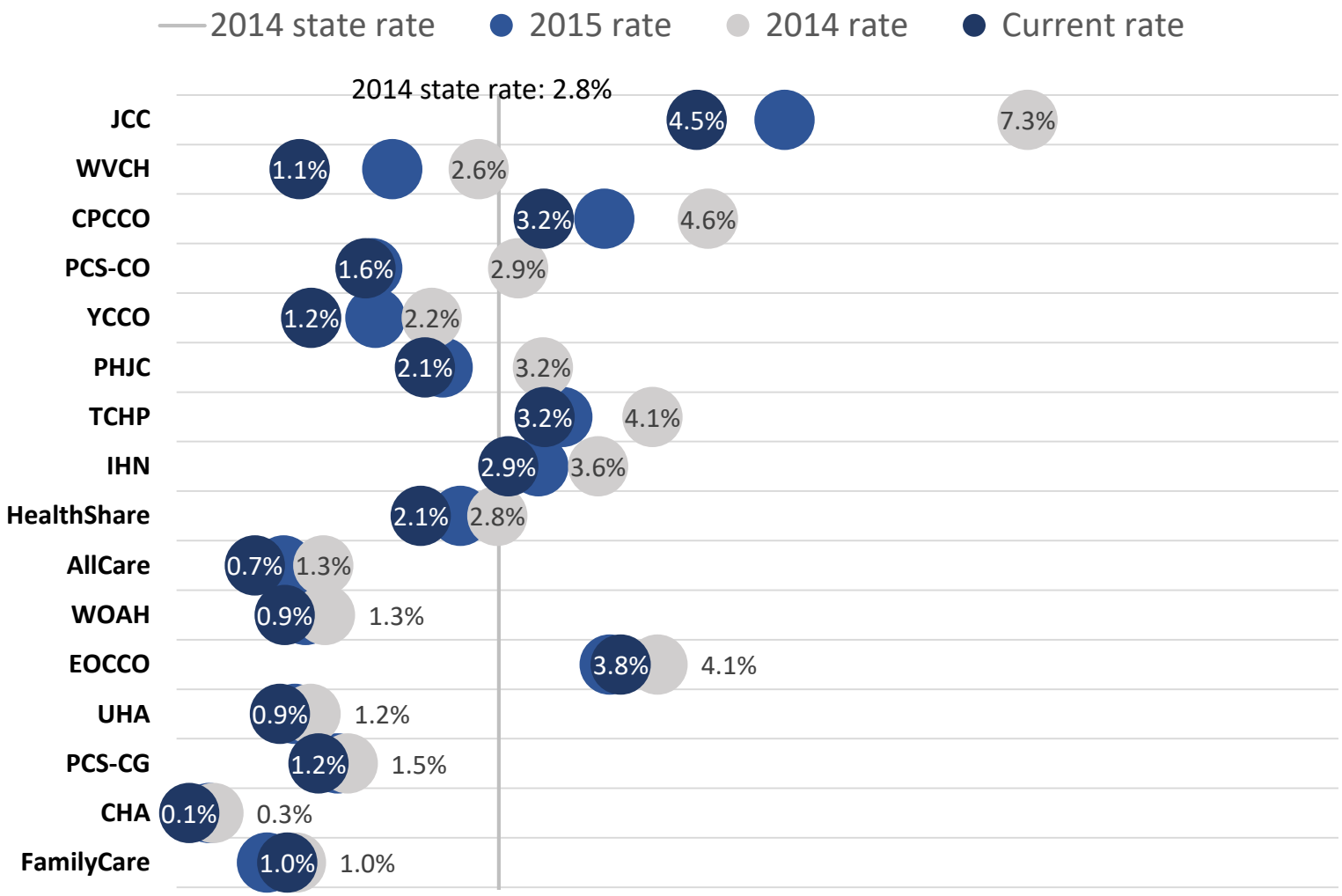
120 mg MED, consecutive 30+ days

Age	CY 2014	CY 2015	12/1/2015 – 11/30/2016
12-17	1 (0.0%)	1 (0.0%)	0 (0.0%)
18 +	3,128 (2.9%)	2,761 (2.4%)	2,019 (2.1%)
Total	3,129 (2.8%)	2,762 (2.3%)	2,019 (2.0%)

$\rho \leq .001$

Consecutive 30 + days >= 120 mg MED, total



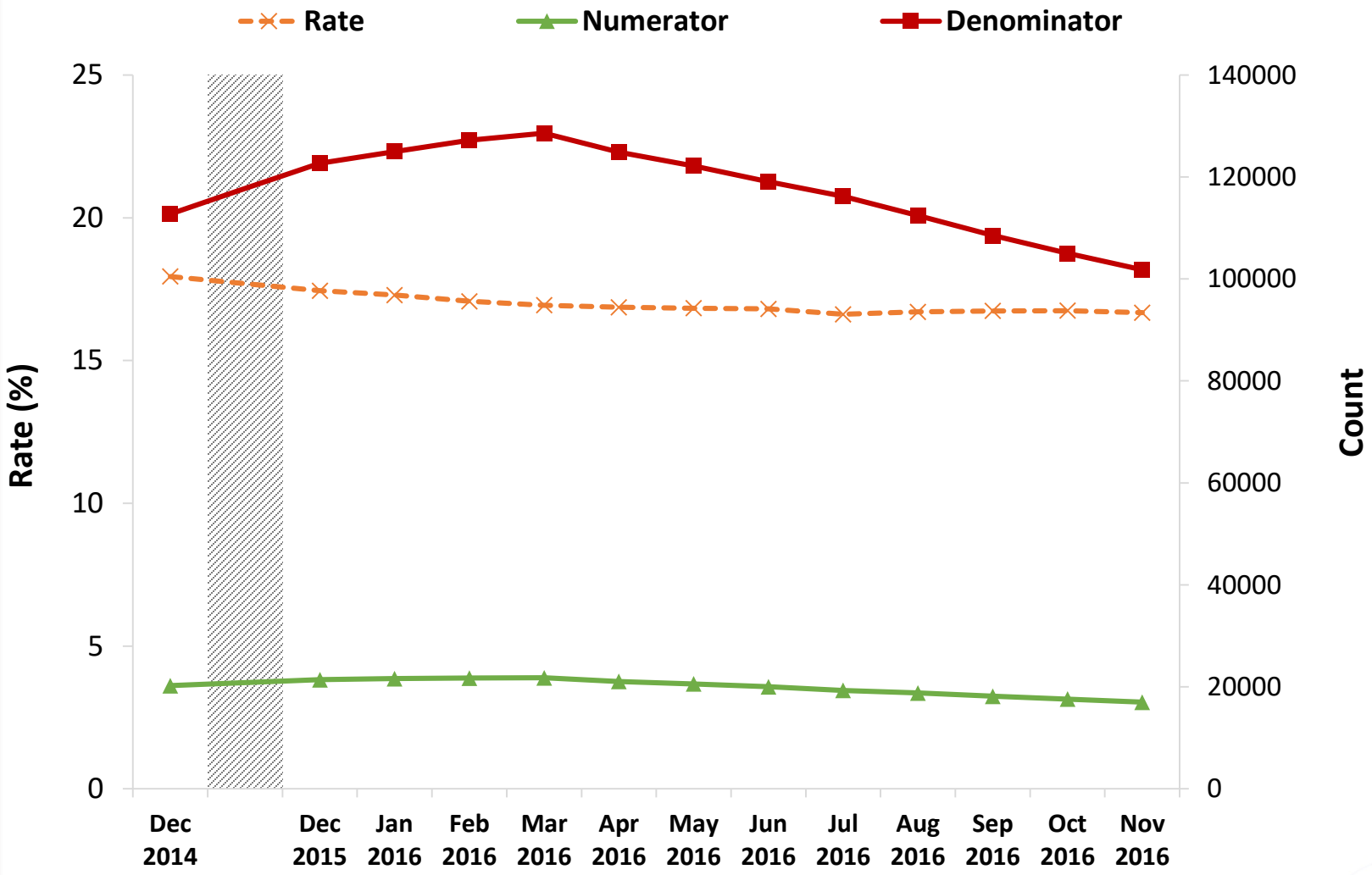
Lower is better

90 mg MED Numerator

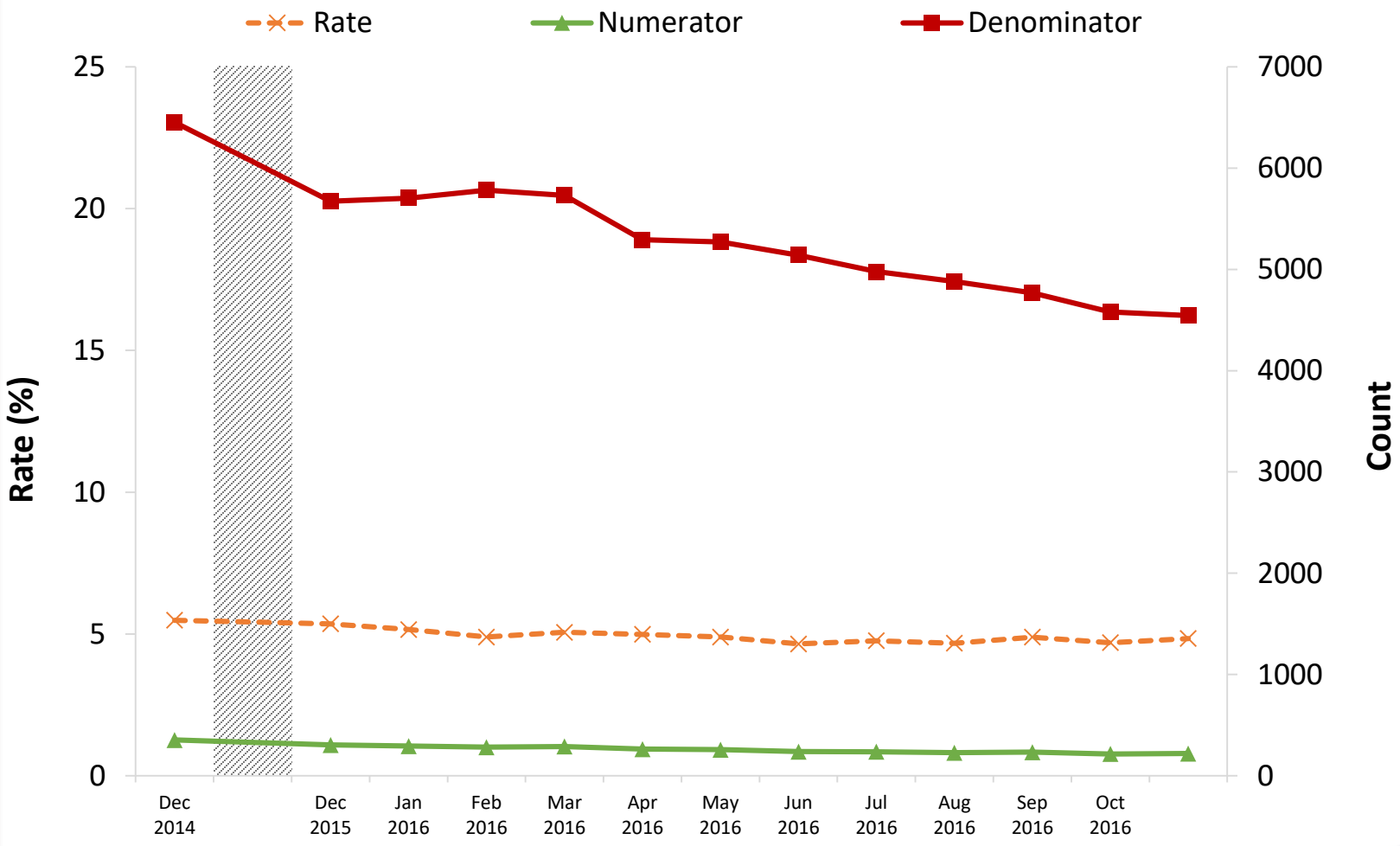
Age	CY 2014	CY 2015	12/1/2015 – 11/30/2016
12-17	354 (5.5%)	304 (5.4%)	220 (4.8%)
18 +	19,881 (18.7%)	21,093 (18.0%)	16,754 (17.2%)
Total	20,235 (17.9%)	21,397 (17.4%)	16,974 (16.7%)

$\rho \leq .001$

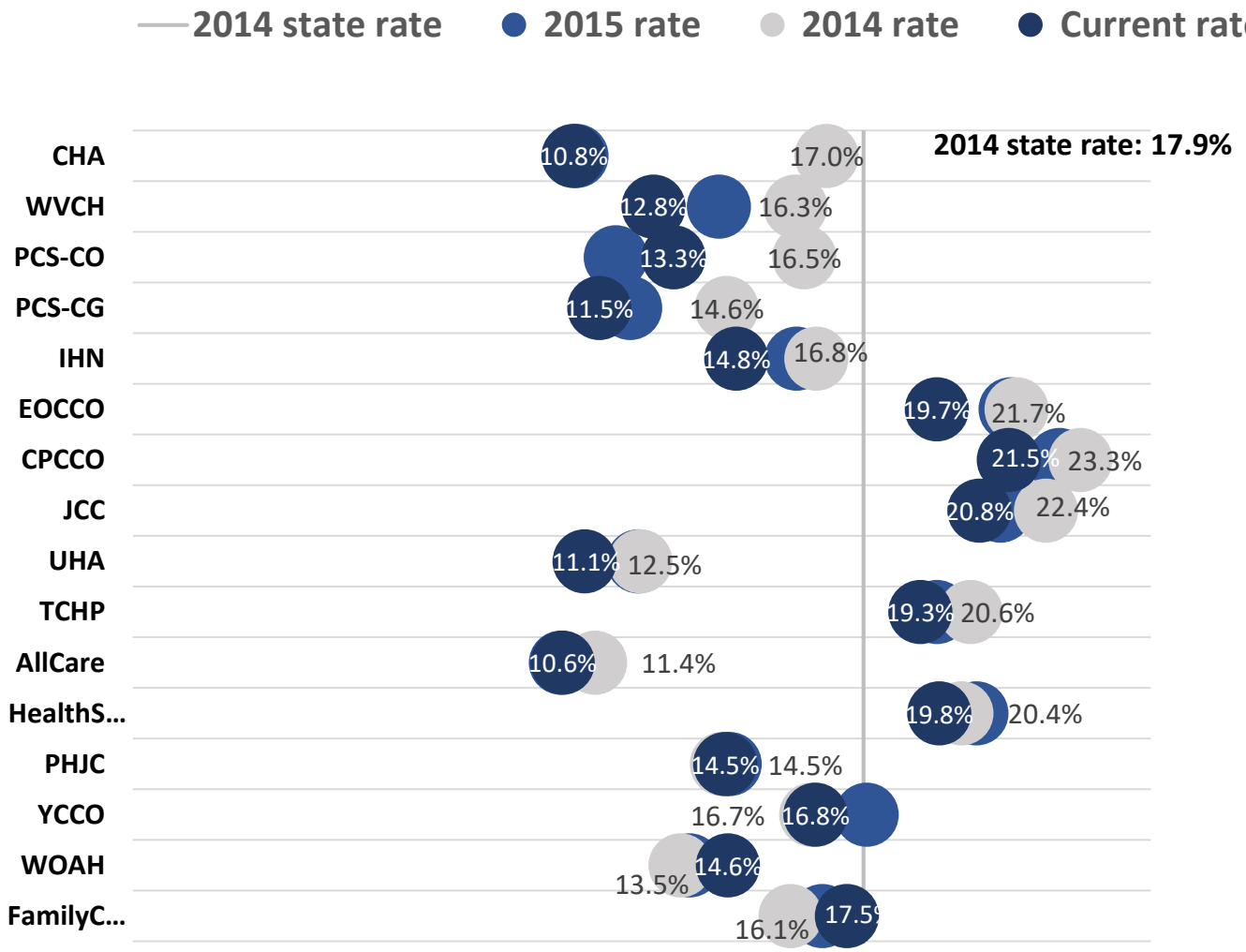
Any day >=90 mg MED, total



Any day >=90 mg MED, ages 12-17



Any day >= 90 mg MED, total



Lower is better

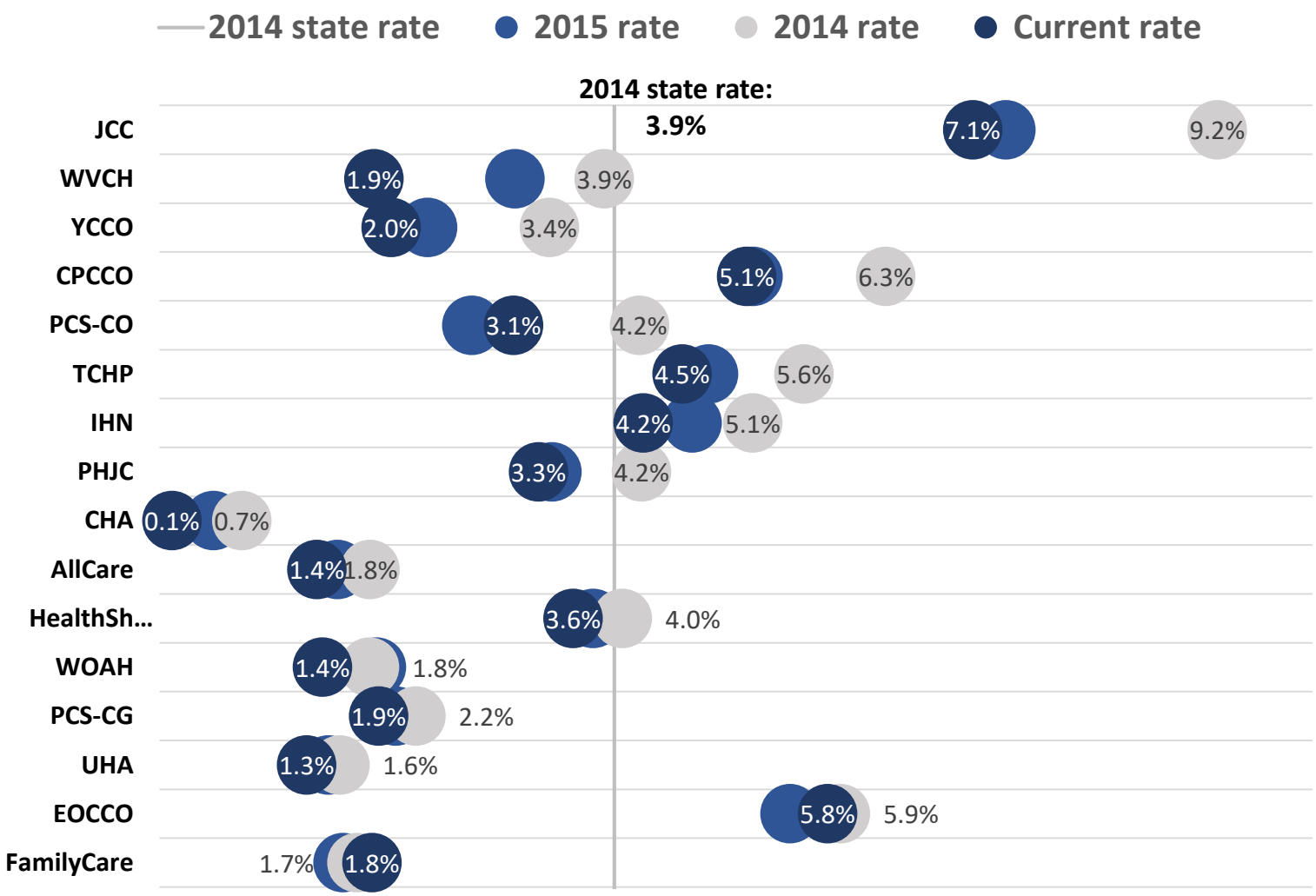
90 mg MED, consecutive 30+ days

Age	CY 2014	CY 2015	12/1/2015 – 11/30/16
12-17	1 (0.0%)	1 (0.0%)	0 (0.0%)
18 +	4,447 (4.2%)	4,195 (3.6%)	3,239 (3.3%)
Total	4,448 (3.9%)	4,196 (3.4%)	3, 329 (3.2%)

$\rho \leq .001$

HealthInsight OREGON

Consecutive 30 + days >= 90 mg MED, total



Lower is better

Summary

- Significant decrease in metrics from baseline (1.24% points on 120 mg MED; 1.27% points on 90 mg MED)
- Decrease in number of people with any prescription for opioids
- Greater decrease in patients age 12-17 with a high dose than patients age 18+
- Wide variation among CCOs at baseline and in improvement

Thank you.

Questions?

Small Group Discussion

1. Conclusions about individual CCO results
2. Interpretation of decreased denominator
3. Additional opioid measures
4. Which interventions appear to be more effective?

Oregon Performance Measure Calculation

Summary Report of 2013 Measures

Oregon Health Authority

Contract No. #142877

June 2014

Presented by:

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Table of Contents

Data Tables ii
PURPOSE AND OVERVIEW 1
Scope of Work 1
REVIEW COMPONENTS 1
Methodology 1
Review Sample 1
Characteristics of the Review Population 4
CLINICAL RECORD REVIEW 8
Gold Standard Review 8
Review Manual 8
Review Process 8
Inter-Rater Reliability 9
Data Collection 10
2013 PERFORMANCE MEASURES INDICATORS 11
Results: Performance Measures 11
Diabetes Control: HbA1c Poor Control 11
Controlling High Blood Pressure 13
Depression Screening and Follow Up 15
Results: Additional Review Elements 18
LDL Cholesterol 18
Nutrition Counseling 18
BMI Calculation 18
Advance Directive, Living Will, and/or POLST 18
Screening, Brief Intervention, and Referral to Treatment (SBIRT) 18
Number of Active Medications 19
Chronic Conditions and Self-Care Management Plan 19

APPENDIX A – DATA DICTIONARY A-1

Data Tables

Table 1. Inclusion and Exclusion Criteria. 3
Table 2. Distribution of Charts Sampled and Reviewed According to CCO. 5
Table 3. Distribution of Charts Sampled and Reviewed According to Measure Sample. 6
Table 4. Demographic Distribution of Charts Sampled and Reviewed 7
Table 5. Mean Kappa Coefficients According to Review Week. 10
Table 6. Prevalence of Diabetes - Denominator Inclusion/Exclusion Criteria 12
Table 7. Diabetes - Poor Control. 12
Table 8. Prevalence of Hypertension Denominator Inclusion/Exclusion Criteria 14
Table 9. Adequate Control of Blood Pressure among Patients with Hypertension. 14
Table 10. Prevalence of Depression Screening Denominator Inclusion/Exclusion Criteria in Full Sample. 16
Table 11. Evidence Based and OHA-Approved Screening Tools Implemented. 16
Table 12. Depression Screening Status, Among Individuals Included in the Denominator. 17
Table 13. Depression Screening Performance Measure, Among Individuals Included in the Denominator. 17
Table 14. Advance Directives, Living Wills, POLST. 18
Table 15. Screening, Brief Intervention, and Referral to Treatment (SBIRT). 19
Table 16. Chronic Conditions. 20
Table 17. Self-Care Management Plan. 21

PURPOSE AND OVERVIEW

Scope of Work

The Oregon Health Authority (OHA) contracted with Acumentra Health to perform a statewide medical record review with the goal of collecting the data elements required to calculate three statewide clinical performance measures:

1. Diabetes Control: Hemoglobin A1c Poor Control
2. Controlling High Blood Pressure
3. Depression Screening and Follow-Up

While examining the medical records, OHA requested that reviewers also collect additional data elements, which included information on

- LDL cholesterol
- body mass index
- nutrition counseling
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- advance directives, living wills, and/or Physician Orders for Life-Sustaining Treatment (POLST)
- chronic conditions and self-care management plans
- active medications

In total, 10 reviewers examined 1,385 medical records in 88 cities over 7 weeks.

REVIEW COMPONENTS

Methodology

OHA created three sample lists of 600 patients each, one for each performance measure using data from the Medicaid Management Information System (MMIS). OHA pulled each sample applying the specific inclusion/exclusion criteria for the measure. For example, the diabetes control sample was intended to capture only individuals with a diagnosis of diabetes. These samples were then sent via secure file transfer to Acumentra Health, which used the samples to conduct the chart review activities.

Review Sample

To ensure that a sufficient number of charts were available for review, an over-sample was produced by OHA. While 411 records were required for each measure, 600 records were identified for each.

OHA applied the inclusion and exclusion criteria for each measure to each sample, according to query allowances by MMIS. After the chart review, Acumentra Health ensured that inclusion

and exclusion criteria were met when calculating the measures. These criteria are presented in Table 1.

Some patients identified in a given sample met inclusion criteria for more than one performance measure and, therefore, were included in the calculation of any performance measure for which they met inclusion criteria. For example, if a patient identified in the diabetes sample met the inclusion criteria for both the diabetes and hypertension performance measures, the patient was included in the calculation of each.

Table 1. Inclusion and Exclusion Criteria.

	Depression Screening and Follow-Up	Diabetes Control	Controlling High Blood Pressure
Inclusion Criteria	• Age 12 years and older by the end of 2013	• Age 18 to 75 years of age by the end of 2013 • At least one outpatient encounter • Diagnosis of diabetes (type 1 or type 2) during 2012 or 2013	• Age 18 to 85 years of age by the end of 2013 • At least one outpatient encounter • Diagnosis of hypertension during the first six months of 2013
Exclusion Criteria	• Patient refuses to participate • Patient is in an urgent or emergent situation • Situations where the patient's motivation to improve may impact the accuracy of results • Patient was referred with a diagnosis of depression • Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period • Severe mental and/or physical incapacity	• Polycystic ovaries • Gestational or steroid-induced diabetes	• End-stage renal disease (ESRD), dialysis, or renal transplant • Pregnancy • Admission to a non-acute inpatient setting

The intent of this review was to visit the primary care provider for each individual. OHA included a parameter in their data query to limit provider type, and all outpatient encounters for each individual were included in the data file sent to Acumentra Health. Acumentra Health analysts then identified the provider with the most encounters for each individual, excluding specialists. This was the provider identified for the chart review, although alternate providers were also available if the chart at the identified primary provider was unavailable or a different provider was determined to be the primary provider.

Some of the sample 600 charts were not reviewed based on one of the following:

- The chart review was halted when a sufficient sample size was achieved ($n \geq 411$) for each of three samples (controlling blood pressure, diabetes control, and depression screening and follow-up). An over-sample was pulled in order to ensure a sufficient number of charts were available for review, but a sufficient sample size was achieved prior to reviewing all available charts.
- Not all charts were available for review. For example, a clinic identified in the encounter data from OHA had no record of the patient.
- Some clinics did not grant Acumentra Health reviewers access to medical records.
- A small number of individuals in the sample had only emergency, urgent care, or specialty care services over the time period reviewed.

Characteristics of the Review Population

This data collection was a statewide sample only and was not intended to represent a particular CCO, region, or demographic group. Therefore, results of the performance measures and additional elements collected are not stratified by demographic characteristics. Demographic characteristics are presented here to demonstrate the distribution of the full sample pulled by OHA compared to the charts actually reviewed, but OHA did not intend this chart review to be representative of any demographic group.

The distribution of charts by CCO is presented below (Table 2) to demonstrate the geographic distribution of the statewide sample.

Table 2. Distribution of Charts Sampled and Reviewed According to CCO.

CCO Name	Charts Reviewed	Charts in Sample	% of Charts Reviewed
AllCare Health Plan, Inc.	63	71	89%
Cascade Health Alliance	31	32	97%
Columbia Pacific CCO, LLC	26	47	55%
Eastern Oregon CCO, LLC	35	60	58%
FamilyCare CCO	75	96	78%
Health Share of Oregon	514	653	79%
Intercommunity Health Network	108	131	82%
Jackson Care Connect	65	71	92%
PacificSource Community Solutions (Central Oregon)	53	70	76%
PacificSource Community Solutions (Columbia Gorge)	15	15	100%
PrimaryHealth Josephine County CCO	13	13	100%
Trillium Community Health Plan	125	152	82%
Umpqua Health Alliance, DCIPA	57	59	97%
Western Oregon Advanced Health	42	44	95%
Willamette Valley Community Health	134	191	70%
Yamhill County Care Organization	29	38	76%
Total	**1385**	**1743**	**79%**

A patient's diagnosis of diabetes or hypertension was a criterion for inclusion in these sample groups, but the diagnosis in the state data was not always found in the patient's medical record (Table 3).

Table 3. Distribution of Charts Sampled and Reviewed According to Measure Sample.

	Original Sample	Charts Reviewed		Charts with Specified Dx*	
Sample Name	**N**	**N**	**%**	**N**	**%**
Hypertension	586	462	79%	413	89%
Diabetes	579	460	79%	376	82%
Depression	578	463	80%	N/A	

*The number of charts with a specified diagnosis is not the number of charts included in the performance measure analysis. Individuals identified for a given sample often met inclusion criteria for more than one performance measure; for example, even though there were only 376 charts reviewed with a diabetes diagnosis in the original diabetes sample, the diabetes performance measure included 531 individuals.

Table 4 presents the number of charts in the original sample according to demographic characteristics, along with the number of charts reviewed, and the percentage of charts in the original sample reviewed (e.g., the charts of 83% of clients age 18–24 in the original sample were reviewed).

Table 4. Demographic Distribution of Charts Sampled and Reviewed.

	Original Sample	Charts Reviewed	
Age	**N**	**N**	**%**
18–24	189	156	83%
19–24	60	48	80%
25–34	155	127	82%
35–44	234	182	78%
45–54	328	257	78%
55–64	426	334	78%
65+	351	281	80%
Gender			
Female	1085	853	79%
Male	658	532	81%
Race			
Missing/Code Error	3	2	67%
Asian	87	69	79%
African-American	115	85	74%
American Indian	26	16	62%
Pacific Islander	10	10	100%
Unknown	215	184	86%
Caucasian	1287	1019	79%
Ethnicity			
Not Hispanic	1561	1233	79%
Hispanic	181	152	84%
Unknown	1	0	0%

CLINICAL RECORD REVIEW

Gold Standard Review

The gold standard review was the process by which four reviewers audited sample records and came to a consensus on the correct answers for each question. Since the work of all reviewers would be combined for data analysis, and to ensure consistency in scoring, it was essential that all reviewers scored records in an identical manner when conducting chart reviews. At the same time, all review tools were tested and adjusted if needed. This provided standardization and the foundation for the chart reviews and for training all other chart reviewers.

Review Manual

Before the reviews began, each reviewer was given a review manual to aid in consistent reviewing and to provide a general overview of on-site review operations. The review manual included sections on equipment use, privacy and security measures, on-site scheduling process, on-site reviewing process, data back-up procedures, database use and data entry, inter-rater process and procedures, and general troubleshooting.

The final addition to the review manual was the data dictionary (see Appendix A). The data dictionary included all data elements being reviewed, response options for each data element, and operational definitions for each data element/response option.

Review Process

To conduct these reviews, Acumentra Health contracted with eight medical professionals qualified and experienced in clinical chart review. They included five registered nurses, two licensed practical nurses, and one chiropractor. Two full-time review staff with Acumentra Health also conducted chart reviews. Contracted reviewers went through orientation which included security and HIPAA training. All reviewers were trained on gold standard review. Acumentra Health provided reviewers with encrypted laptop computers and mobile phones with hot spot capability for wireless Internet access. Two reviewers also received a portable scanner used to scan charts for inter-rater testing.

Before Acumentra Health contacted providers to begin scheduling reviews, coordinated care organizations (CCOs) were given the option of coordinating the review process for their providers, initializing provider notification of the review, or leaving all aspects of review notification and coordination to Acumentra Health. Most CCOs chose to remain uninvolved in the process. Five CCOs chose to inform their providers about the review prior to notification from Acumentra Health. One CCO, Umpqua Health Alliance, chose to coordinate their provider's reviews.

OHA furnished Acumentra Health and the CCOs with a memorandum introducing the review process to providers. Acumentra Health first contacted providers by phone using the clinic phone number identified in the sample, and then a contact person for each clinic was established. The clinic contact was usually the general office manager or medical records manager. Acumentra Health provided the clinic contact with the OHA memorandum and a formal request for review, which included a list of individual charts to be reviewed. Clinic contacts confirmed whether or not charts were available, and an onsite chart review was scheduled.

For many of the clinics that are under larger umbrella agencies, charts were reviewed at a central location rather than at each individual clinic. Oregon Health & Science University, Providence Health Services, and Salem Clinic all provided remote access of their electronic health records (EHRs) to reviewers. These records were either reviewed in the reviewer's home or in Acumentra Health's office.

Reviews at individual clinics were initially scheduled by each reviewer. During this time, the manager and coordinator worked with larger agencies to either apply for remote access to EHRs or to access the EHRs through a centralized location. Once the reviewers were conducting reviews, the manager and coordinator scheduled the reviews at the remaining clinics.

Chart reviews began on March 17, 2014, and were completed by May 9, 2014. Reviewers primarily worked alone. Review teams of two were used at clinics with larger numbers of charts when more than one reviewer could be accommodated. Reviewers looked at the entire clinical chart for calendar year 2013 as well as diagnostic information from 2012.

Inter-Rater Reliability

Each week during the review period an assigned reviewer was asked to randomly select and scan three individual records from the agency at which they were reviewing. These scanned records were saved into a secure network folder, organized by week, where all reviewers were able to access them and review them each week. All inter-rater reviews were tracked to ensure timely completion, and any inconsistencies were identified and addressed by the team.

Within the first week, minor discrepancies to a specific question on the inter-rater reviews prompted a further examination of that question, the chart involved, and directions provided in the data dictionary. Language in the data dictionary was honed and additional training was provided to reviewers to further mitigate potential misinterpretation or inconsistent scoring by reviewers.

Each week, the kappa coefficient was calculated to determine agreement between reviewers on the three charts randomly selected for inter-rater review (Table 5). Two calculations were made: one kappa coefficient that only took into consideration the elements that were used to inform the three performance measures, and a second that included all review elements, including those unrelated to the performance measures but added by OHA. A kappa coefficient can range between 0.0 and 1.0, where a higher coefficient indicates better agreement between reviewers.

Table 5. Mean Kappa Coefficients According to Review Week.

Week	Performance Measure Elements Only	All Review Elements
Week 1	0.96	0.90
Week 2	0.90	0.83
Week 3	0.92	0.85
Week 4	0.97	0.90
Week 5	0.94	0.88
Week 6	0.90	0.83
Week 7	0.99	0.93
Total Average	**0.94**	**0.87**

Data Collection

All data collected during this review was stored in a Microsoft Access database specifically designed for this review. The database included the following six tabs/forms for data entry: demographics, diabetes questions, hypertension questions, depression questions, general questions, and chronic conditions. All questions were programmed to include a pop-up dialogue box that contained the data point specifications/definitions predetermined by the team and laid out in the data dictionary (Appendix A). Any questions that required a value response were programmed to include a dialogue box with an expected range for the value. Any values that fell outside the expected range prompted a reminder for the reviewer to double check the value entered. These safeguards helped ensure minimal data entry errors and maintain the integrity of the data collected.

At the end of each day, each reviewer was required to back up their data to Acumentra Health's secure network and store all review-related equipment in a secure location.

2013 PERFORMANCE MEASURES INDICATORS

The Metrics and Scoring Committee was established in 2012 by Senate Bill 1580 for the purpose of recommending outcomes and quality measures for the CCOs. Members are selected by the director of OHA. The Committee identified 17 incentive measures, most of which can be calculated using encounter data submitted to OHA, or survey data submitted by a vendor. For three of these measures, the numerator and denominator could only be determined by medical record review or data extraction from EHR systems. These three clinical measures were diabetes control, controlling high blood pressure, and depression screening and follow-up.

In 2014, all CCOs submitted a technology plan, outlining how they intended to extract this information from their EHR(s). Once the technology plan was approved, the CCOs submitted proof of concept data, demonstrating on a small scale the data file that they were able to extract in preparation for larger and more comprehensive extracts in the future.

In 2015, the CCOs will run a full extract of their EHRs and submit the data to OHA for calculation of these three clinical measures for the 2014 calendar year. However, in order to collect and report data for the 2013 calendar year, a medical chart review was required. The data collected from the 2013 calendar year will be used to present state-wide measure performance to the Centers for Medicare & Medicaid Services (CMS).

Presented below are the results of the three performance measures, along with additional elements requested by OHA.

Results: Performance Measures

Diabetes Control: HbA1c Poor Control

Measure Description: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing as a result, or if an HbA1c test was not done during the measurement year. This measure is based on National Quality Forum (NQF) measure 0059.

Numerator: The number of individuals found in the denominator whose HbA1c test value was ≥9.0 percent during the last encounter of the measurement year.

Denominator: Members 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Exclusions: Exclude members with a diagnosis of polycystic ovaries who did not have a face-to face-encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Tables 6 and 7 show these results. The denominator total includes the total number of people who met all inclusion criteria and did not meet any exclusion criteria. The number of individuals outside of the inclusion age range is not displayed in the table, but is reflected in the denominators. The full review population includes all charts reviewed, regardless of the sample group from which the individual was identified. Many individuals met the denominator criteria

for the diabetes performance measure calculation even though they were not identified in the diabetes sample. The diabetes sample population includes only charts reviewed of individuals identified by OHA in the diabetes sample.

Table 6. Prevalence of Diabetes – Denominator Inclusion/Exclusion Criteria.

Inclusion/Exclusion Criteria*	Full Review Population				Diabetes Sample Population			
	Yes		No		Yes		No	
	N	%	N	%	N	%	N	%
At least one face-to-face outpatient visit in 2013	1369	98.8%	14	1.0%	456	99.1%	4	0.9%
Diagnosis of diabetes mellitus present in 2012 or 2013	601	43.4%	784	56.6%	376	81.7%	84	18.3%
Gestational diabetes	4	0.3%	1381	99.7%	1	0.2%	459	99.8%
Steroid-induced diabetes	3	0.2%	1382	99.8%	2	0.4%	458	99.6%
Polycystic ovaries	2	0.1%	1383	99.9%	1	0.2%	459	99.8%

*Those excluded based on age criteria are not shown in the table, but are reflected in the denominators in the table below.

Table 7. Diabetes – Poor Control.

	Full Review Population		Diabetes Sample Population	
	N	%	N	%
Hemoglobin A1c NOT documented	65	12.2%	45	13.3%
Hemoglobin A1c documented: Poor Control (≥9.0%)	83	15.6%	51	15.0%
Hemoglobin A1c documented: Not Poor Control (<9.0%)	383	72.1%	243	71.7%
Total	**531**	**100.0%**	**339**	**100.0%**

Among individuals who met the inclusion criteria for the diabetes performance measure denominator (n=531) and had a documented Hemoglobin A1c value in 2013, the average value was 7.41 and the standard deviation was 1.77.

Among those who met the diabetes denominator inclusion criteria, 242 (45.6%) individuals had a documented foot exam within the measurement year.

Controlling High Blood Pressure

Measure Description: The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. This measure is based on NQF measure 0018.

Numerator: The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Denominator: Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension during the first six months of the measurement year.

Exclusions: Exclude all patients with evidence of ESRD on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD. Exclude all patients with a diagnosis of pregnancy during the measurement year. Exclude all patients who had an admission to a non-acute inpatient setting during the measurement year.

Tables 8 and 9 show these results. The denominator total includes the total number of people who met all inclusion criteria and did not meet any exclusion criteria. The number of individuals outside of the inclusion age range is not displayed in the table, but is reflected in the denominators. The full review population includes all charts reviewed, regardless of the sample group from which the individual was identified. Many individuals met the denominator criteria for the hypertension performance measure calculation even though they were not identified in the hypertension sample. The hypertension sample population includes only charts reviewed of individuals identified by OHA in the hypertension sample.

Table 8. Prevalence of Hypertension Denominator Inclusion/Exclusion Criteria.

Inclusion/Exclusion Criteria*	Full Review Population				Hypertension Sample Population			
	Yes		No		Yes		No	
	N	%	N	%	N	%	N	%
Diagnosis of hypertension in first 6 months of 2013	828	59.8%	557	40.2%	413	89.4%	49	10.6%
Outpatient encounter in the first 6 months of 2013	1218	88.1%	164	11.9%	434	94.1%	27	5.9%
ESRD, dialysis, or renal transplant	10	0.7%	1375	99.3%	0	0.0%	462	100.0%
Pregnant	23	1.7%	1362	98.3%	0	0.0%	462	100.0%
Admission to a non-acute inpatient setting	20	1.4%	1365	98.6%	4	0.9%	458	99.1%

*Those excluded based on age criteria are not shown in the table, but are reflected in the denominators in the table below.

Table 9. Adequate Control of Blood Pressure among Patients with Hypertension.

	Full Review Population		Hypertension Sample Population	
	N	%	N	%
Adequate control of hypertension (<140/90)	460	61.8%	218	55.3%
Inadequate control of hypertension (>140/90)	278	37.4%	173	43.9%
No blood pressure values documented in 2013	6	0.8%	3	0.8%
Total	**744**	**100.0%**	**394**	**100.0%**

Among individuals meeting hypertension denominator inclusion criteria, the mean systolic value was 131 (standard deviation 19), and the mean diastolic value was 78 (standard deviation 12).

Depression Screening and Follow Up

Measure Description: Percentage of patients age 12 years and older screened for clinical depression using a standardized tool and follow up plan documented. This measure is based on NQF measure 0418 and modified by OHA to include adolescents ages 12–18, rather than including only adults as the NQF measure is written. OHA maintains a list of approved standardized tools, each of which is designated as appropriate for youth and/or adults.

Numerator: Patients screened for clinical depression with an OHA-approved, age appropriate, standardized depression screening tool, and if positive, have a follow-up plan documented on the same day as the positive screen.

Denominator: Patients 12 years of age or older.

Exclusions: A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools (for example: certain court-appointed cases)
- Patient was referred with a diagnosis of depression
- Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools.

Tables 10–13 show these results.

Table 10. Prevalence of Depression Screening Denominator Inclusion/Exclusion Criteria in Full Sample.

	N	%
Depression screening was completed in 2013	**283**	**20.4%**
Among those with a completed depression screening in 2013, exclusion criteria were NOT present (patient was screened appropriately)*	166	58.7%
Among those with a completed depression screening in 2013, exclusion criteria were present (patient was screened but should not have been)	117	41.3%
Depression screening was NOT completed in 2013	**1102**	**79.6%**
Among those without a depression screening in 2013, exclusion criteria were present at every visit (patient was not screened, and should not have been)	645	58.5%
Among those without a depression screening in 2013, exclusion criteria were NOT present at every visit (patient was not screened, but should have been)*	457	41.5%

*The denominator (n=623) is made up of individuals with no exclusion criteria who may or may not have received a depression screening in 2013.

Table 11. Evidence-Based and OHA-Approved Screening Tools Implemented in Full Sample.

Screening Tool	N	%
Annual SBIRT Questionnaire	2	0.7%
Beck Depression Inventory (BDI or BDI-II)	2	0.7%
Beck Youth Depression Inventory	1	0.4%
Duke Anxiety-Depression Scale (DADS)	1	0.4%
Geriatric Depression Scale (GDC)	1	0.4%
Global Appraisal of Individual Needs - Short Screener (GAIN-SS)	4	1.4%
Patient Health Questionnaire (PHQ9)	141	49.8%
Prime MD-PHQ2	104	36.7%
The Zung Self-Rating Depression Scale (SDS)	3	1.1%
Other	24	8.5%
None	1102	

Table 12. Depression Screening Status, Among Individuals Included in the Denominator.		
Depression Screening (among denominator population, n=623)	**N**	**%**
Depression screening was completed at eligible visit(s)	166	26.6%
Depression screening was not completed at eligible visit(s)	457	73.4%
Of those with a completed depression screening at eligible visit(s) (n=166)…		
the screening was age appropriate and standardized	69	41.6%
the screening was completed with a non-standardized or unapproved tool	93	56.0%
the screening was completed with a standardized tool, but it was not age appropriate	4	2.4%
Of those with an age appropriate and standardized depression screening completed at eligible visit(s) (n=69)…		
the screening yielded a positive result	24	34.8%
Of those with an age appropriate and standardized depression screening completed at eligible visit(s), with a positive result (n=24)…		
a follow up plan was completed on the same day	9	37.5%

Table 13. Depression Screening Performance Measure, Among Individuals Included in the Denominator.		
	N	**%**
Performance Measure Met: Age appropriate and standardized tool used, with positive result, and follow-up plan on the same day	**9**	**1.5%**
Performance Measure Not Met: Age appropriate and standardized tool used, with positive result, but no follow up plan	15	2.4%
Performance Measure Not Met: Age appropriate and/or standardized tool not used, or screening not completed at eligible visit(s)	554	88.9%
Not Eligible to Meet Performance Measure: Age appropriate and standardized tool used, but negative or unknown screening result (no follow up plan required)	45	7.2%
Total	**632**	**100.0%**

Results: Additional Review Elements

LDL Cholesterol

LDL cholesterol was documented in 2013 for 666 (48%) individuals whose chart was reviewed. Among these individuals, the mean LDL value was 100.9, with a standard deviation of 36.8.

Nutrition Counseling

Nutrition counseling was documented in the medical records of 498 (36%) individuals.

BMI Calculation

A body mass index (BMI) calculation was recorded in the medical records of 1,224 (88%) individuals whose chart was reviewed. Among these individuals, the mean BMI value was 32.2, and the standard deviation was 9.7.

Advance Directive, Living Will, and/or POLST

Medical records were reviewed to determine whether an advance directive, living will, and/or POLST were offered, refused, and/or present in the record. Table 14 shows these results.

Table 14. Advance Directives, Living Wills, POLST.

	Yes		No		N/A*
Advance directive, living will, and/or POLST offered	103	7.4%	1239	89.5%	42
(if offered) advance directive, living will, and/or POLST refused	10	0.7%	79	5.7%	14
Advance directive present in medical record	53	3.8%	1331	96.1%	
Living will present in medical record	40	2.9%	1344	97.0%	
POLST present in medical record	52	3.8%	1332	96.2%	

*N/A means the advance directive, living will, and/or POLST was not offered.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an evidence-based process to identify and address concerning alcohol and drug use. Medical records were reviewed to determine whether this tool was utilized. Table 15 shows these results.

Table 15. Screening, Brief Intervention, and Referral to Treatment (SBIRT).

	Yes		No		N/A*	
	N	%	N	%	N	%
SBIRT short screening was conducted	904	65.3%	481	34.7%		
(if yes) screening was positive	120	13.3%	755	83.5%	29	3.2%
(if short screen was conducted and was positive, n=120)						
Full screening was conducted	8	6.7%	107	89.2%	5	4.2%
(if short screen was conducted, was positive, and full screening was conducted, n=8)						
Brief intervention was conducted	6	75.0%	2	25.0%		
(if short screen was conducted and was positive; full screening was conducted; and brief intervention was conducted, n=6)						
Referral to treatment was made	4	66.7	1	16.7	1	16.7

*N/A means either the short screen was not conducted, or the short screen was conducted but was negative.

Number of Active Medications

The average number of active medications documented in a medical record was 9.0, with a standard deviation of 6.7. The 25th percentile was 4 medications, the median was 8 medications, the 75th percentile was 13 medications. Medication counts included all prescription and over-the-counter medications, including vitamins and supplements.

Chronic Conditions and Self-Care Management Plan

Among the 1,385 charts reviewed, 1,281 (93%) had at least one chronic condition documented. While reviewers documented all chronic conditions, CMS has published a list of 15 categories of chronic conditions, which is presented as a summary below (Table 16). This is not an exhaustive list, nor does it capture all the chronic conditions documented by reviewers.

Table 16. Chronic Conditions.

	N	%
Chronic alcohol or drug dependence	38	2.7%
Autoimmune disorders (limited)	17	1.2%
Cardiovascular disorders (limited)	99	7.1%
Chronic heart failure	67	4.8%
Dementia	7	0.5%
Diabetes	585	42.2%
End stage liver disease	1	0.1%
End stage renal disease requiring dialysis	0	0.0%
Severe hematologic disorders	5	0.4%
HIV/AIDS	5	0.4%
Chronic lung disorders	326	23.5%
Chronic and disabling mental health conditions	161	11.6%
Neurologic disorders	50	3.6%
Stroke related neurologic deficit	2	0.1%
Osteoarthritis	0	0.0%

Note: The percentages shown will not total 100.

If at least one chronic condition was documented, reviewers examined the self-care management plan (if present). Among individuals with at least one chronic condition documented, a self-care management plan was present in 959 (75%) records as shown in Table 17.

Reviewers assumed that if a patient did not understand the goal and plan, the provider would continue working with them to ensure they did understand. As such, “No” was not an answer option to this question; rather, the patient’s understanding was either documented (“yes”) or there was no documentation of understanding (“unknown”).

Table 17. Self-Care Management Plan.

	Yes		No		Unknown		Partial	
	N	%	N	%	N	%	N	%
Self-care management plan present	959	75.0%	319	25.0%				
Mutually agreed upon goal present	315	24.6%	344	26.9%	619	48.4%		
Goal is measurable and time sensitive	186	14.6%	702	54.9%			390	30.5%
Patient understands goal and plan	333	26.1%			945	73.9%		

Office of Mental Health and Addiction Services External Quality Review Report

OMHAS 2005 Quality Strategy Review

OMHAS Contract #109162

May 2006

Presented by

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Table of Contents

Executive Summary 1
Background 3
Review Results 5
State responsibilities 5
Enrollee access standards 7
Structure and operation standards 12
Measurement and improvement standards 14
EQR activities 18
Summary and Recommendations 19
Appendix A. Evaluation Matrix for the 2005 OMHAS Quality Strategy A-1

Index of Tables

Table 1. State responsibilities standards partially met or not met 5
Table 2. Enrollee access standards partially met or not met.....8
Table 3. Structure and operation standards partially met or not met.....12
Table 4. Measurement and improvement standards partially met or not met 15

Executive Summary

As the External Quality Review Organization (EQRO) for the Office of Mental Health and Addiction Services (OMHAS), Acumentra Health (formerly known as OMPRO) evaluated OMHAS's Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy, revised in August 2005. The Quality Strategy describes OMHAS's plan for overseeing mental health organizations (MHOs) that serve Medicaid enrollees through the Oregon Health Plan (OHP). This report summarizes the first evaluation of the strategy under the external quality review (EQR) contract.

Federal regulations specify the minimum contents of state quality strategies. Acumentra Health evaluated the OMHAS Quality Strategy for compliance with federal standards related to quality assessment and performance improvement (QA/PI), including state responsibilities, enrollee access, managed care structure and operation, measurement and improvement, and EQR. For each section of the regulations, Acumentra Health determined whether the strategy met, partially met, or did not meet the relevant standards. Acumentra Health then recommended improvements for OMHAS's next revision of the strategy.

Evaluation results

The 12-page OMHAS Quality Strategy touches on many of the relevant federal standards. It successfully addresses some elements of the state's duties in ensuring quality and appropriateness of mental health care, enrollee access, and services for enrollees with special healthcare needs.

However, the Quality Strategy needs to provide more concrete details about what MHOs are expected to do and how OMHAS will oversee the MHOs to hold them accountable. A more detailed framework would make it easier for the MHOs (or other involved parties) to apply the Quality Strategy effectively to their business practices and to align them with OMHAS's goals for the delivery of services to OHP enrollees.

The Quality Strategy is vague in many areas. For example, some sections simply refer to OMHAS's MHO contract without citing specific provisions that relate to the federal standards. As a result, the Quality Strategy does not address fully the majority of the Medicaid managed care regulations.

State responsibilities: Partially met. OMHAS has complied with regulations related to its responsibilities in developing and reviewing the Quality Strategy. However, the strategy omits some required elements of state quality strategies and only partially addresses others.

Enrollee access: Not met. The strategy does not address most elements of these standards and only partially addresses others. In particular, it omits language about ensuring coordination and continuity of care for all enrollees and about ensuring coverage and authorization of services.

Structure and operations: Not met. The strategy does not address most of these standards and only partially addresses others. It does not refer to federal requirements related to enrollee confidentiality, enrollment and disenrollment procedures, grievance systems, and subcontractual relationships and delegation. The 2005 EQR Annual Report, issued in December 2005, identified the latter area as a particular problem, as the majority of MHOs lacked policies for monitoring and managing the activities delegated to contractors and subcontractors.

Measurement and improvement: Partially met. The strategy refers to QA/PI programs that form part of the MHOs' quality improvement (QI) work plans. However, it does not address fully the requirement for MHOs to develop and use practice guidelines. References to performance measurement and to MHOs' performance improvement projects (PIPs) do not identify these as key components of QA/PI programs. The strategy touches on basic elements of health information systems but does not address requirements for MHOs to collect encounter data from providers, verify the data, and report to OMHAS.

External quality review: Substantially met. The strategy addresses requirements related to contracting with an independent EQRO and conducting the annual EQR, and it covers the mandatory and optional EQR activities. However, it omits mention of a provision that allows the EQRO to provide technical assistance to groups of MHOs in conducting EQR-related activities.

Recommendations

This report cites additions and refinements needed to address standards that were not incorporated into the Quality Strategy. Additional suggested improvements are intended to enhance the usefulness of the strategy in communicating OMHAS's missions and goals and in identifying best practices.

The summary at the end of the report offers recommendations for structural changes that would enable OMHAS to move beyond the compliance environment to a more proactive strategy. The recommendations include forming a quality improvement committee within OMHAS that would be responsible for overseeing MHOs' responsibilities and defining their scope of work.

Background

Under the Balanced Budget Act (BBA) of 1997, a state that contracts with managed care organizations (MCOs) to provide Medicaid services must have a written strategy for assessing and improving the quality of managed care services. The state must conduct periodic reviews of the strategy to evaluate its effectiveness and must update the strategy as needed. Also, the state must ensure that MCOs comply with QA/PI standards established by the state in accordance with federal regulations for managed care programs (42 CFR §438, Subpart D).

BBA regulations specify that the state quality strategy must contain, at a minimum:

- the MCO contract provisions that incorporate the standards specified in Subpart D;
- procedures that
    - assess the quality and appropriateness of care and services furnished to Medicaid enrollees and to people with special healthcare needs
    - identify the race, ethnicity, and primary language spoken of each Medicaid enrollee
    - regularly monitor and evaluate MCO compliance with the standards
- for MCOs, any national performance measures and levels that may be identified and developed by the Centers for Medicare & Medicaid Services (CMS)
- arrangements for annual external reviews of the quality outcomes and the timeliness of and access to services covered under each MCO contract
- appropriate use of intermediate sanctions to be imposed on MCOs that violate legal or contractual provisions
- an information system that supports operation and review of the quality strategy
- standards at least as stringent as the federal standards for access to care, MCO structure and operations, and quality measurement and improvement

OMHAS's Medicaid Managed Mental Health Care Quality Assessment and Improvement Strategy describes the agency's plan for overseeing the MHOs that serve OHP enrollees. Adopted in August 2003, reviewed in August 2004, and revised in August 2005, the Quality Strategy incorporates elements of state and federal regulations and of the MHO contract. Data obtained from the oversight activities described in the strategy ultimately are analyzed and evaluated as part of the annual EQR technical report.

OMHAS's Quality Strategy is organized under the following main headings:

Introduction

I. Process for quality strategy development, review, and revision

II. Managed care program goals and objectives

III. Medicaid contract provisions

IV. Procedures for assessing quality and appropriateness of care

V. Procedures for race, ethnicity, and primary language

VI. State procedures for compliance monitoring and evaluation

VII. National performance measures and levels

VIII. External quality reviews `

IX. MCO use of intermediate sanctions

X. Information system

XI. State standards for access, structure and operation, and quality measurement and improvement

Evaluation approach

In evaluating the Quality Strategy, Acumentra Health reviewed the Medicaid managed care regulations, OMHAS's current contract with MHOs, and the CMS Protocols for External Quality Review of Medicaid Managed Care Organizations.

This evaluation is organized to address the standards in Subpart D, which are divided into three sections: Access; Structure and Operation; and Measurement and Improvement. For each section, Acumentra Health determined whether the Quality Strategy met, partially met, or did not meet the relevant standards. Appendix A (adapted from Attachment C of the CMS protocol for evaluating state quality strategies) presents detailed comments.

The items cited as required improvements identify areas in which OMHAS did not incorporate the relevant standards into the Quality Strategy. In some cases where the strategy did address certain standards, Acumentra Health noted opportunities for further improvement. OMHAS may wish to consider these suggested improvements for developing a comprehensive strategy that clearly communicates its mission and goals.

Review Results

State responsibilities

The Quality Strategy addresses all elements of 42 CFR §438.202, listing state responsibilities related to developing the strategy and reviewing it internally. The strategy incorporates procedures to assess the quality and appropriateness of care and provides for an annual EQR. However, as shown in Table 1, the strategy does not incorporate contract provisions related to the managed care standards, and it addresses several other required elements of state quality strategies only partially. For additional details, refer to Appendix A.

Table 1. State responsibilities standards partially met or not met.

Standard	Partially met	Not met
42 CFR §438.204(a). Elements of State quality strategies. Contract provisions that incorporate the managed care standards *Strategy refers to the MHO contract but does not specify provisions that incorporate standards.*		●
§438.204(b)(2). Procedures that identify race, ethnicity, and primary language of each enrollee *Strategy needs to specify that the state provides this information to the MHOs for each enrollee.*	●	
§438.204(c). National performance measures that CMS may develop *Strategy does not specify whether or how performance measures were developed.*	●	
§438.204(e). Appropriate use of intermediate sanctions *Strategy refers to the MHO contract but does not specify this provision.*		●
§438.204(f). Information system that supports operation and review *Strategy refers to the information system, but not in the context of supporting operation and review.*	●	

Comments

The introductory material is informative, succinct, and well organized. OMHAS deserves recognition for dedicating resources to the independent review of its Quality Strategy document.

Required improvements

- Quote or cite all relevant provisions of the MHO contract in the text of the Quality Strategy or in an appendix. References to the contract in the current document are either too vague or, in one case, inaccurate.
- Add language that addresses
  - the state's obligation to provide information for MHOs on enrollees' race, ethnicity, and primary language, *§438.204(b)(2)*
  - how the health information supports operation and review of the Quality Strategy, *§438.204(f)*

Suggested improvements

- Update the Introduction to reflect results of the 2005 EQR review.
- Describe how OMHAS, the Office of Medical Assistance Programs, and other divisions of the Department of Human Services (DHS) will interact to carry out the strategy.
- Describe the mechanisms by which OMHAS plans to evaluate the strategy's overall effectiveness and determine the need for changes. Include language describing the EQRO's role in evaluating the strategy.
- Provide examples of how OMHAS incorporates its mission and goals into the Quality Strategy. Review the mission and goals to ensure that they are still appropriate in relation to overall DHS and MHO strategies.
- Incorporate 2006 revisions of the EQR protocol into the Quality Strategy.
- Describe how the Quality Strategy relates to the EQR process and ultimately to the annual EQR technical report. The technical report should serve as one of the catalysts for updating the Quality Strategy.

Enrollee access standards

These standards cover availability of services for enrollees, assurance of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

The Quality Strategy lists specific methods that OMHAS uses to ensure that all services covered under the state plan are available and accessible to enrollees, meeting the basic rule under 42 CFR §438.206. The strategy also addresses other requirements of this section of the regulations by

- stating that OMHAS will evaluate the MHOs' provider networks to evaluate access to services and the capacity of MHO delivery systems
- requiring MHOs to conduct credentialing reviews of their providers at least biannually
- referring to the need for culturally and linguistically appropriate programs

The strategy addresses basic elements of §438.207, Assurance of adequate capacity and services, and of §438.208, Coordination and continuity of care. It devotes particular attention to identifying and assessing enrollees with special healthcare needs (SHCN) and developing treatment plans for those enrollees.

However, the strategy does not address other significant elements of enrollee access and only partially addresses others, as shown in Table 2. In particular, it omits language related to ensuring coordination and continuity of care for *all* enrollees (not only those with SHCN) and ensuring coverage and authorization of services. For additional details, refer to Appendix A.

Table 2. Enrollee access standards partially met or not met.

Standard	Partially met	Not met
42 CFR §438.206(b)(1)(i)–(ii). MHOs must consider anticipated Medicaid enrollment and expected utilization of services *Strategy does not refer to "anticipated" enrollment, nor to "expected" utilization.*	●	
§438.206(b)(1)(iii). MHOs must consider numbers and types of providers required *Strategy should refer more specifically to training, experience, and specialization.*	●	
§438.206(b)(1)(iv)–(v). MHOs must consider numbers of network providers not accepting new Medicaid patients and the geographic location of providers and enrollees *No language found.*		●
§438.206(b)(3). MHOs must provide for second opinions from qualified professionals *No language found.*		●
§438.206(b)(4). MHOs must cover necessary out-of-network services adequately and timely *No language found.*		●
§438.206(b)(5). MHOs must require out-of-network providers to coordinate with the MHO with respect to payment *No language found.*		●
§438.206(c)(1). MHOs must require providers to meet state standards for timely access *Strategy addresses SHCN enrollees only. No language regarding urgency of need for services or required hours of operation.*		●
§438.207(d). State review and certification to CMS *No language found.*		●
§438.207(e). CMS's right to inspect documentation *No language found.*		●
§438.208(b). MHOs must coordinate delivery of primary care and services for all enrollees *No language found.*		●
§438.208(b)(1). MHOs must ensure appropriate source of primary care for each enrollee *No language found.*		●

Table 2. Enrollee access standards partially met or not met (cont.).

Standard	Partially met	Not met
§438.208(b)(2). Coordinate services the MHO furnishes with services the enrollee receives from any other MHO *Strategy addresses care coordination only for SHCN enrollees.*	●	
§438.208(b)(3). Share results of identification and assessment of special health care needs *No language found.*		●
§438.208(b)(4). In coordinating care, protect enrollee privacy per federal requirements *No language found.*		●
§438.208(c)(3). Development of treatment plans for SHCN enrollees *No language that addresses timeliness of primary care provider's care plan for SHCN enrollees or adherence to utilization review standards*.	●	
§438.208(c)(4). Direct access to specialists for SHCN enrollees *No language found.*		●
§438.210(a). MHOs must provide services sufficient in amount, duration, and scope to achieve the purpose for which services are furnished *No language found.*		●
§438.210(b). MHOs must follow written policies and procedures for service authorization *No language found.*		●
§438.210(c). MHOs must notify requesting providers and enrollees of any decision to deny a service authorization request *No language found.*		●
§438.210(d). MHOs must meet standards for timely delivery of notices of action *No language found.*		●
§438.210(e). Compensation for utilization management activities may not provide incentives to deny, limit, or discontinue necessary services *No language found.*		●

Comments

Under BBA regulations, the state Medicaid agency has some latitude in overseeing compliance with the many standards for enrollee access. For both OMHAS and the MHOs, it would be constructive if OMHAS were to specify in the Quality Strategy the documentation required of the MHOs.

Required improvements

Availability of services

- Add language about the requirements for MHOs to consider, in establishing their delivery networks:
  - the numbers of network providers who are not accepting new Medicaid enrollees, *§438.206(b)(1)(iv)*
  - geographic locations of network providers and enrollees, *§438.206(b)(1)(v)*
- Add specific language regarding the requirements for MHOs to:
  - provide for second opinions, *§438.206(b)(3)*
  - cover out-of-network services adequately and timely if needed services are unavailable within the network, *§438.206(b)(4)*
  - coordinate with out-of-network providers with respect to payment and ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network, *§438.206(b)(5)*
- Specify that MHOs must take corrective action if standards for timely access are not met. *§438.206(c)(1)(vi)*

Assurance of adequate capacity and services

- Add language about requirements related to state review and certification of MHOs' compliance with these standards and to CMS's right to inspect documentation. *§438.207(d)–(e)*

Coordination and continuity of care

- Add language regarding primary care and coordination of services for *all* MHO enrollees, not only those with SHCN. *§438.208(b)(1)*
- Add language about requirements for sharing results of the identification and assessment of SHCN enrollees and for ensuring enrollees' privacy during coordination of care. *§438.208(b)(3)–(4)*
- Specify that OMHAS requires MHOs to approve treatment plans for SHCN enrollees in a "timely manner" that includes the enrollee's input, and that these enrollees have direct access to specialists. *§438.208(c)(4)*

Coverage and authorization of services

- State clearly that OMHAS requires the MHOs to
  - cover services to OHP enrollees according to contractual definitions and specifications of the amount, duration, and scope of each required service, *§438.210(a)*
  - have in place and follow policies and procedures to ensure consistent application of criteria for authorization decisions, including consultation with the requesting provider when appropriate, *§438.210(b)*
- For notices of adverse action, specify that the MHO must notify the requesting provider and the enrollee. *§438.210(c)*
- For prior authorization review, specify the time frames for standard and expedited decisions and for enrollee or provider requests for extension. *§438.210(d)*
- Add language about compensation for utilization management activities. *§438.210(e)*

Suggested improvements

Availability of services

- Consider incorporating more detailed guidelines for practices by which MHOs can meet federal requirements for ensuring availability of services. Examples of such practices could be obtained from MHO site reviews, information from MHO contractor or QI coordinator meetings, or a literature review.

Coordination and continuity of care

- Provide examples of how OMHAS and OMAP would coordinate services that enrollees receive from multiple MHOs and MCOs and would share assessment information with the MHOs. *§438.208(b)(2)–(3)*

Structure and operation standards

These standards address provider selection, enrollee information, confidentiality, enrollment and disenrollment, grievance systems, and subcontractual relationships and delegation. As shown in Table 3, the Quality Strategy omits language on most of these standards and only partially addresses others. For additional details, see Appendix A.

Table 3. Structure and operation standards partially met or not met.

Standard	Partially met	Not met
42 CFR §438.214(a). Provider selection. General rules *Strategy needs to mention the requirement for MHOs to implement policies and procedures in this area.*		●
§438.214(b)(1). State must establish a uniform credentialing and recredentialing policy *No language found.*		●
§438.214(b)(2). MHOs must follow documented process for credentialing and recredentialing *Language does not address recredentialing.*	●	
§438.214(c). Nondiscrimination against certain providers *No language found.*		●
§438.214(d). Excluded providers *No language found.*		●
§438.214(e). Additional state requirements *No language found.*		●
§438.218. Enrollee information *Strategy addresses some but not all required elements.*	●	
§438.224. Confidentiality *No language found.*		●
§438.226. Enrollment and disenrollment *No language found.*		●
§438.228. Grievance systems *No language found.*		●
§438.230. Subcontractual relationships and delegation *No language found.*		●

Comments

Structure and operation standards address important elements of enrollee rights and of the MHO's day-to-day operations. These standards are comprehensive and require substantial oversight to ensure compliance.

Required improvements

Provider selection

- Specify that MHOs must have in place and follow written policies and procedures for credentialing and recredentialing. List all pertinent provisions in this section (e.g., nondiscrimination, excluded providers). *§438.214*

Enrollee information

- List the specific contract requirements regarding enrollee information (e.g., reading level for enrollee materials, alternative format and language requirements, enrollee handbook contents). Specify the procedures for monitoring MHOs' compliance with these standards with reference to the current MHO agreement. The reference in the current version of the Quality Strategy is out of date. *§438.218*

Confidentiality

- Specify the requirements for MHOs to protect the confidentiality of enrollee information. *§438.224*

Enrollment and disenrollment

- Include the contractual provisions that define the decision making roles of the state and MHOs with regard to enrollment and disenrollment, including grievance processes. *§438.226*

Grievance systems

- Add specific language about the requirement for MHOs to have grievance systems and for the state to conduct random reviews to ensure that MHOs comply with notice-of-action requirements. *§438.228*

Subcontractual relationships and delegation

- Specify that the MHO oversees and is accountable for functions delegated to any subcontractor; that the MHO evaluates each prospective subcontractor's ability to perform delegated activities; that the MHO has a specific written agreement addressing delegated activities and responsibilities; and that the MHO monitors the subcontractor's performance and takes corrective action if necessary. *§438.230*
- Describe OMHAS's expectations of how an MHO will evaluate a prospective subcontractor's ability to perform delegated activities. Consider recommending that MHOs apply the National Committee for Quality Assurance standards for pre-delegation evaluation of prospective subcontractors. *§438.230(b)(3)*

Measurement and improvement standards

These standards address practice guidelines, QA/PI programs, and health information systems. Again, the Quality Strategy addresses most of these standards only partially or not at all, as shown in Table 4. For additional details, refer to Appendix A.

Various sections of the Quality Strategy refer to QA/PI programs that MHOs must maintain. The strategy identifies the requirement for MHOs to have mechanisms for assessing care furnished to SHCN enrollees (§438.240(b)(4)). Also, it refers to reviewing MHOs' QI work plans to evaluate the clarity of goals, objectives, and performance measures and to identify significant problem areas.

The strategy refers to the adoption and application of practice guidelines only as a topic of discussion at Quality Improvement Committee meetings, not as a specific requirement of managed care regulations. It refers only vaguely to performance measurement and to MHOs' PIPs, and it fails to identify these as key components of QA/PI programs. The text provides little detail on PIP requirements or on OMHAS's role in overseeing these projects.

The strategy touches on the basic elements of health information systems but does not address the required capabilities of an MHO's system, nor the requirements for MHOs to collect encounter data from providers, verify the data's accuracy and timeliness, and report to OMHAS.

Washington Department of Social and Health Services, Medical Assistance Administration External Quality Review

Quality Strategy Compliance Review

WAMAA Contract #0435-47199

August 2005

Presented by

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MAA 2003 Quality Strategy Compliance Review

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Medical Assistance Administration

Contents

Executive Summary 1
Background 2
Evaluation of the MAA Quality Strategy 2
Introduction of the MAA Quality Strategy 3
Access standards 4
Structure and operations standards 6
Measurement and improvement standards 6
External quality review (EQR) standards 7
Summary and Recommendations 8

Index of Tables

Table 1. Compliance with state responsibilities for quality strategies 3
Table 2. Access standards partially met or not met 4
Table 3. Structure and operations standards not met 6
Table 4. Compliance with measurement and improvement standards 6
Table 5. EQR requirements partially met 7

Executive Summary

The State of Washington Department of Social and Health Services, Medical Assistance Administration (MAA), selected OMPRO to conduct a validation of the MAA 2003 Quality Strategy. OMPRO evaluated the Quality Strategy for compliance with federal standards for Medicaid managed care, examined its strengths and limitations, and recommended improvements for implementing the strategy.

The evaluation addressed standards regarding enrollee access, managed care structure and operations, and measurement and improvement, as well as the Introduction of the Quality Strategy and the section on external quality review (EQR). For each section, OMPRO rated the standards as Met, Partially Met, or Not Met, as outlined below.

Overall, the MAA Quality Strategy complied with the Medicaid rules and regulations. The recommended improvements address a small number of standards that were not incorporated into the 2003 Quality Strategy. In addition, OMPRO suggests other improvements to help MAA identify structural changes to move beyond compliance to a proactive quality strategy.

Introduction of the Quality Strategy. The introduction and overview met federal requirements for the elements of state quality strategies. OMPRO suggests a number of improvements to the content.

Access. These standards comprise more than 60 regulations, most of which MAA met. MAA failed to meet or only partially met certain standards regarding availability of services, assurance of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

Structure and operations. Of these 20 standards, MAA complied with all but one, regarding subcontractual relationships and delegation. OMPRO recommends adding language to the strategy addressing MAA's expectations of how a Medicaid managed care organization will evaluate a prospective subcontractor's ability to perform delegated duties.

Measurement and improvement. MAA met these standards addressing practice guidelines, quality assurance and performance improvement programs, and health information systems.

External quality review. MAA partially met the standards in this area. OMPRO recommends that MAA add a description of the required and optional EQR quality improvement activities that MAA is conducting and discuss the activities conducted by MAA and those that have been contracted out.

Background

MAA selected OMPRO, a nonprofit External Quality Review Organization (EQRO), to conduct a validation of the MAA 2003 Quality Strategy. OMPRO evaluated the Quality Strategy for compliance with federal standards, examined strengths and limitations, and recommended improvements for implementing the strategy. As part of the evaluation, OMPRO reviewed the federal Medicaid managed care rules and regulations (42 CFR §438), the 2003–2005 MAA Healthy Options/SCHIP contract, and the Centers for Medicare & Medicaid Services (CMS) *Protocols for External Quality Review of Medicaid Managed Care Organizations*. OMPRO also assessed other states' quality strategies to determine best practice standards.

The federal Balanced Budget Act (BBA) of 1997 requires each state Medicaid agency contracting with a managed care organization (MCO) to develop and implement a written strategy for assessing and improving the quality of managed care services (42 CFR §438.202). The strategy must comply with provisions established by the U.S. Department of Health and Human Services (DHHS), issued in the June 2002 *Federal Register*. States must either adopt DHHS protocols for independent external review of MCO compliance with federal quality standards, released by DHHS in February 2003, or implement protocols consistent with those standards.

The BBA regulations are intended to provide important beneficiary protections and result in improved patient care outcomes and satisfaction over the long term. The law significantly increased Medicaid regulatory requirements in comparison with those that existed before the BBA. State Medicaid agencies and healthcare organizations must dedicate significant time and resources to ensure compliance with the new federal standards.

A written quality strategy provides an opportunity to inform MAA leadership and stakeholders of MAA's plan for oversight of MCOs. MAA's Quality Strategy incorporates elements of the MCO contract, state and federal regulations, and the CMS managed care protocols. Data obtained from the oversight activities described in MAA's Quality Strategy ultimately will be submitted to OMPRO for analysis and evaluation as part of the EQR Technical Report.

Evaluation of the MAA Quality Strategy

This evaluation is organized to address the standards outlined in Subpart D of the BBA Medicaid managed care rules and regulations. Subpart D is divided into three sections: Access, Structure and Operations, and Measurement and Improvement standards. For each of these sections, OMPRO evaluated the MAA Quality Strategy's compliance with the federal standards, rating the standards as Met, Partially Met, or Not Met. This evaluation expanded these categories to include the Introduction of the Quality Strategy and the section on External Quality Review.

This evaluation includes suggestions and recommendations for improvement. The required improvements address areas in which MAA did not comply with the federal standards. Even for standards where compliance was met, OMPRO noted opportunities for further improvement. The suggested improvements provide MAA with opportunities to move beyond compliance to a comprehensive strategy that would accurately reflect MAA's mission and goals.

Introduction of the MAA Quality Strategy

The Quality Strategy begins with an Introduction, an Overview of the MAA (Mission and Goals and Managed Care Organizational Structure), and a section on the Quality Strategy Development and Review process. The evaluation rated these elements as complying with federal requirements for the elements of state quality strategies, as shown in Table 1.

Table 1. Compliance with state responsibilities for quality strategies.

Standard	Met	Partially Met	Not Met
42 CFR §438.202 State responsibilities.	•		
42 CFR §438.204 Elements of state quality strategies.	•		

Comments

The information provided in the Introduction and Overview is informative, succinct, and organized in a manner that is easy to follow. A best practice review revealed that MAA is unique in dedicating resources to the independent review of its Quality Strategy document.

Suggested improvements

- Update the Overview section to reflect current budget and demographic information.
- Add the Washington Medicaid Integration Partnership (WMIP) and the Medicare and Medicaid Integration Programs (MMIP) to the Overview section
- Determine how the Primary Care Case Management (PCCM) program should be incorporated into the Quality Strategy.
- Provide examples of how MAA incorporates its goals into the Quality Strategy. Review the MAA mission and goals to ensure that they are still appropriate in terms of how they relate to the overall DSHS and MAA strategies.
- Expand the Managed Care Organizational Structure section to include a description of TEAMonitor.
- Update the Quality Strategy to reflect the EQRO's role in evaluating the strategy. Add a Quality Strategy Standards section listing the standards that MAA must incorporate into its strategy. Describe how the Quality Strategy relates to the EQR process and ultimately to the EQR Technical Report. The Technical Report should serve as a catalyst for updating the Quality Strategy.
- Describe in the Managed Care Organizational Structure section how the five divisions of MAA interact to carry out the strategy.

Access standards

These standards address availability of services for enrollees, assurance of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. The Access standards represent more than 60 regulations, and MAA met the majority of the standards. Table 2 displays only those standards that were partially met or not met.

Table 2. Access standards partially met or not met.

Standard	Partially Met	Not Met
42 CFR §438.206(b)(5) Availability of services. *No language found in strategy.*		•
42 CFR §438.206(c)(1)(vi) Availability of services. *No language that denotes corrective action if there is a failure to comply*.		•
42 CFR §438.207(c)–(e) Assurance of adequate capacity and services. *No language found.*		•
42 CFR §438.208(b)(3) Coordination and continuity of care. *No language found.*		•
42 CFR §438.208(c)(2) Coordination and continuity of care. *Includes language regarding the MCO's responsibilities for special healthcare needs (SHCN) assessment and ongoing monitoring.*	•	
42 CFR §438.208(c)(3)(ii)–(iii) Coordination and continuity of care. *No language found that addresses timeliness of primary care provider's care plan for SHCN or utilization review standards*.		•
42 CFR §438.208(c)(4) Coordination and continuity of care. *No language in strategy about SHCN enrollees' direct access to specialists; however, this language is included in the MCO contract.*		•
42 CFR §438.210(b)(1)–(2); (d)–(e) Coverage and authorization of services. *No language referring to the role of policy and procedures with subcontracts.*		•
42 CFR §438.210(b)(2)(i)–(ii) Coverage and authorization of services. *Add language for "consistent application review."*	•	
42 CFR §438.210(d)(1) Coverage and authorization of services. *Language not found.*		•

Comments

The BBA regulations allow state Medicaid agencies some flexibility with regard to oversight of several access standards. However, it would benefit both MAA and the MCOs if MAA determined and specified the detail and type of documentation to be submitted by the MCO. For example, certification of network adequacy is not new to MCOs; however, the process of implementing routine methods to monitor under- and overutilization to determine adequate capacity and services can be challenging. Network adequacy and capacity are dynamic, and the absence of a consistent monitoring process has direct impact on the enrollee.

Required improvements

Availability of services

- Add language and expectations to address requiring the MCO to coordinate with out-of-network providers with respect to payment and ensuring that cost to the enrollee is no greater than it would be if the services were furnished within the network. *§438.206(b)(5)*
- Add language that requires MCOs to take corrective action if the standard for timely access is not met. *§438.206(c)(1)(vi)*

Assurance of adequate capacity and services

- Clarify expectations for timing of documentation for network adequacy. Consider aligning certification of network adequacy (GeoAccess Report) with the Office of the Insurance Commissioner's 2005 annual report requirement to reduce burden of duplication for the MCOs. *§438.207(c)*
- Add language stipulating that MAA is required to certify to CMS that all MCOs submit access documentation. *§438.207(d)–(e)*

Coordination and continuity of care

- Determine whether MAA needs to include the new dual eligible programs, WMIP and MMIP, into the strategy. *§438.208(a)(3)(i)–(ii)*
- Add language that MAA requires MCOs to approve treatment plans for SHCN enrollees in a timely manner that includes input of the enrollee, and that SHCN enrollees must have direct access to specialists. This language appears in the 2003–2005 Healthy Options contract. *§438.208(c)(3)(ii)–(iii); (c)(4)*

Coverage and authorization of services

- Appendix A does not state clearly that MCOs must have policies and procedures in place to ensure consistent application of review criteria for authorization decisions. The strategy also should state that the authorization process includes a consultation with the requesting provider when appropriate. *§438.210(b)(1)–(2)*
- For prior authorization review, add language that clarifies the timeframe for decisions, enrollee or provider request for extension, and expedited decisions. *§438.210(d)*
- Add language that addresses compensation for utilization management activities. *§438.210(e)*

Suggested improvements

Availability of services

- Consider incorporating examples of MCO best practice standards into the Quality Strategy. Best practice examples can be obtained from TEAMonitor reviews or literature review.
- Offer an example of supporting documentation that demonstrates the MCO's capacity to serve the expected enrollment in its service area.

Coordination and continuity of care

- Strengthen the language on implementing mechanisms to assess each enrollee. Address the fact that enrollees become SHCN enrollees after they are assigned to a plan. Will the MCO monitoring system screen for this? *§438.208(c)(2)*
- Provide examples of how MAA will provide coordination of services that enrollees receive from multiple MCOs and how MAA will share assessment information with the MCOs. *§438.208(b)(2)–(3)*

Structure and operations standards

These standards address provider selection, enrollee information, confidentiality, enrollment and disenrollment, grievance systems, and subcontractual relationships and delegation.Table 3 shows the only standard out of 20 that did not meet compliance.

Table 3. Structure and operations standards not met.

Standard	Met	Partially Met	Not Met
42 CFR §438.230(a)–(b) Subcontractual relationships and delegation.			•

Comments

Structure and operations standards address enrollee information and grievance systems, among other elements. Both sets of standards are comprehensive and require substantial oversight to ensure compliance.

Required improvements

- Add language that addresses MAA's expectations of how an MCO will evaluate a prospective subcontractor's ability to perform the activities to be delegated. The National Committee for Quality Assurance (NCQA) standards provide a good example for pre-delegation evaluation of prospective subcontractors and can be applied to all potential delegated activities. Consider providing the NCQA pre-delegation standard as MAA's recommendation. *§483.230(a)–(b)*

Measurement and improvement standards

These standards address practice guidelines, quality assessment and performance improvement programs, and health information systems.

Table 4. Compliance with measurement and improvement standards.

Standard	Met	Partially Met	Not Met
42 CFR §438.236–438.242	•		

Comments

These standards offer MAA a potential foundation on which to build an effective oversight program that would move MAA from minimum compliance to a progressive, proactive quality strategy. MAA has incorporated unique features into the managed care

program. Examples include MCO Quality Incentives, a joint TEAMonitor annual review team, and the incorporation of the NCQA quality improvement standards into the MCO contract. MAA's Quality Incentives program has a downstream effect, as MCOs are now including quality incentives in their provider contracts. Implementing these distinctive programs demonstrates MAA's desire to increase MCO satisfaction while improving access to quality health care for Medicaid enrollees.

Suggested improvements

- Describe the infrastructure MAA has developed to support the MCO oversight evaluation and activities. Consider adding a description of how MAA plans to evaluate the overall effectiveness of the Quality Strategy and the process for adopting and implementing new quality activities.

External quality review (EQR) standards

These standards address state responsibilities, EQR protocols, qualifications of EQROs, state contract options, activities related to EQR, nonduplication of mandatory activities, and EQR results.

Table 5. EQR requirements partially met.

Standard	Met	Partially Met	Not Met
42 CFR §438.358 Activities related to external quality review.		•	

Comments

EQR standards and CMS protocols require that MAA conduct an annual review of the MCO performance improvement projects and a comprehensive review every three years. It is unclear how MAA plans to determine its level of MCO oversight in the alternate comprehensive review years.

Required improvements

- Add a description of the required and optional EQR quality improvement activities that MAA is conducting. Discuss activities conducted by MAA and those that have been contracted to the EQRO. *§438.358*

Suggested improvements

- Describe the decision process that MAA uses to prioritize oversight activities and the funding of optional activities or focused studies.
- Create a quality improvement committee (QIC) responsible for overseeing the TEAMonitor audit activities. QIC members would approve the annual workplan and the scope of work for the contract year. Describe the MAA infrastructure that supports the oversight activities of the managed care contracts.
- Consider including MCO partners in a steering committee to plan the scope of work and to help identify the potential impact on MAA and MCO resources. This committee could address conclusions and recommendations from the EQR Technical Report.

Summary and Recommendations

Overall, the MAA Quality Strategy complies with the federal Medicaid rules and regulations. The required improvements address a small number of standards that were not incorporated into the 2003 Quality Strategy. The suggested improvements are offered to help MAA identify structural changes to move beyond compliance to a proactive quality strategy.

Goals

To begin this process, MAA may wish to evaluate its goals to determine whether they are relevant in the new BBA environment and whether they align with the overall strategic plan of DSHS. Optimally, MAA's goals will be incorporated throughout the Quality Strategy and used to prioritize decisions that affect the oversight design of the managed care program.

Structure of the Quality Strategy

The written quality strategy should be structured in a manner that makes it easy to understand the specific roles of the MCO and MAA. Rather than simply stating that the federal standards are incorporated into the MCO contract, MAA should list the standards and then describe how MAA designed oversight for that standard by listing the separate duties of the MCO, MAA, and the EQRO. The Minnesota Quality Strategy[1] illustrates a best practice of this structured format, defining the duties, oversight, and report and evaluation of each standard. Structuring the document in this manner would set clear expectations for both MAA and the MCO and would help MAA identify elements of its infrastructure that need to be updated to support MCO oversight activities.

Expectations for the MCO

Although BBA language gives state Medicaid agencies flexibility in achieving some managed care standards, the state can make it easier for MCOs to comply with the standards by specifying clearly what is expected of MCOs in terms of documentation and other compliance activities. MAA should consider incorporating examples of best practice standards into the Quality Strategy. However, including this level of detail would require dedicated resources.

Moving beyond compliance

In the regulatory environment surrounding implementation of the BBA standards, states and MCOs may tend to focus solely on compliance, losing sight of what the standards are meant to achieve. MAA and the MCOs already have implemented many of the BBA provisions. As they work to improve access to quality health care for all Washington Medicaid managed care enrollees, MAA can advance this goal by acting more as a partner with the MCOs, rather than as a regulator or auditor. MAA has an opportunity to

[1] http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs_id_009237.pdf

move toward a system in which MAA takes on the role of a trainer or mentor for the MCOs. This role of collaboration and partnership could have far-reaching benefits for the managed care system. Giving the MCOs a voice in shaping the managed care standards will help ensure a transparent, consistent system.

MAA and the MCOs face the challenge of complying with complex requirements while serving the most complex and vulnerable of patient populations. To meet this challenge, the parties must move from a compliance-driven relationship toward a collaborative approach, enabling the state to comply with BBA regulations in a manner that provides the highest quality health care for managed care enrollees.

2013 External Quality Review Annual Report

Washington State Healthy Options Program
Children's Health Insurance Program
Division of Behavioral Health and Recovery
Washington Medicaid Integration Partnership

December 2013

DSHS Contract No. 0834-34555

Presented by

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2013 External Quality Review Annual Report

Washington State Healthy Options

Children's Health Insurance Program

Division of Behavioral Health and Recovery

Washington Medicaid Integration Partnership

December 2013

Presented to the Washington Health Care Authority and the Division of Behavioral Health and Recovery

Timeliness of mental health care

These observations and recommendations arose from the RSN site reviews during 2013.

Strengths

- All mental health assessments for children by CDRSN's providers were completed or updated within the past year.
- Several PIPs that addressed issues related to timeliness of care earned a rating of Fully Met.
  - NSMHA's clinical PIP focused on timely access to medication evaluations through "planful discharge" in outpatient services.
  - SWBH's nonclinical PIP (initiated by Clark County RSN in 2011) tested the use of collaborative discharge planning to improve the percentage of enrollees receiving non-crisis outpatient service within seven days after discharge from an inpatient psychiatric facility.

Opportunities for improvement

Nearly one-quarter of mental health assessments for children in the clinical record review were more than a year old, and in many cases, the assessments were three to five years old. In one case, there was no current assessment for a teenager; the only assessment in the record had been conducted when the child was less than 10 years old.

- ***DBHR needs to work with the RSNs to ensure that providers update enrollees' assessments at least annually to document changes in the enrollee's functioning and life circumstances.***

One PIP related to timeliness of care continued for more than three years without demonstrating statistically significant improvement in the study indicator.

- ***RSNs need to develop PIPs with the intention of completing the project within two remeasurement periods. DBHR should review and approve any PIP extensions beyond the second remeasurement period.***

Quality of mental health care

These observations and recommendations arose from the RSN site reviews in 2013.

Strengths

- Acumentra Health's clinical record review indicated that the RSNs did an excellent job of ensuring that mental health assessments for both adults and children documented medical necessity and justified the enrollee's diagnosis.
- On the whole, RSNs' provider agencies did an excellent job of documenting in the assessments the child's living environment, support systems, and involvement in activities outside of the home.
- The majority of treatment plans reviewed were consistent with information in the assessments. Almost all treatment plans contained individualized treatment objectives and had interventions and goals that were consistent with the child's assessment. More than three-quarters of treatment plans contained strength-based activities and documented family/guardian participation in developing the plans.
- The majority of progress notes for children demonstrated the use of services based on the children's strengths.
- "Golden thread" elements were generally stronger in the children's charts than in the adult charts. However, more adult records demonstrated continuity between the progress notes and treatment plan.
- Six PIPs that focused on quality of care earned Fully Met ratings:
    - CDRSN (Permanent Options for Recovery Centered Housing program)
    - KCRSN (weight reduction in adults with severe mental illness)
    - OPRSN (consumer voice in treatment planning)
    - PRSN (weight monitoring)
    - TMRSN (wraparound services for high-risk youth)
    - TRSN (improving care coordination and improving treatment outcomes for adults with depression)

Opportunities for improvement

Although children's treatment plans typically included interventions and goals identified in the assessment, documentation in the progress notes was inconsistent. Most progress notes did not document the child's response to the interventions identified in the treatment plan or the child's progress toward meeting the goals negotiated with the child or guardian. Many notes documented only that the child or guardian was present and that discussion centered around how well the child or guardian was doing.

- ***DBHR needs to direct the RSNs to work with their providers to ensure that progress notes fully document children's treatment, including the child's response to clinical interventions and progress toward stated goals.***

Many of the PIPs related to quality of care focused on care coordination but did not provide evidence to support the validity of the selected study indicator. Several RSNs did not provide data to demonstrate the relevance of the study topic for the local Medicaid population.

- ***DBHR should establish a process to approve each RSN's PIP topics before the RSN begins implementation.***

DBHR Quality Strategy review

Acumentra Health is contracted to review DBHR's Quality Strategy every three years. DBHR submitted its current Quality Strategy to CMS in 2007, and collaborated with HCA in drafting an updated joint Quality Strategy in 2012. At the time of this review, the agencies had not yet approved the joint strategy.

Acumentra Health was directed to assess how effectively DBHR has implemented processes designed to achieve the expected outcomes stated in the 2012 Quality Strategy draft:

- Ensure compliance with federal and state statutory and regulatory requirements for quality.
- Assess and improve the quality of managed care services using performance measurement, quality initiatives, and strategic planning.
- Further integrate behavioral and physical health care for the managed care delivery systems to achieve better outcomes for enrollees.

Acumentra Health negotiated a review process with DBHR staff. During the 2013 site visits, Acumentra Health reviewers asked the following questions of staff from each RSN.

1. How does DBHR support your efforts to deliver quality care to Medicaid enrollees (as defined in the Quality Strategy)?
2. How does DBHR ensure compliance with federal and state statutory and regulatory requirements for quality, access, and timeliness?
3. What processes are in place to assess and improve the quality of care using performance measurement, quality initiatives, and strategic planning (regional and statewide performance measures, redundancy of reviews, and disparities)?
4. In your opinion, which efforts have been successful in improving quality over time? Which efforts could be improved? Do you have any suggestions to make DBHR's efforts more effective?
5. What is DBHR doing to integrate behavioral and physical health care to achieve better outcomes for enrollees?
6. In your opinion, which efforts have been successful in integrating behavioral and physical health care? Which efforts could be improved? Do you have any suggestions to make DBHR's efforts more effective?

Summary of interviews with RSNs by outcome domain

1. DBHR's support of RSNs' efforts to deliver quality care to Medicaid enrollees

RSNs' positive comments

- RSNs participate in a state-sponsored performance measure workgroup.
- DBHR has sponsored Peer Support training for RSNs and statewide meetings for child care coordinators.
- DBHR has facilitated RSNs' access to the Predictive Risk Intelligence System (PRISM) database, designed to identify high-risk Medicaid clients who would likely benefit from chronic care management.
- DBHR gives RSNs access to System for Communicating Outcomes, Performance, & Evaluation (SCOPE-WA) reports through DSHS's Mental Health Performance Indicator reporting system. SCOPE-WA is a web-based query and reporting service for mental health and substance abuse professionals across the state.

RSNs' concerns

- RSN administrators expressed concerns about the lack of a current Quality Strategy.

Oregon Health Authority Managed Care: 2016 External Quality Review Annual Report

April 2017

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Oregon Health Authority Managed Care
2016 External Quality Review Annual Report

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Table of Contents

EXECUTIVE SUMMARY 1
INTRODUCTION 7
Review Activities 7
Oregon's Coordinated Care Organizations 9
OHA's Quality Improvement Activities 10
RESULTS 15
Access 15
Timeliness 17
Quality 18
COMPLIANCE FOLLOW-UP REVIEW 22
Recommendations for OHA 36
PERFORMANCE MEASURE VALIDATION 38
Validation Results 39
Information Systems Capabilities Assessment 43
State-level ISCA review results 44
CCO-level ISCA review results 46
PERFORMANCE IMPROVEMENT PROJECTS 50
Statewide PIP: Improving the safety of Opioid Management 51
CCO-Specific PIPs and Focus Projects 57
GOBHI REVIEW RESULTS 60
DISCUSSION AND OVERALL RECOMMENDATIONS 66
APPENDIX A: CCO Profiles A-1
APPENDIX B: Statewide PIP Report B-1
APPENDIX C: Results of State-Level ISCA Follow-up Review C-1

Index of Tables

Table 1. CCOs' OHP Enrollment, December 2016 9

Table 2. Performance Measure Validation Ratings, 2016 41

Table 3. Scoring Scheme for ISCA Elements 44

Table 4. CCO-Level ISCA: Major Areas for Improvement and Recommendations. 49

Table 5. CCO-Specific PIP Topics and Objectives 58

Index of Figures

Figure 1. State-Level ISCA Scores, 2014 and 2016 45

Figure 2. Aggregated Statewide Results for ≥120 mg MED Metric from Baseline to Remeasurement Period 54

Figure 3. Aggregated Statewide Results for ≥90 mg MED Metric from Baseline to Remeasurement Period 54

Abbreviations and Acronyms Used in This Report

APD	Aging and People with Disabilities
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CCO	coordinated care organization
CHW	community health worker
CMS	Centers for Medicare & Medicaid Services
DPN	dental provider network
ED	emergency department
EDIE	Emergency Department Information Exchange
EDV	encounter data validation
EHR	electronic health record
ISCA	Information Systems Capabilities Assessment
MAT	medication-assisted treatment
MMIS	Medicaid Management Information System
NEMT	non-emergent medical transportation
OHA	Oregon Health Authority
OHP	Oregon Health Plan
PCP	primary care provider
PCPCH	patient-centered primary care home
PIP	performance improvement project
PMV	performance measure validation
QA/PI	quality assessment and performance improvement
QHOC	Quality and Health Outcomes Committee
QI	quality improvement
SBIRT	Screening, Brief Intervention and Referral to Treatment
SHCN	special health care needs

Acronyms for individual CCOs are listed on page 9.

EXECUTIVE SUMMARY

Oregon implemented coordinated care organizations (CCOs) in 2012 to deliver managed care for Medicaid recipients, following approval of the state's 1115 Medicaid Demonstration waiver by the Centers for Medicare & Medicaid Services (CMS). The current 16 CCOs manage physical, behavioral and dental health services for Oregon Health Plan (OHP) members across the state.

Federal law requires states to conduct an annual external quality review (EQR) of Medicaid services delivered through managed care. The Oregon Health Authority (OHA) contracts with HealthInsight Oregon to perform the annual EQR in Oregon. HealthInsight Oregon (formerly known as Acumentra Health) has conducted the EQR for Oregon since 2005.

The major review areas for 2016 were:

- *Compliance* with federal and state regulations and contract provisions governing managed care delivery
- *Validation of statewide performance measures*, including a full Information Systems Capabilities Assessment (ISCA) of state and CCO information systems, data processing and reporting procedures
- *Validation of performance improvement projects (PIPs)* that the CCOs conducted with the goal of improving care for OHP members, including a Statewide PIP

HealthInsight Oregon reviewed the activities of all 16 CCOs and reported the results for each CCO, identifying specific strengths and areas for improvement. This annual report summarizes the CCO reviews, focusing on common strengths and improvement needs. Detailed profiles of the individual CCO reviews appear in Appendix A.

HealthInsight Oregon also conducted a review of Greater Oregon Behavioral Health, Inc. (GOBHI), a managed mental health organization. Results of that review appear in a separate section of the report narrative.

Compliance Follow-up Review

In 2014, HealthInsight Oregon (then Acumentra Health) evaluated the CCOs' compliance with regulations and contract provisions related to enrollee rights, grievance systems and program integrity. In 2015, the compliance review

addressed quality assessment and performance improvement (QA/PI) standards. In 2016, HealthInsight Oregon followed up with CCOs regarding steps they had taken to address deficiencies identified in 2014 and 2015.

The CCOs have matured as organizations since their inception in 2012. Most have hired CCO-level administrative staff and brought functions in-house that were performed by delegates in previous years. Mental health services are now routinely integrated into the CCOs' care management services.

The CCOs have increased the number of patient-centered primary care homes (PCPCHs) and the number of enrollees served by them. According to OHA, all CCOs have met the challenge benchmark of at least 60% enrollment in PCPCHs.[1] In general, the large medical clinics have become PCPCHs. The CCOs have used transformation funds to initiate innovative projects to transform care.

Overall strengths

- All CCOs have been able to expand their delivery networks in response to Medicaid expansion by increasing practitioner caseloads and/or adding new clinics and providers.
- The CCOs have established robust care management processes.
- All CCOs have made progress in integrating physical and behavioral health care, particularly through co-location strategies.
- Most CCOs working to increase coordination and integration of dental provider networks (DPNs) through workgroup meetings with the DPNs, other CCOs and OHA.
- Most CCOs have begun monitoring their delegates for compliance with managed care requirements. A few have issued corrective action plans for noncompliance.

Major areas for improvement and recommendations

HealthInsight Oregon developed recommendations for the individual CCOs and for OHA to help the CCOs address their improvement needs. Some general recommendations appear below.

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[1] Oregon Health Authority. Oregon's Health System Transformation: CCO Metrics 2015 Final Report. June 2016. Available online: https://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf.

Service integration. Overall, the CCOs have made progress in transitioning to fully integrated care delivery systems, having added dental care and non-emergent medical transportation (NEMT) services to their benefit plans during 2014–2015. However, integration and standardization across physical, behavioral and dental health services remain incomplete. Lack of integrated data systems creates a barrier to care management, especially for enrollees with special health care needs (SHCN).

To date, integration has occurred mainly at the practice level in the PCPCHs where behavioral health staff are embedded. CCOs continue to identify the need to improve communication between primary care and mental health. In many cases, dental care remains a separate service delivery system.

For the majority of CCOs, member grievances indicate significant concerns related to access to NEMT services. Members have not made it to their appointments or have arrived late, creating barriers to receiving care. Some CCOs are addressing these concerns through technical assistance and corrective action plans.

- ***OHA needs to continue to support the CCOs in developing integrated policies and procedures, data systems, network and capacity planning and care coordination for all required services.***

Oversight of delegated functions. Since the delegation readiness review in 2013, the CCOs have been clarifying the roles and responsibilities of their partners and delegates. Continuing work is needed to ensure that delegated functions are performed as required by the managed care contract. The CCOs need to revise their delegation agreements to clearly specify delegate performance expectations. CCOs also need to establish mechanisms to conduct oversight activities, and take action when delegates' and partners' performance is lacking.

Certifications and program integrity. All CCOs are working toward effective compliance programs. Many CCOs monitor and audit internal and external risks. However, some CCOs incur significant risk by not screening key personnel monthly for exclusion from federal health care programs, not performing criminal background checks and not monitoring gifts, gratuities and vendor compensations and relationships.

- ***OHA needs to clarify its expectations for CCOs to screen key personnel for exclusion from federal health care programs, conduct criminal background checks and monitor for conflicts of interest to reduce CCOs' overall risk.***

For more details, see the compliance review section beginning on page 22.

Performance Measure Validation (PMV)

Of the state's 17 incentive performance measures for CCOs, 7 measures were calculated using only encounter data that OHA collects and maintains. Per OHA's direction, HealthInsight Oregon validated those seven measures, seeking to determine whether the data used to calculate the measures were complete and accurate and whether the calculation adhered to CMS specifications.

The associated ISCA activities examined state and CCO information systems and data processing and reporting procedures to determine the extent to which they supported the production of valid and reliable performance measures.

PMV results

HealthInsight Oregon assigned a "substantially met" score to all seven measures reviewed. In past years, performance measures have been scored as "partially met" because of concerns about data integrity and completeness and about a limited and undocumented validation process. The 2016 PMV found that OHA has made substantial improvements in both areas. The state's code review and measure calculation process was adequate, but HealthInsight Oregon remains concerned about the validity of the data used to calculate the measures.

Among other recommendations, HealthInsight Oregon recommends that OHA either conduct an encounter data validation (EDV) or require the CCOs or a third party to conduct an EDV, to ensure that complete and valid encounter data are submitted to OHA.

For additional details, see pages 38–42.

ISCA results

HealthInsight Oregon conducted a full ISCA review of OHA's data management and reporting systems and those of the individual CCOs.

The state ISCA review found that OHA continues efforts to strengthen its infrastructure and IT processes and procedures by performing daily backups of Medicaid data and replicating the backups to an offsite location. OHA reported continuing efforts to expand server, database and storage capability to handle workload increases due to Medicaid expansion. CCOs reported that OHA continues to improve the integrity of member eligibility data sent to the CCOs. OHA continues working to address issues related to:

- maintenance and ongoing support for Medicaid Management Information System hardware and software
- expanding the teams responsible for processing, reviewing and auditing the CCOs' claims and encounter data
- inconsistencies in data submission by the CCOs
- regular review and updating of policies, procedures and business continuity/disaster recovery plans

Overall, the individual CCOs have made significant progress in integrating all required services and associated claims/encounter data into their IT systems. Most CCOs have successfully integrated mental health and dental data into their IT systems and reporting. Some CCOs have integrated data on NEMT services, while others are still working toward that goal. To perform appropriate monitoring and oversight of in-house and outsourced IT services, the CCOs need to improve their understanding of service authorization processes, eligibility data flow and data validation for all services.

HealthInsight Oregon developed recommendations for OHA to work with the CCOs on specific issues related to IT systems integration, encounter data certification, delegated IT activities and responsibilities, disaster recovery plans, provider directories and zero- and low-dollar claims. See the ISCA section beginning on page 43.

Appendix C presents detailed results of the state ISCA review. The CCO profiles in Appendix A summarize the results of each CCO's ISCA review.

CCO Performance Improvement Projects (PIPs)

The managed care contract requires the CCOs to conduct PIPs that are "designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and nonclinical areas that are expected to have favorable effect on health outcomes and OHP Member satisfaction." The CCOs must conduct three PIPs and one focus study targeting improvements in care in designated quality improvement (QI) focus areas. One of the required PIPs is being conducted as a statewide collaborative and addresses the integration of primary care and behavioral health.

Statewide PIP

The first Statewide PIP (2013–2015) addressed monitoring for diabetes in people with schizophrenia or bipolar disorder. The second Statewide PIP focuses on improving the safety of prescription opioids, using a dosing threshold as the study indicator. The CCOs are measuring the percentage of their members age 12 years and older with opioid prescriptions for ≥120 mg and for ≥90 mg morphine equivalent dosage per day. Individual CCOs have the option of measuring one or both of the dosage thresholds.

HealthInsight Oregon is responsible for facilitating and documenting the overall PIP in accordance with CMS guidelines. CCOs are responsible for developing their own interventions and for documenting their progress in quarterly reports submitted to OHA. At the end of the first remeasurement period (January 1–December 31, 2016), HealthInsight Oregon evaluated each CCO's fulfillment of the criteria for PIP Standard 8 (Improvement Strategies).

The CCO profiles in Appendix A report each CCO's interventions, barriers and next steps for the Statewide PIP, as well as the topics of additional PIPs and focus projects the CCO conducted in 2016. Appendix B reports the interim results of the Statewide PIP.

INTRODUCTION

The Balanced Budget Act of 1997 (BBA) requires an annual EQR in states that use a managed care approach to provide Medicaid services. OHA contracts with 16 CCOs, and with GOBHI, to deliver services to OHP members through managed care. In turn, the CCOs contract with physical and mental health, addiction treatment and dental service providers, and with pharmacy management companies and hospitals, to deliver care. Each CCO is responsible for ensuring that services are delivered in a manner that complies with legal, contractual and regulatory obligations to provide effective care.

Review Activities

BBA regulations specify three mandatory activities that the EQR must cover in a manner consistent with protocols established by CMS:

- a review every three years of health plan compliance with federal and state regulations and contract provisions regarding access to care, managed care structure and operation, quality measurement and improvement and program integrity
- annual validation of PIPs, a required element of health plans' QI programs
- annual validation of performance measures reported by plans or calculated by the state, including an ISCA

HealthInsight Oregon and the CCOs completed the first three-year cycle of EQR reviews in 2016. The reviews have covered each CCO's compliance with standards for Enrollee Rights, Grievance Systems, Certifications and Program Integrity and QA/PI. HealthInsight Oregon has conducted two full ISCA reviews of OHA and CCO information systems, and has reviewed and scored the CCOs' work on two Statewide PIPs.

In 2016, HealthInsight Oregon followed up with CCOs on the results of the 2014 and 2015 compliance reviews; conducted PMV-related activities, including full ISCA reviews; facilitated and documented the Statewide PIP, and began evaluating CCO-specific PIPs and providing feedback to OHA. These review activities addressed the following questions:

1. Does the CCO meet CMS regulatory requirements?
2. Does the CCO meet the requirements of its contract with OHA?

3. Does the CCO monitor and oversee contracted providers in their performance of any delegated activities to ensure regulatory and contractual compliance?
4. Does the CCO conduct effective interventions for the Statewide PIP?
5. Do the CCOs' information systems and data processing and reporting procedures support the production of valid and reliable state performance measures and the capacity to manage the health care of enrollees?

Each section of this report describes the procedures used to assess the CCO's compliance with CMS standards related to the specific EQR activity. Procedures were adapted from the following CMS protocols and approved by OHA:

- *EQR Protocol 1: Assessment of Compliance with Managed Care Regulations*, Version 2.0, September 2012
- *EQR Protocol 3: Validating Performance Improvement Projects (PIPs)*, Version 2.0, September 2012
- *Appendix V: Information Systems Capabilities Assessment*, September 2012

General procedures, adapted from the CMS protocols, consisted of these steps:

1. The CCO received a written copy of all interview questions and documentation requirements prior to onsite interviews.
2. The CCO used a secure file transfer site to submit requested documentation to HealthInsight Oregon for review.
3. HealthInsight Oregon staff visited the CCO to conduct onsite interviews and provided each CCO with an exit interview summarizing the results of the review, or conducted telephone interviews for follow-up reviews.
4. HealthInsight Oregon weighted the oral and written responses to each question and compiled results.

The scoring plan for each activity was adapted from CMS guidelines. Oral and written answers to the interview questions were scored by the degree to which they met regulatory- and contract-based criteria, and then weighted according to a system developed by HealthInsight Oregon and approved by OHA.

Oregon's Coordinated Care Organizations

Nearly 9 out of 10 OHP members receive managed care through a CCO. After extending Medicaid coverage to additional Oregonians as authorized by the federal Affordable Care Act, OHP now covers more adults (60%) than children (40%). Table 1 displays the current CCOs and their enrollment totals as of December 2016.

Table 1. CCOs' OHP Enrollment, December 2016.

CCO	Total Enrollees
AllCare Health Plan	48,005
Cascade Health Alliance (CHA)	16,787
Columbia Pacific CCO (CPCCO)	24,605
Eastern Oregon CCO (EOCCO)	45,097
FamilyCare CCO	114,314
Health Share of Oregon (HSO)	210,001
Intercommunity Health Network (IHN)	52,862
Jackson Care Connect (JCC)	28,970
PacificSource Community Solutions–Central Oregon (PSCS-CO)	46,956
PacificSource Community Solutions–Columbia Gorge (PSCS-CG)	11,899
PrimaryHealth of Josephine County (PHJC)	10,383
Trillium Community Health Plan (TCHP)	88,347
Umpqua Health Alliance (UHA)	25,000
Western Oregon Advanced Health (WOAH)	19,739
Willamette Valley Community Health (WVCH)	94,915
Yamhill Community Care Organization (YCCO)	24,160
Total	**862,040**

Source: Oregon Health Authority. Oregon Health Plan: Coordinated Care, Managed Care and Fee for Service Enrollment for December 15, 2016.

OHA's Quality Improvement Activities

OHA's Quality and Health Outcomes Committee (QHOC) convenes monthly meetings of CCOs' clinical leadership to coordinate QI efforts that support the implementation of innovative health care practices. Learning collaboratives for CCO leaders and community partners provide peer-to-peer learning experiences, education by subject matter experts and QI strategies.

OHA's Transformation Center is the innovation and QI hub for Oregon's health system transformation efforts. The center offers Transformation Fund Grant Awards to CCOs to support innovations in health care delivery. All 16 CCOs have received such grants to support a wide range of projects, which are summarized on the OHA website.[2]

The Transformation Center administers the Patient-Centered Primary Care Home program, which provides technical assistance to help primary care clinics transform to PCPCHs, and works with stakeholders across Oregon to support adoption of the PCPCH model. OHA requires the CCOs to include PCPCHs in their care delivery networks to the extent possible.

The center issues semiannual reports on the CCOs' performance on key quality and financial measures. The mid-2016 update reported ongoing improvements in areas such as developmental screening for young children, PCPCH enrollment and reduced hospital admissions for asthma and chronic obstructive pulmonary disease, while other measures show room for improvement.[3] The center provides targeted technical assistance to CCOs on specific incentive measures.

OHA reports to the legislature regularly on the progress of Oregon's health care transformation. OHA's quarterly legislative report presents data related to OHP demographics, CCO performance on quality metrics, member satisfaction, health disparities, finance, PCPCHs, eligibility and enrollment and other topics.[4]

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[2] See http://www.oregon.gov/oha/Transformation-Center/Documents/Transformation-Fund-Final-Report.pdf.

[3] Oregon Health Authority, Office of Health Analytics. Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report. Available online: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf.

[4] Oregon Health Authority. Oregon's Health System Transformation Quarterly Legislative Report, Q2 and Q3 2016. Available online: https://www.oregon.gov/oha/analytics/Documents/LegislativeReport_Q2-Q3_2016.pdf.

Managed care quality strategy

42 CFR §438.202 requires each state Medicaid agency contracting with managed care organizations to develop and implement a written strategy for assessing and improving the quality of managed care services. The strategy must comply with requirements of the U.S. Department of Health and Human Services.

CMS renewed Oregon's 1115 Medicaid Demonstration waiver in January 2017. The state has committed to continuing and expanding all elements of the 2012 waiver related to integration of behavioral, physical and oral health, with a new focus on social determinants of health, population health and quality of care.

OHA's Quality Strategy describes how CCOs will be held accountable for a model of care that relies on increased transparency, clear expectations and incentives for improvement. Key elements have included creation of the Transformation Center and Innovator Agents; learning collaboratives and technical assistance; health equity initiatives to reduce disparities; and use of PCPCHs, community advisory councils, community health workers (CHWs) and alternative payment models.

Behavioral health initiatives

OHA developed its 2015–2018 Behavioral Health Strategic Plan with input from state mental health advisory committees and stakeholders across Oregon. The plan identifies six strategic initiatives aimed at building and expanding an integrated, coordinated and culturally competent behavioral health system. Key principles include health equity, access to care, behavioral health promotion and prevention, and supporting successful recovery in the community.[5]

In late 2016, OHA received a two-year demonstration grant award to establish Certified Community Behavioral Health Clinics (CCBHCs), as part of an eight-state demonstration program representing the single largest federal investment in community behavioral health in more than 50 years. The CCBCHs will serve adults with serious mental illness, children with serious emotional disturbance and those with long-term and serious substance use disorders, as well as others with mental illness and substance use disorders.

5 Oregon Health Authority. 2015–2018 Behavioral Health Strategic Plan. November 2014. Available online: http://www.oregon.gov/oha/amh/Pages/strategic.aspx.

OHA and its state agency partners have implemented the System of Care Wraparound Initiative in all regions of the state, providing services and supports for youth with complex behavioral health needs. Wraparound is an intensive care coordination process for young people involved in multiple child-serving systems, e.g., mental health, addictions, child welfare, developmental disabilities, juvenile justice and special education. The wraparound approach builds on each youth's and family's strengths and needs to develop an individualized plan for services and care coordination.

According to OHA, the wraparound initiative has delivered better outcomes at lower cost by supporting the integration and reorganization of state-funded services. CCOs coordinate local activities and are reimbursed for wraparound services under capitation.

Consumer surveys

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

OHA uses CAHPS survey results to evaluate two CCO incentive measures—access to care and satisfaction with care—as well as for statewide measures of tobacco use and member health status.

Mental health services surveys

On behalf of OHA, HealthInsight Oregon conducts the annual Mental Health Statistics Improvement Program (MHSIP) Consumer Survey for Adults, the Youth Services Survey for Families (YSS-F) and the Youth Services Survey (YSS).[6] OHA adds questions to each survey to collect additional data to help evaluate the progress of ongoing programs. Survey participants have the option to complete the survey online or on paper.

Adult survey results. In 2016, Acumentra Health distributed a survey to adults who had received outpatient mental health services through OHP, and to adults in residential treatment programs or foster care, during July–December 2015. The survey was mailed to 9,280 adults who had received outpatient services and

[6] MHSIP is supported by the Substance Abuse & Mental Health Services Administration of the U.S. Department of Health and Human Services. The YSS-F is endorsed by the National Association of State Mental Health Program Directors.

1,507 adults in either residential or foster care. In all, 1,046 adults returned surveys, for a response rate of 18%, down from 19% the previous year.[7]

The survey probed issues related to services in seven domains defined by MHSIP: general satisfaction, access to services, service quality, daily functioning, social connectedness, treatment participation and treatment outcomes.

Percentages of respondent satisfaction in most domains have been relatively consistent since 2012, though the percentage of those satisfied in the daily functioning domain has trended significantly upward. In 2016 as in previous years, outpatient respondents were less satisfied in most domains than were respondents in foster care and residential care; the differences were significant in treatment outcomes, daily functioning and social connectedness. In certain domains, the survey also revealed significantly different long-term trends in satisfaction depending on respondents' age and gender.

Youth survey results. The YSS-F asked about caregivers' perception of services delivered for their children during May–December 2015 in seven domains: access to services, appropriateness of services, cultural sensitivity, daily functioning, family participation in treatment, social connectedness and treatment outcomes. The YSS-F had an overall response rate of 23%, higher than in 2015 but similar to previous years, with 3,212 responses from caregivers of 13,794 children.[8]

The YSS asked young people age 14 to 18 years about their perceptions of services they received. The YSS, like the YSS-F, included a cluster of questions designed to assess the youths' perceptions of various aspects of access, appropriateness, cultural sensitivity, participation and outcomes. The YSS also asked young people about where they had lived in the past six months, school absences, utilization of health care services, medication for emotional/behavioral problems and arrest history. The YSS received 1,025 responses from 5,714 adolescents who received a survey, for an overall response rate of 22%, higher than the 2015 response but similar to other recent years.

Reported satisfaction in all YSS-F domains increased slightly in 2016. Satisfaction in the cultural sensitivity, outcomes and social connectedness domains has

7 HealthInsight Oregon. 2016 Oregon Mental Health Statistics Improvement Project Survey for Adults–Outpatient and Residential. March 2017.

8 HealthInsight Oregon. 2016 Oregon Youth Services Survey for Families and Youth Services Survey Report. January 2017.

trended significantly upward since 2012. Satisfaction with access to residential and day treatment services was significantly lower in 2016 than satisfaction with outpatient access, although satisfaction with treatment outcomes and daily functioning has trended significantly higher in the past five years.

Looking at the YSS, the percentage of young respondents who were satisfied with their treatment outcomes has shown a significant downward trend over the past five years. While satisfaction in other domains has fluctuated from year to year, none has showed a significant upward or downward trend.

RESULTS

Federal regulations identify *access* to care and the *quality* and *timeliness* of care as the cornerstones of EQR analysis (42 CFR §438.320). However, no standard definitions or measurement methods exist for access, timeliness and quality. HealthInsight Oregon used contract language, definitions of reliable and valid quality measures and research literature to guide the analytical approach.

Access is the process of obtaining needed health care; thus, measures of access address the enrollee's experience *before* care is delivered. Access depends on many factors, including availability of appointments, the enrollee's ability to see a specialist, adequacy of the health care network and availability of translation and transportation services.

Timeliness can affect service utilization, including both the appropriateness of care and over- or underutilization of services. Presumably, the earlier an enrollee sees a health care professional, the sooner he or she can receive needed services. Postponing needed care may result in increased hospitalization and utilization of crisis services.

Quality encompasses access and timeliness as well as the *process* of care delivery (e.g., use of evidence-based practices) and the *experience* of receiving care. Although enrollee outcomes also can serve as an indicator of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as enrollees' adherence to treatment.

Access

Strengths

- All CCOs experienced large increases in enrollment in 2014 due to Medicaid expansion. The CCOs continue to make progress in expanding access to primary care, behavioral health care and dental care, and in providing specialists to meet members' needs. Strategies for improving access include:
    - co-locating mental health and substance use disorder treatment practitioners in primary care clinics
    - co-locating physical health practitioners in mental health clinics (behavioral health home/CCBCH model)

  - co-locating dental care at some clinics and school-based health centers
  - authorizing timely out-of-network services when needed
  - using geo-access software to identify participating and non-participating providers in relation to members' addresses

- All CCOs have met the incentive measure for PCPCH enrollment. As of December 2016, there were more than 630 recognized PCPCHs in Oregon. In 2016, the program began transitioning from a three-tier to a five-tier designation to encourage clinics to continue to transform care.

Areas for improvement

- CCOs continue to struggle with integrating dental care into their delivery systems. Many CCOs and DPNs have taken formal steps to work together to integrate care and meet managed care requirements.
- Member grievances have identified access issues related to NEMT services—providers not providing rides, late pickups leading to missed appointments, lack of communication—as a significant concern. Some CCOs have implemented training, technical support and corrective action plans to address these issues.
- More work is needed to improve access to care in rural areas, and to improve processes for identifying and coordinating care for members with SHCN. Some CCOs have employed strategies such as increasing after-hours availability, using mobile units to serve rural communities and recruiting and retaining additional providers. A few CCOs have enhanced their networks by contracting with nonparticipating providers willing to serve members with SHCN.

  CCOs need to continue to work toward ensuring access to services for all enrollees.

- During 2016, most CCOs did not monitor contractual requirements for provider network access. Some CCOs lacked system-wide mechanisms to monitor network capacity to ensure access to all required services.

  CCOs need to monitor the capacity of their entire service delivery networks to ensure an appropriate distribution of services and to identify service gaps or disparities.

- Few CCOs' policies and procedures for providing direct access to specialists address access to behavioral health and dental care specialists.

  The CCOs need to develop overarching policies regarding direct access to specialists in all service categories.

- As of mid-2016, the majority of CCOs reported a decrease in childhood and adolescent access to primary care providers. No CCOs met the benchmark for this performance measure.
- Although health assessments for children in DHS custody generally increased, no CCOs met the benchmark for this incentive measure.

Timeliness

Strengths

- Most CCOs have reduced avoidable emergency department (ED) utilization. With OHA support, all CCOs are working to adopt the use of PreManage (real-time notifications to CCOs when their members have ED or inpatient hospital events) and the Emergency Department Information Exchange (EDIE). Alerting care coordinators/case managers to members' hospital visits enables timely care coordination and discharge planning.
- As of mid-2016, most CCOs exceeded the incentive measure benchmark for developmental screening in the first 36 months of life.
- Most CCOs have developed policies and procedures addressing the required time frames for informing members of service authorization decisions, and have begun monitoring their delegates to ensure the timeliness of routine and expedited authorization decisions.

Areas for improvement

- Most CCOs do not closely monitor the timeliness of access to routine, urgent and emergent mental health services, substance use disorder treatment, dental care or NEMT services.
- Although avoidable ED utilization has declined, most CCOs reported an increase in overall ED utilization from 2015 to mid-2016.

  CCOs need to monitor the timeliness of access to routine, urgent and emergent care across the entire service delivery network.

- Some CCOs still lack mechanisms to ensure that their delegates are screening practitioners on a monthly basis for exclusion from participation in federal health care programs.

  CCOs need to ensure that all partners, delegates and downstream entities perform monthly screening for exclusion from participation in federal health care programs.

Quality

Strengths

- All CCOs made progress on **integrating physical, behavioral and dental health care** during 2016.
  - Some CCOs have hired behavioral health managers, dental managers and administrative staff to help facilitate service integration. Many CCOs are participating in workgroups with the DPNs to coordinate expectations, regulations and requirements.
  - Several CCOs meet monthly with mental health and substance use treatment providers and Aging and People with Disabilities (APD) staff. Some CCOs jointly develop care plans for enrollees engaged in care with multiple systems. All CCOs' care management staff follow up on enrollee referrals to specialists.
- All CCOs provide robust **care management**.
  - All CCOs use interdisciplinary teams to guide care coordination efforts. These teams represent primary care, mental health, dental care, law enforcement, APD, home health, substance use disorder treatment and enrollees and their family members.
  - CCO staff members regularly meet with community partners to better coordinate care for members with complex needs.
- Many CCOs have invested in predictive modeling programs for **population management**. Some use this resource to guide care coordination and utilization management and to address the needs of high-cost/high-utilizing enrollees. A few CCOs have developed fully integrated data warehouses that encompass medical, mental health, substance use disorder, pharmacy and dental services.

- Many CCOs have made strides in the areas of **health equity and cultural considerations**.
  - Some CCOs have recruited culturally specific providers to fill identified gaps in their service array.
  - Many CCOs have recognized the importance of using qualified and certified health care interpreters. Training has been provided statewide. Many CCOs use CHWs as certified health care interpreters.
  - One CCO, in partnership with a local health care coalition, trains providers on health equity and diversity. This CCO has created a Health Equity and Inclusion action team to focus on related initiatives across the provider network.
  - One CCO meets monthly with mental health directors and the Alliance of Culturally Specific Behavioral Health Providers and Programs to promote routine communication of unmet needs, outreach and engagement strategies, emerging best practices and new program development for specific populations.
- CCOs are **employing CHWs as practice extenders**. Some CCOs assign these workers to enrollees with high utilization to reduce inappropriate use of the emergency room.
- All CCOs take part in the Statewide PIP to **improve the safety of opioid management**. This PIP has assisted the CCOs in implementing strategies to reduce inappropriate prescribing of opioids, developing practice guidelines related to opioid prescribing and collaborating within their communities to reduce inappropriate use of opioids and offer alternative treatment options for members with chronic pain.

Areas for improvement

- **Care integration.** The CCOs have made progress toward care integration, but more work is needed.
  - *Policies/procedures and provider manuals.* Most CCOs' policies and manuals do not address integrated care. For example, policies and procedures need to address second opinions not only in primary care but in mental health, substance use disorder treatment and dental care. Many CCOs lack overarching policies covering all contractual and

regulatory requirements. Policies need to be approved by a CCO-level authority, and all providers need to be guided on how the CCO expects compliance issues to be handled.

CCOs need to ensure that all partners and delegates are aware of the expectations for care integration, and that services delivered across the entire network are aligned with the CCOs' policies and procedures.

- *Mental health and dental care.* Policies and practices for integrating these services into the CCOs' delivery networks have lagged. In many CCOs, mental health provider agencies amount to a separate specialty care delivery system. In some cases, the DPNs are fully autonomous with little CCO oversight.

CCOs need to continue to work on integrating mental health and dental care at the administrative and service delivery levels, and on integrating these services into the CCOs' electronic clinical data systems.

- *Practice guidelines.* Most CCOs' practice guidelines address only physical health. Practice guidelines for behavioral health or dental care are not integrated into the CCOs' processes for development, review, approval and dissemination of guidelines.

CCOs need to integrate mental health, substance use disorder treatment and dental health practice guidelines into their clinical infrastructure.

- **Delegation oversight:** Many CCOs lack mechanisms to monitor certain functions that are delegated to partners and providers. The CCOs exercise limited oversight of functions delegated to the DPNs.
  - *Utilization management.* Most CCOs lack mechanisms to ensure that review criteria are applied consistently when authorization decisions are made by delegates.
  - *Care coordination.* Most CCOs do not oversee the delivery of mental health, substance use disorder treatment and dental care for members with SHCN.
  - *Credentialing.* The CCOs conduct little oversight of the credentialing activities delegated to mental health agencies or DPNs. Most CCOs rely on the state's certification of licensed mental health practitioners to ensure that those providers are qualified to deliver care for CCO

enrollees. Most CCOs have delegated dental credentialing to the DPNs and have not developed mechanisms to monitor this function.

CCOs need to work with their partners and delegates to clarify expectations and increase oversight of activities delegated to the partners and other entities.

- *Data integration.* The CCOs have made progress in integrating data on physical, behavioral and dental health services. However, more work is needed to ensure that CCOs can use the data to manage the care delivered to enrollees, including those with SHCN.

  Each CCO needs to continue to work toward developing a single data repository to support integrated care across the delivery network.

COMPLIANCE FOLLOW-UP REVIEW

In 2014, HealthInsight Oregon (then Acumentra Health) reviewed the CCOs' compliance with federal and state regulations and contract provisions related to enrollee rights, grievance systems and program integrity. In 2015, the review covered compliance with QA/PI standards.

In 2016, HealthInsight Oregon followed up with each CCO regarding steps it had taken to address its 2014 and 2015 compliance findings and recommendations. In the past, HealthInsight Oregon followed up only on findings, but this year followed up on recommendations and findings at OHA's request.

The following results reflect the status of CCOs' compliance with specific standards as of 2016.

Enrollee Rights

This section of the compliance protocol assesses the degree to which the CCO has written policies in place on enrollee rights, communicates annually with enrollees about those rights and makes that information available in accessible formats and in language that enrollees can understand.

Major strengths

Member information. All CCOs had an integrated enrollee handbook. Many handbooks were well-designed and visually appealing. Most of the CCOs' websites offered member handbooks in both English and Spanish. Some websites posted the CCO's policies and procedures, grievance process and forms, provider manuals and educational materials. A few CCOs issued member newsletters with information about enrollee rights.

The CCOs informed enrollees of their rights through "welcome" calls to new members and by employing health navigators to help members with complex needs obtain care. The CCOs provided member information in appropriate formats and languages to meet members' needs.

Provider communication. All CCOs worked with providers to ensure that they knew about and honored enrollee rights. Many CCOs held provider orientations and trainings related to enrollee rights. Some CCOs met often with providers, hospital discharge planners and provider office staff to review enrollee rights.

Some CCOs visited provider offices to assess access to appointments, access to medical records and privacy. One CCO distributed the results of member/patient satisfaction surveys to providers.

Customer service. Many CCOs provided training for customer service and other staff on enrollee rights. Most CCOs monitored customer service calls to evaluate whether the calls were handled in an appropriate and timely manner.

Member satisfaction. The CCOs used a variety of methods to gather input from members about their satisfaction with services and to identify service gaps. The CCOs closely monitored CAHPS survey scores on overall customer satisfaction with care quality and access.

Cultural diversity and competency. Many CCOs had initiated cultural diversity and competency strategies. One CCO convened a workgroup to explore health equity. Other CCOs established diversity and equity committees and learning sessions for providers, or conducted annual diversity training.

Seclusion and restraint. During credentialing and recredentialing, most CCOs asked to see providers' policies on the use of seclusion and restraint.

Major areas for improvement

Monitoring of enrollee rights. In general, the CCOs lacked mechanisms to monitor enrollee rights across all service categories. More work is needed in the following areas.

- *Respect, dignity and privacy.* Most CCOs lacked a process to monitor their delegates and providers to ensure that they are honoring members' rights to be treated with respect and consideration for dignity and privacy.
- *Advance directives and mental health treatment declarations.* Most CCOs lacked mechanisms to monitor for the presence of these directives for members and to ensure that providers knew about and observed these directives.
- *Seclusion and restraint.* Most CCOs did not monitor providers' and facilities' use of seclusion and restraint to ensure that members were free from the use of these high-risk activities as a means of coercion, discipline, convenience or retaliation.

Information about providers. Many CCOs' provider directories lacked required information for all services, particularly mental health, such as individual

practitioners' names, addresses, specialties, language capacities and whether practitioners were accepting new enrollees.

Many CCOs had posted provider directories on their websites. However, when tested, many websites proved incomplete. This was particularly true for mental health and dental services. Most CCOs listed mental health agencies without a mechanism to provide the required information for an individual practitioner. Very few CCOs listed individual dentists; often the enrollee was directed to call the dental organization or was routed to the dental organization's website. CCOs need to ensure that provider directories are available, easily searchable and contain the required elements.

Lack of integrated policies and procedures. Integration of CCO policies and procedures across all service areas remains incomplete. Many of the CCOs' physical health policies and processes addressed enrollee rights requirements, but those policies often did not refer to mental or dental health.

Grievance Systems

This review section evaluates the CCO's policies and procedures regarding grievances and appeals, state fair hearings and the CCO's process for monitoring adherence to mandated timelines.

Major strengths

Most CCOs had robust grievance systems for physical health. Systems were in place to elevate grievances to the highest clinical or administrative level within the organization as necessary. Most CCOs investigated grievances thoroughly and conducted thorough analyses. Grievance reports were routinely reviewed in QI committee meetings. When a trend was identified, the CCO might modify an internal process or coach a provider or the provider's office staff. A few CCOs followed up with enrollees to ensure that they were satisfied with the handling of their grievances.

Working with providers. Most CCOs used a sequential process to address quality-of-care grievances. This process might begin with coaching the provider and lead to corrective action for noncompliance. Most CCOs incorporated quality-of-care concerns into provider recredentialing reviews. The CCOs were working with DPNs and NEMT vendors to ensure that grievance processes were in place that met state requirements and CCO expectations.

Delegation and monitoring of grievances. Most CCOs had established systems to monitor and oversee their delegates' grievance systems. A few CCOs handled all grievances rather than delegating grievances to mental health or dental care providers. Other CCOs met with delegates to review grievances and appeals.

The CCOs have made progress with monitoring grievances in all service areas. Most CCOs have developed processes to monitor the resolution and disposition of grievances and appeals, and to monitor the timeliness of member notices that are delegated to providers. Most CCOs reviewed all or a sample of notice-of-action (NOA) letters sent to members, and were working to ensure that NOA letters issued by delegates were written in easily understood language.

Integrated policies and procedures. Most CCOs had developed policies defining the timing of notices for termination, suspension or reduction of previously authorized Medicaid-covered services, as well as the exceptions for providing notice to members. Most had policies and procedures on the time frames for authorization decisions and for expedited authorization decisions.

Adjudication of final appeals. Most CCOs adjudicated final appeals as required by the OHA contract, though they often relied on their delegates' expertise.

Major areas for improvement

Lack of updated, integrated policies and procedures. Although improvements have been made, in many instances the CCO's physical health policies and procedures related to grievances had not been updated to incorporate mental health and dental services.

Discrepancies in handling grievances for physical and mental health. Many CCOs did not demonstrate that their grievances were handled consistently across all service categories. In particular, very few mental health grievances were reported. More work is needed to bring the two systems into alignment regarding how members' expressions of dissatisfaction are handled.

In some instances, members did not receive a grievance resolution letter that detailed the concern and the CCO's response. Several CCOs routinely extended the time frame for resolving grievances without notifying the member. More work is needed to ensure that enrollees are appropriately informed about how the CCO handles their quality-of-care concerns.

In most instances, mental health providers issued few NOA letters because the providers rarely denied services. The providers' position is that if care is not denied in the amount, duration or scope requested, no NOA is required. More work is needed to determine whether this reflects differences between the two service sectors in terms of practice patterns, culture or the definitions of denial, termination, suspension or reduction in service.

Language in NOA letters. Almost all CCOs continued to struggle with ensuring that NOA letters were written in easy-to-understand language. The NOA letters often contained medical jargon, abbreviations and/or vague denial reasons such as "not medically appropriate," procedure "above the line" or "you are not likely to benefit from the procedure." More work is needed to make sure that members understand why a certain procedure is denied. A few CCOs had enlisted their citizen advisory boards to help in this effort.

Monitoring. Some CCOs performed no monitoring to ensure that their delegates acknowledged grievances in writing. Although great strides have been made, the CCOs need to continue to work with their partners and delegates to ensure that the grievance system is implemented consistently across all service types.

Certifications and Program Integrity

This section of the review protocol is designed to assess whether the CCO has systems in place to avoid conflicts of interest; mechanisms to verify that persons and entities are not excluded from participating in Medicaid programs; and administrative and management arrangements or procedures, including a compliance plan, designed to guard against fraud and abuse.

Major strengths

Most CCOs had developed compliance programs that addressed the required elements. Most CCOs conducted external audits, and a few conducted internal audits of all departments, enabling those CCOs to conduct an annual evaluation of the effectiveness of their programs. All CCOs had a compliance officer with direct access to the governing board. A few compliance officers were certified in health care compliance or held other compliance-related certifications.

Compliance training. All CCOs conducted annual compliance training for employees. Many CCOs provided training for their boards of directors, and some also held training for providers. Many CCOs required board members to

complete conflict-of-interest attestations, and some extended that requirement to staff. A few CCOs included constraints against vendor gifts and gratuities in their codes of conduct.

Screening for exclusion. Most CCOs' credentialing and recredentialing of licensed providers included screening for exclusion from participation in federal health care programs. Most CCOs conducted screening monthly. A few screened non-contractor providers for exclusion before paying those providers' claims.

Major areas for improvement

Conflict-of-interest disclosures. Although all CCOs had compliance policies and procedures, many policies omitted at least one required disclosure. Conflict-of-interest disclosures often applied to governing board members but not to CCO staff or delegates. Many CCOs addressed vendor gifts and gratuities on some level, while others lacked guidelines for staff and governing board members. More work is needed to ensure that providers, subcontractors, staff and governing board members disclose conflicts of interest.

Inadequate monitoring. Some CCOs did not monitor governing board members or non-licensed staff and providers for exclusion from participation in federal health care programs. Some CCOs screened for exclusion upon hire or at recredentialing, rather than monthly. More work is needed to ensure that no Medicaid funds are used to pay for services provided by individuals or facilities on the exclusion list.

Delivery Network

This section of the compliance protocol assesses the degree to which the CCO establishes, maintains and monitors a network of providers, ensures adequate and timely access to all services covered under contract and provides for second opinions. In network planning, CCOs need to consider and monitor:

- anticipated enrollment of Medicaid and fully dual-eligible (Medicaid and Medicare) individuals
- an appropriate range of preventive and specialty services for the population enrolled or expected to be enrolled
- expected utilization of services based on the characteristics and health care needs of enrollees

- numbers and types (training, experience, specialization) of providers required to furnish the contracted Medicaid services
- number of network providers who are accepting new Medicaid enrollees
- geographic location of participating providers and enrollees, considering distance, travel time, transportation and physical access issues

If adequate and timely services are not available within the network, the CCO must obtain medically necessary services outside the network.

OHA requires each CCO to submit an annual Delivery System Network (DSN) report demonstrating the CCO's capacity to serve the expected enrollment in its service area, in accordance with state standards for access to care. As a special EQR project in 2016, OHA asked HealthInsight Oregon to review the CCOs' DSN reports and provide feedback and recommendations. Results of that review appear in a separate report submitted to OHA in February 2017.

Major strengths

All CCOs had expanded their network capacity to accommodate Medicaid expansion. Strategies included opening new clinics, extending providers' office hours, forming mobile teams, contracting with additional dental and behavioral health providers and providing incentives for primary care providers (PCPs) to locate and stay in rural areas. Most CCOs had begun to incorporate access to behavioral health and dental care into their network planning to determine and maintain adequacy.

Out-of-area care. Most CCOs assessed care patterns of providers in out-of-area locations. The CCOs' care management teams knew which specialty services were not available within the network, and were experienced in arranging medically necessary care from out-of-network providers. Some CCOs had established long-term relationships with out-of-area specialists.

Cultural competency. CCOs had implemented strategies to improve members' access to culturally competent services. All CCOs had provided training for staff and providers to improve member interactions. CCOs had implemented several programs designed to increase enrollee engagement and activation.

Major areas for improvement

In general, the inadequate number of providers across the state creates ongoing access problems. Most CCOs struggled to provide timely access to services

covered under the contract (including access to specialists, dental care and out-of-network services). Challenges included recruiting PCPs and specialists to rural areas, as well as monitoring capacity and access to ensure an appropriate distribution of services in metropolitan areas.

Second opinions. Many CCOs lacked policies and procedures to ensure that members receiving mental health or dental care had access to second opinions. Many CCOs had not communicated clearly to staff, providers and enrollees how to facilitate access to second opinions for all services. CCOs often did not know how many in-network second opinions were requested or provided.

Out-of-network services. A few CCOs lacked integrated policies on out-of-network services. Some CCOs' enrollee handbooks lacked information about how to obtain services outside the network.

Some CCOs' policies did not specify that out-of-network providers must coordinate with the CCO with respect to payment. CCOs generally did not monitor to ensure that the cost to the enrollee for out-of-network services was no greater than it would have been if services were furnished within the network. Many enrollee complaints and grievances have been related to billing, though such issues have decreased. It is unclear how many billing issues are connected with out-of-network providers' billing practices.

Timely access to all contracted services. Many CCOs had inadequate processes for ensuring timely access to routine, urgent and emergent services and access to specialists. Some CCOs lacked methods to ensure that members had timely access to mental health and dental care.

Primary Care and Coordination of Services

This review section evaluates the CCO's policies and procedures regarding delivery of primary care and coordination of health care services for all enrollees, operationalizing the state's definition of "special health care needs" and enabling direct access to specialists for those identified with such needs.

Major strengths

All CCOs achieved the benchmark of 60% of enrollees assigned to a PCPCH. Some CCOs had embedded PCPs in behavioral health clinics. Many CCOs had behavioral health providers within their PCPCHs.

Care management. Some CCOs had invested in population health management programs to identify enrollees with SHCN. CCOs' care management staffs conducted outreach to the identified enrollees. All CCOs had expanded care management programs to include nurse case managers, behavioral health providers and CHWs. Many CCOs supported the use of traditional health workers and other non-billable providers to increase care coordination and to connect members to services.

The CCOs had negotiated memoranda of understanding with APD and the Area Agencies on Aging to improve coordination of care for CCO members. All CCOs took part in multidisciplinary teams with APD, behavioral health providers and other agencies serving enrollees. Some CCOs brought substance use treatment providers into their care management meetings. In some cases, these teams had established unified care plans for enrollees with exceptional needs.

Major areas for improvement

Care coordination. Many CCOs lacked policies and procedures integrating dental, behavioral and physical health. A few CCOs demonstrated poor communication between providers of dental, behavioral and physical health services (including screening and referral for alcohol and substance misuse and mental health problems).

Special health care needs. OHA has expanded its definition of enrollees with SHCN beyond the rate categories (aged/blind/disabled, children in foster care, dual-eligibles) for which the former fully capitated health plans received funds to provide case management. The definition now includes people with high health care needs, multiple chronic conditions, substance use disorder or mental illness who have functional disabilities or who live with a health or social condition that puts them at risk for developing functional disabilities. Some CCOs have not updated their policies and practices to address this broader population.

Many CCOs lacked a process to periodically update needs assessments and to monitor treatment/care plans for enrollees with SHCN. Many CCOs lacked mechanisms to ensure that mental health and dental providers were complying with care standards. Many CCOs' assessments and care plans for enrollees with SHCN did not address cultural or linguistic factors.

Coverage and Authorization of Services

This section of the review protocol assesses whether the CCO has systems in place to ensure consistent application of review criteria for authorization decisions; ensure that denials or reductions of service requests are made by a health care professional with appropriate experience in treating the enrollee's condition; send appropriate notice of adverse actions; comply with required time frames for standard and expedited decisions; ensure that no incentives are in place to deny, limit or discontinue medically necessary services; and ensure that the CCO covers and pays for emergency and post-stabilization services.

Major strengths

Many CCOs performed routine inter-rater reviews of internal authorization processes to ensure consistent application of review criteria. All physical health service denials were reviewed by medical staff. The CCOs had improved their processes to monitor the timeliness of routine and expedited authorization decisions.

CCOs' utilization management committees reviewed the use of emergency services in an effort to reduce avoidable ED utilization. Most CCOs had adopted incentive payments for physical health providers to reduce readmissions and avoidable ED utilization, and to increase outpatient utilization.

Major areas for improvement

Authorization processes. Some CCOs lacked a mechanism to ensure consistent application of review criteria when making authorization decisions and to ensure that providers were notified of adverse actions. Some CCOs lacked policies and procedures to address post-stabilization service requirements.

Delegated authorizations. Many CCOs exhibited little oversight of delegates (particularly DPNs) with respect to service authorization. CCOs need to closely monitor the delegation of service authorization, including the NOA process, to ensure that delegates are comfortable with the complexities of performing those activities.

Provider Selection

This section of the compliance protocol assesses the degree to which the CCO implements policies and procedures for selecting and retaining providers, and follows a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the CCO, including any delegated processes. Provider selection must not discriminate against practitioners who serve high-risk populations or who specialize in conditions that require costly treatment. CCOs must not employ or contract with providers excluded from participating in federal health care programs.

Major strengths

All CCOs had rigorous credentialing and recredentialing processes for physical health practitioners. Most CCOs assessed the quality, safety and accessibility of provider offices during initial credentialing through site visits. Most CCOs monitored member complaints and visited medical offices when a threshold of complaints had been received. A few CCOs performed credentialing and recredentialing of licensed mental health practitioners.

Major areas for improvement

Credentialing and recredentialing. Most CCOs lacked policies and procedures that adequately addressed the credentialing and recredentialing expectations of delegates, including monitoring mechanisms and credentialing requirements for mental health professionals, dental hygienists, peer support specialists, CHWs and NEMT providers. Issues ranged from needing to establish a credentialing committee to developing more comprehensive screening processes.

Many CCOs addressed credentialing of licensed or certified professionals but did not address other types of employees and/or paraprofessionals.

Monitoring for excluded providers. A few CCOs did not monitor their staff and governing boards for exclusion from participation in federal health care programs. Many CCOs lacked processes to monitor their delegates to ensure monthly screening of providers and downstream entities.

Subcontractual Relationships and Delegation

This review section evaluates the CCO's practices for monitoring the functions and responsibilities that it delegates to any subcontractor. The CCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated, and must have a written agreement that specifies the activities and reporting responsibilities and outlines revocation or sanctions if performance is inadequate. If a CCO identifies deficiencies or areas for improvement, the CCO must work with the subcontractor on a corrective action plan.

Major strengths

Most CCOs conducted pre-delegation assessments and provided technical assistance to ensure that providers could meet contractual requirements.

Strategies for oversight of delegated functions and entities varied among CCOs. CCOs' oversight committees or compliance departments were responsible for tracking delegates' performance. A few CCOs conducted annual evaluations of delegates and required corrective action as needed. Many CCOs monitored their delegates to track progress on the work plans.

Major areas for improvement

Many CCOs had draft policies and procedures pertaining to monitoring and oversight of delegates. CCOs need to follow through with monitoring of their delegates to ensure that they meet CCO expectations.

CCO delegates often subdelegated some or all of the delegated activities to other downstream entities. In some cases, contracts between the CCO and delegates failed to specify performance and reporting expectations, revocation or sanctions for inadequate performance, CCO monitoring of the delegate's performance and action the CCO would take when deficiencies were identified.

In a few instances, the CCO had required corrective action but had not followed up to ensure that the issue was addressed. Many CCOs had not performed annual evaluations of all delegates.

Practice Guidelines

This section of the review protocol assesses whether the CCO adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals; reflect the needs of CCO enrollees; are adopted in consultation with the contracting health care professionals; and are updated periodically, as appropriate. CCOs must disseminate practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. CCOs need to demonstrate that decisions for utilization management and coverage of services are consistent with the guidelines.

Major strengths

All CCOs based physical health utilization management decisions on practice guidelines such as those of the Health Evidence Review Commission, American Diabetes Association, American Academy of Pediatrics, National Heart, Lung and Blood Institute and Milliman Care Guidelines. Some CCOs had developed practice guidelines for prescribing opioids and hepatitis C drugs.

CCOs' Clinical Advisory Panels often participated in identifying and adopting practice guidelines.

Major areas for improvement

Some CCOs lacked documentation of how their delegates adopted practice guidelines. Some CCOs lacked a policy or consistent procedure for disseminating clinical guidelines for all practice areas. Websites might provide access to one or two medical or mental health guidelines, but not dental practice guidelines.

A few CCOs lacked monitoring mechanisms to ensure that internal decisions on utilization management were consistent with CCO guidelines. Most CCOs lacked mechanisms to ensure consistency of delegates' authorization decisions.

Section 7: QA/PI General Rules and Basic Elements

This section of the review protocol assesses whether the CCO has an ongoing QA/PI program that includes:

- conducting PIPs on clinical and nonclinical topics to improve quality
- reporting specified performance measures to the state
- mechanisms to detect under- and overutilization of services

- mechanisms to assess the quality and appropriateness of care furnished to enrollees with SHCN
- maintaining a health information system that can collect, analyze, integrate and report data

Major strengths

The CCOs generally had aligned their QA/PI programs with their transformation plans. The CCOs' annual evaluations addressed grievances, performance on quality metrics and progress on PIPs and focus areas. A few CCOs' quality work plans included objectives to reduce health care disparities.

QI committees. In most cases, the CCOs had added behavioral health providers and specialists to their QI committees; a few committees included pharmacy and dental care representatives. Many CCOs' QI committee processes included analysts who produced comprehensive management reports.

Risk management. Most CCOs had invested in risk and population care management programs. The CCOs used predictive risk management software to produce probability ratings for individual enrollees related to inpatient admissions, ED visits and potential adverse incidents. In most cases, PCPs received this information about CCO members assigned to their practice. One CCO provided risk model performance reports to hospitals considered essential for the CCO's ability to meet quality incentive goals.

Major areas for improvement

CCOs generally need to expand their QA/PI programs to apply to mental health and dental services as well as physical health. QA/PI programs need to define the scope of QI activities for all services; describe the results of CCO monitoring of utilization, care coordination/case management efforts and delegated activities; specify the CCO's quality oversight body; and include guidance for downstream entities on the program's mission, objectives and priorities.

Enrollees with SHCN. In general, the CCOs lacked mechanisms to track the quality and appropriateness of programs to assess the needs of enrollees with SHCN. Little information was available on the volume of services delivered and the effectiveness of those programs.

Health information systems. Many CCOs need to work toward establishing a single, fully integrated source of data on physical and mental health, addictions, vision, pharmacy and dental services to enable aggregated reporting. CCOs and their delegates need to ensure that processes are in place to ensure accuracy and timeliness of encounter data, including encounter data validation.

Recommendations for OHA

Enrollee Rights

- Continue to assist CCOs in ensuring that member materials and communications are available in easily understood language.
- Continue to work with CCOs to ensure members' free choice of providers, specifically mental health providers.
- Continue to assist CCOs in coordinating and honoring advance directives and mental health treatment declarations for the benefit of members.
- Clarify expectations with respect to monitoring providers and facilities for the use of high-risk activities of seclusion and restraint.

Grievance Systems

- Continue to work with the CCOs to ensure that grievances are gathered and reported consistently as expected. OHA may need to define what constitutes a grievance, which grievances need to be reported, etc.

Certifications and Program Integrity

- Clarify the CCOs' obligation to search the Office of Inspector General's exclusion database monthly for all employees, providers, provider entities, contractors and individuals with ownership or control interests.
- Clarify OHA's expectation of who should undergo criminal background checks upon hire or credentialing.
- Clarify expectations for disclosure of information related to vendor relations, gifts, gratuities and other compensations.

Quality Assessment and Performance Improvement

- Continue to work with CCOs to address how they maintain and monitor a DSN of appropriate providers (including specific subcontracted activities) to provide adequate access to all covered services, including for enrollees with SHCN.

- Direct the CCOs to use proactive means to monitor providers' compliance with standards of timely access to care and services, such as through regular reporting, access surveys, etc.
- Assist the CCOs in exploring additional means beyond review of grievances to monitor availability of services.
- Direct the CCOs to report how they monitor specific subcontracted activities related to ensuring provider capacity. OHA may need to clarify the intent of this requirement. Many CCOs reported what they were doing to monitor the delegates' provider capacity. The delegates also need to be monitored on their oversight of downstream providers.

PERFORMANCE MEASURE VALIDATION

The purpose of performance measure validation (PMV) is to determine whether the data used to calculate each performance measure are complete and accurate and whether the calculation adheres to CMS specifications.

OHA's Metrics and Scoring Committee uses 17 CCO Incentive Measures to evaluate Oregon's performance on health care quality and access, and to hold CCOs accountable for improved outcomes. In the 2015 performance measure calculation period, OHA added two measures and dropped two measures. Additional changes were made in 2016 and planned for 2017, but this review covers the 2015 calculation period only.

The 17 incentive measures used in 2015 are listed below. CCOs receive funds from a quality pool based on their performance on these measures and whether the CCOs meet state benchmarks or demonstrate improvement from their own baselines.

- Adolescent well-care visits
- Alcohol or other substance misuse (SBIRT)[9]
- Ambulatory care: outpatient and emergency department utilization
- CAHPS composite: access to care
- CAHPS composite: satisfaction with care
- Colorectal cancer screening
- Controlling high blood pressure
- Dental sealants *(added in 2015)*
- Depression screening and follow up plan
- Developmental screening in the first 36 months of life
- Diabetes: HbA1c poor control
- Effective contraceptive use *(added in 2015)*
- Electronic health record (EHR) adoption
- Follow-up after hospitalization for mental illness[10]
- Health assessments within 60 days for children in DHS custody
- PCPCH enrollment
- Timeliness of prenatal care

[9] Modified in 2015: age reduced from 18 to 12.

[10] Modified in 2015: same-day follow-up services added to the numerator.

Scope of the Review

Seven of the 17 measures were calculated using *only* encounter data that OHA collects and maintains. Per OHA's instruction, HealthInsight validated only those seven measures. The remaining 10 measures are calculated with clinical data collected by record review or EHR extraction, with non-encounter data from other systems or with data from the CAHPS survey, administered by a contractor. Some measures combined encounter data with one or more of these alternate data sources.

Validation Results

Dental sealants and effective contraceptive use were new measures in 2015, and as such, they received full validation by OHA. All other existing measures received a full validation in 2014 and varying degrees of validation in 2015, depending on the scope of measure specification changes from previous years.

The full validation process is quite comprehensive. First OHA sends complete encounter data files to the Providence Center for Outcomes Research and Education (CORE). Refresh data are sent monthly. CORE writes its own metric code, calculates the metrics using the data from OHA and sends the results back to OHA. OHA then validates the results by calculating the metrics using its own code and sends the same data to CORE. CORE and OHA use frequent email communication and weekly meetings to discuss agreement and discrepancies between results, and to troubleshoot any variation. This process continues until OHA's results are within 3% of CORE's results, at which point OHA approves the CORE code.

Once approved, CORE publishes CCO-specific results to a CCO-specific dashboard housed in an online data repository called Business Objects. The CCOs are invited to validate their results by downloading member-level data from the dashboard, which includes flags for members in the numerator and denominator of each measure. Many CCOs ran their own measure code in-house and compared results, identifying discrepancies and working with OHA to resolve them. While CCO validation is not required until the calendar year-end report, OHA encourages CCOs to perform interim data quality checks.

Simultaneously, the Oregon Health Care Quality Corp. (Q Corp), through its contractor Milliman, validated the metric code and results as well. Milliman

validated the measures using data sent by OHA, writing its own code in collaboration with Q Corp. This additional validation was performed only for the new incentive measures in the 2015 calculation period.

In October 2015, CMS issued the International Classification of Diseases, 10th Revision (ICD-10) for medical coding and reporting, replacing the ICD-9. This change affected the codes used to identify patients in the numerator and denominator of many measures. OHA created crosswalks to validate the new code sets used to identify patients in the numerator and denominator.

In past years, performance measures have been scored "partially met" because of concerns about data integrity and completeness and concerns about a limited and undocumented validation process. As OHA has made substantial improvements in both areas, all seven performance measures are scored as "substantially met" this year (see Table 2). The code review and measure calculation process for these measures was adequate, but the measures are not scored as "fully met" because HealthInsight Oregon still has concerns about the validity of the data used to calculate the measures.

Incentive measures are now reported according to member race and ethnicity as identified on the Medicaid enrollment forms. This is a positive step forward in addressing health equity. However, member race and ethnicity are not required fields on the enrollment forms, so information is missing for a large proportion of Medicaid enrollees, rendering these stratified results unreliable.

OHA has no system in place to determine the volume of encounter data that is not submitted or that is submitted but rejected by the EDI Translator. In addition, the CCOs' data submission processes vary widely. While some CCOs review their encounter data before submitting the data to the state, other CCOs and their partner organizations transmit the data directly to the state without review. This is important because performance measure calculations based on incomplete or inaccurate data will not yield valid results. OHA recognizes these deficiencies and has plans to address them at the state level, as follows.

First, encounter data staff in the Service Data Reporting Unit of OHA's Health Systems Division will be reorganized into entry-level and senior-level positions, performing data mining and providing better monitoring of incoming encounter data. This is commendable, but the CCOs are also responsible and should be held accountable. Conducting an encounter data validation (EDV) would enable CCOs to identify and correct any anomalies before sending data to the state, and

to identify encounters that were rejected. OHA does not currently require CCOs to conduct EDV.

Second, OHA plans to rework the 1% withhold rule. Currently, CCOs are subject to financial withholds for late encounter submissions, and thus appear to be incentivized *not* to submit encounters if they are late. This creates a risk of calculating performance measures on the basis of incomplete data (in addition to lower capitation payments to the CCO). The planned rule revision would make adjudication part of the withholding rule. This change is intended to reduce the number of pended encounters, improving the completeness of OHA's encounter data.

The CCO validation process is laudable and appears effective in increasing the validity of the metrics as new members are discovered to enter the numerator and denominator. However, the QI processes implemented to find these members should encompass the entire system, ensuring that all data are complete and valid, not only those data that inform the incentive measures. An all-encompassing QI initiative would also reduce the burden on CCOs to validate member-level data for each performance measure.

Table 2 shows the validation ratings for each of the seven performance measures reviewed from the 2015 measurement year.

Table 2. Performance Measure Validation Ratings, 2016.

Measure	Status	Compliance Rating
Adolescent well-care visits	Complete validation by OHA	Substantially met
Alcohol or other substance misuse (SBIRT)[11]	Complete validation by OHA	Substantially met
Ambulatory care: emergency department utilization	Complete validation by OHA	Substantially met
Dental sealants	Complete validation by OHA	Substantially met
Developmental screening in the first 36 months of life	Complete validation by OHA	Substantially met
Effective contraceptive use	Complete validation by OHA	Substantially met
Follow-up after hospitalization for mental illness	Complete validation by OHA	Substantially met

[11] In advance of the 2017 incentive measure calculation year, the Metrics and Scoring Committee voted to remove the SBIRT measure due to data completeness shortcomings identified through OHA's validation process.

Recommendations

- OHA should document processes, policies and procedures specific to each performance measure, specifying steps to ensure that:
  - OHA receives complete encounter data from all CCOs in a timely manner
  - the data flow between and within OHA systems, and the data flow with external partners, is documented and understood
  - OHA communication with CCOs is documented and consistent
  - current relationships with external partners are documented, as are any future changes in associations, roles or responsibilities
- OHA should either conduct an EDV or require the CCOs or a third party to conduct an EDV, to ensure submission of complete and valid encounter data to OHA
- OHA should follow through with its plans to reorganize staff in the Service Data Reporting Unit and to rework the withholding rule.
- OHA should require race and ethnicity fields to be completed on Medicaid enrollment forms.

Information Systems Capabilities Assessment

The ISCA examines an organization's information systems and data processing and reporting procedures to determine the extent to which they support the production of valid and reliable state performance measures and the capacity to manage health care for the organization's enrollees.

42 CFR §438.242 requires states to ensure that each managed care organization "maintains a health information system that collects, analyzes, integrates, and reports data" to meet objectives related to quality assessment and performance improvement:

> "The State must require, at a minimum, that each MCO and PIHP comply with the following:
>
> (1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.
>
> (2) Ensure that data received from providers is accurate and complete by—
>
> (i) Verifying the accuracy and timeliness of reported data;
>
> (ii) Screening the data for completeness, logic, and consistency; and
>
> (iii) Collecting service information in standardized formats to the extent feasible and appropriate.
>
> (3) Make all collected data available to the State and upon request to CMS, as required in this subpart."

Although CCOs may subcontract certain activities to outside entities, the CCO is responsible for all duties and responsibilities included in its contract with OHA, and must monitor contractors' and subcontractors' performance. CCOs may not delegate certification of claims and encounter data (see Exhibit B–Part 4, 11.d, and Exhibit B–Part 8, 7.c–d).

In 2016, HealthInsight Oregon conducted a full ISCA review of both OHA's data management and reporting systems and those of the individual CCOs. Results of those reviews are summarized below.

Review procedures

HealthInsight Oregon organized the ISCA in 10 sections, each of which contains review elements corresponding to relevant federal standards.

- Information Systems
- Staffing
- Configuration Management (hardware systems)
- Security
- Administrative Data (claims and encounter data)
- Enrollment Systems (Medicaid eligibility downloads)
- Vendor Data Integration and Ancillary Systems
- Report Production and Integration and Control of Data for Performance Measure Reporting
- Provider Data
- Meaningful Use of Electronic Health Records

HealthInsight Oregon's review drew on information that OHA or the CCO provided in the ISCA questionnaire; interviews with the organization's staff, partners and providers; and the results of a security walkthrough of data center facilities operated by the CCO. Within each review section, HealthInsight Oregon scored each element on a scale from 1 to 3 (see Table 3).

Table 3. Scoring Scheme for ISCA Elements.

Score	Rating	Definition
2.6–3.0	Fully met (pass)	Met or exceeded the element requirements
2.0–2.5	Partially met (pass)	Met essential requirements of the element, but is deficient in some areas
< 2.0	Not met (fail)	Did not met essential requirements of the element
–	N/A	Not applicable

State-level ISCA review results

Figure 1 below shows OHA's scores from the 2016 ISCA review, compared with scores from the 2014 review. As shown, the scores have improved in all review sections except Administrative Data, with all sections now rated either fully or partially met.

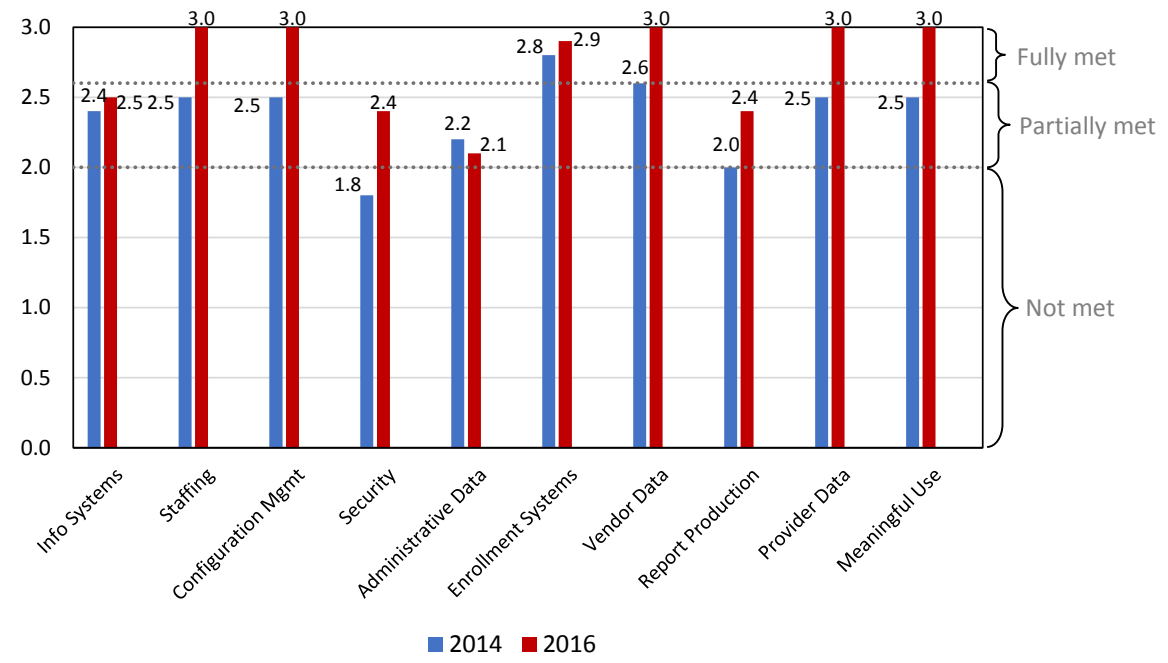
OHA's data systems exhibit several high-level strengths. OHA updates its data warehouse weekly, performs daily backups of Medicaid data and replicates the backups to an offsite location. CCOs reported that the accuracy of member eligibility files received from the state has improved significantly.

Moving forward, OHA needs to address deficiencies related to:

- lack of a state-level business continuity/disaster recovery (BC/DR) plan to ensure the preservation of data in Medicaid information systems
- lack of a requirement for individual CCOs to maintain working BC/DR plans and to test the plans regularly
- non-performance of encounter data validation (EDV) to ensure accuracy and completeness of encounter data submitted by CCOs to OHA
- uncertainty as to whether CCOs are receiving notification of receipt of their data files and the transaction status of claims/encounters in the files

See Appendix C for additional details.

Figure 1. State-Level ISCA Scores, 2014 and 2016.



CCO-level ISCA review results

The CCO profiles in Appendix A summarize each CCO's ISCA results. High-level results are summarized below.

IT systems integration. Overall, the CCOs have made significant progress in integrating all required services and associated claims/encounter data into their IT systems. Most CCOs have successfully integrated mental health and dental data into their IT systems and reporting. Some CCOs have integrated NEMT data, while others continue to work toward that goal.

Less than complete integration of all services into the CCOs' IT systems has impeded the efficiency of CCO reporting as workloads have continued to expand. Many CCOs have collaborative relationships with multiple partner organizations, adding complexity to this task. The CCOs need to improve their understanding of service authorization processes, eligibility data flow and data validation for all services in order to perform appropriate monitoring and oversight of in-house and outsourced services.

OHA needs to:

- work with CCOs to expedite the integration of IT activities, communication, policies and procedures across all CCO services
- encourage CCOs to continue integrating all service data into a single data repository for each CCO, to enable better reporting on integrated care
- encourage CCOs to develop internal reporting capabilities so that the CCOs rely less on state data for quality assessment and performance improvement
- encourage CCOs to continue to reduce the number of paper claims received

Encounter data certification. The OHA contract prohibits CCOs from delegating the certification of claims and encounter data (see Exhibit B, Part 4, 11.d; Exhibit B, Part 8, 7.c (1)(2); and Exhibit B, Part 8, 7.e).

Many CCOs are combining encounter/claims data from multiple sources without a process to validate the completeness and accuracy of data. Many CCOs lack adequate understanding or documentation of the different sources and flow of encounter data. Some CCOs continue to work on enhancing their documentation and processes for certifying encounter data.

OHA needs to:

- clarify its expectation of requirements for certifying encounter data completeness, accuracy and truthfulness
- ensure that CCOs have appropriate documentation (such as a data flow diagram) to establish the sources of all types of encounter data

EDV. OHA does not require CCOs to validate their encounter data against clinical records, nor does OHA validate the submitted data. OHA should determine where in the claims life cycle this validation should occur and who should perform this activity.

OHA needs to:

- either conduct EDV or require the CCOs or a third party to conduct EDV, to ensure submission of complete and valid encounter data to OHA
- communicate its expectations of EDV performance to the CCOs

Delegated activities and responsibilities. Although CCOs may subcontract numerous activities to outside entities, the CCO is responsible for all duties and responsibilities included in its contract with OHA, and must monitor contractors' and subcontractors' performance.

OHA needs to:

- continue to work with the CCOs to ensure that they define the roles and responsibilities of the CCO in monitoring the completeness and accuracy of encounter data
- encourage the CCOs to develop processes for monitoring their providers to enforce contractual requirements for timely data submission, IT security and business continuity planning

Security policies/procedures and disaster recovery plans. OHA reported that it does not have a contractual requirement for the CCOs to maintain BC/DR plans.

OHA needs to:

- ensure that the CCOs review and update their data security policies and procedures, and those of their delegates, at least every two years
- ensure that the CCOs have BC/DR plans that address all CCO activities and that the plans are tested annually or whenever a plan is updated
- ensure that all CCOs have encryption policies that apply to transportation and storage of all protected health information

- work with the CCOs to implement appropriate strategies for upgrading and replacing critical hardware, and for enforcing similar practices on the part of their partner organizations

Provider directories. The CCOs continue to work to develop integrated and accessible directories with practitioner-level details for all CCO services. Some CCOs need to make it easier for members to search for providers. Directories are required to include certain information for all types of providers (physical health, behavioral health and dental), including specialty, languages spoken and provider type. In addition, including the practitioner's gender in directories would enable members to make more informed choices.

OHA should add language to the CCO contract to require provider directories to include each practitioner's gender. OHA also should work with CCOs to:

- make it easier for members to search for all type of providers (physical health, behavioral health, and dental)
- ensure that provider directories present information on practitioners' specialties, languages spoken, provider type and gender
- develop and implement formal processes for updating provider directories

Zero- and low-dollar claims. OHA reported that the CCOs are required to ensure that providers submit zero-dollar claims. The CCOs and OHA were not able to confirm that all providers were submitting all such claims. OHA should evaluate adding language to the CCO contract requiring CCOs to monitor providers for submission of zero-dollar claims.

OHA needs to work with CCOs to:

- ensure that all partner organizations understand that zero- and low-dollar claims must be submitted to OHA
- develop standards and policies for providers related to zero- and low-dollar claims
- continue to monitor for and resolve issues related to failure to submit zero-dollar claims

Table 4 lists major areas for improvement noted in the CCO ISCA reviews, with associated reecommendations.

Table 4. CCO-Level ISCA: Major Areas for Improvement and Recommendations.	
Improvement Area	**Recommendations**
CCO monitoring of delegates' IT activities *OHP 410-141-0180(1)* Most CCOs did not provide evidence of monitoring and oversight of their contracted or partner organizations' security practices. This should include monitoring for TPAs, delegates, partners, and provider organizations.	• CCOs should maintain written policies and procedures describing how they maintain the security of records as required by HIPAA and other federal regulations. • CCOs should communicate these policies and procedures to their delegates, partners, providers and third-party administrators. • CCOs should regularly monitor compliance with these policies and procedures and take corrective action where necessary.
Encounter data validation (EDV) Almost all CCOs do not conduct EDV to verify the accuracy and completeness of encounter data against clinical records. EDV processes can uncover services that should have been encountered and were not reported, or can provide additional information on how encounters are captured and reported.	• CCOs should work with their providers to ensure that all data submitted to OHA are accurately processed and included in the state data set. • CCOs should develop and implement processes to regularly validate a sample of the state's encounter data against clinical records for all service types (e.g., dental) in order to assess the completeness and accuracy of encounter data.
Monitoring of zero-dollar claims Most CCOs did not provide evidence of monitoring and oversight of partners' and providers' practices regarding submission of zero-dollar claims. Multiple provider and partner organizations reported that they did not report zero-dollar claims.	• CCOs should work with partner and provider organizations to ensure that all Medicaid encounters are submitted to OHA, regardless of the dollar amount associated with the claim. • CCOs should develop monitoring processes to ensure that zero-dollar claims are appropriately received and submitted to OHA.

Provider policies
OAR 943-120-0170(2)
Most CCOs need to address security issues related to maintaining policies and procedures and monitoring the IT practices of provider and partner organizations.
	• CCOs should implement formal processes to regularly review and update their IT policies and procedures.
	• CCOs should monitor provider and partner organizations' performance with regard to:
	  ○ verifying eligibility at the time of service
	  ○ data breach reporting strategies
	  ○ updating and regularly testing BC/DR plans
	  ○ password complexity standards, forced-change practices and multi-factor authentication processes in alignment with business standards
	  ○ encrypting protected health information and/or portable media
	  ○ hardware destruction and disposal

PERFORMANCE IMPROVEMENT PROJECTS

The purpose of PIPs is to assess areas of need and develop interventions intended to improve health outcomes. OHA's contract requires CCOs to conduct PIPs that are "designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and OHP Member satisfaction."

CCOs are required to conduct three PIPs and one focus study designed to improve care in at least four of the seven QI focus areas:

1. Reducing preventable rehospitalizations
2. Addressing population health issues (such as diabetes, hypertension, and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and aligned federal and state programs
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by "super-users"
4. Integrating primary care and behavioral health
5. Ensuring that appropriate care is delivered in appropriate settings
6. Improving perinatal and maternity care
7. Improving primary care for all populations through increased adoption of the PCPCH model of care throughout the CCO network

One of the required PIPs is conducted as a statewide collaborative project addressing the integration of primary care and behavioral health. The Statewide PIP is conducted in accordance with the 2012 CMS protocol. HealthInsight Oregon is responsible for facilitating and documenting the PIP. The CCOs are responsible for developing interventions that meet local community needs (Standard 8 of the PIP protocol) and for documenting the development and implementation of their interventions in quarterly reports to OHA.

In addition to the Statewide PIP, CCOs are required to conduct two PIPs and one focus project of their choice on topics from the list of seven QI focus areas. In 2016, HealthInsight Oregon began evaluating these CCO-specific projects and providing OHA with recommendations for follow-up.

Statewide PIP: Improving the Safety of Opioid Management

Discussions about topic selection for the second Statewide PIP were held at QHOC meetings in spring 2015. After reviewing CCOs' feedback about possible metrics and dosage thresholds, as well as data provided by the Office of Health Analytics, CCO QI directors selected the following PIP study metrics:

> *Percentage of Medicaid enrollees who filled prescriptions totaling ≥120 mg morphine equivalent dose (MED) on at least one day within the measurement year*
>
> *Percentage of Medicaid enrollees who filled prescriptions totaling ≥90 mg MED on at least one day within the measurement year*

In addition to the study metric data, OHA collected and reported data on two supplemental metrics (percentage of Medicaid enrollees on dosages of ≥120 mg and on ≥90 mg MED for 30 or more consecutive days) to track progress on addressing this subpopulation at the state and CCO levels.

Technical assistance

HealthInsight Oregon continues to provide support and technical assistance to the CCOs in presentations at monthly QHOC meetings and in technical assistance meetings and calls with individual CCOs.

QHOC meeting topics have included development and implementation of non-opioid therapies, overview of medication-assisted treatment (MAT), elements of a successful MAT program, updates from Oregon researchers on opioid prescribing, general themes from CCO progress reports and revisions of the PIP quarterly report template.

From the inception of the Statewide PIP, HealthInsight Oregon has offered CCOs individualized technical assistance meetings quarterly or upon request. In 2016, HealthInsight Oregon met with representatives from all CCOs at least once, and most CCOs took part in several technical assistance meetings.

Standard 8 validation and scoring

Following the first remeasurement period (January 1–December 31, 2016), HealthInsight Oregon evaluated each CCO's Standard 8 Part 1 and January 2017 quarterly report submissions for the degree of completeness of each of the Standard 8 criteria (see Appendix B, Attachment G). Each CCO received a rating

of met, partially met or not met for each of the Standard 8 criteria and a summary of strengths and opportunities for improvement. All CCOs had the option of either accepting their initial evaluation or resubmitting their Standard 8 documentation for re-evaluation. Five of the 16 CCOs asked to be re-evaluated on their January 2017 quarterly reports.

Overall, CCOs did a good job of conducting data and barrier analyses linking their analyses to expected improvement in the study indicator, developing interventions to address aspects of the opioid problem and describing any barriers encountered in implementing those interventions. The areas of cultural and linguistic appropriateness and tracking and monitoring criteria were the most challenging for CCOs.

Following is a brief review of high-level themes drawn from the CCO quarterly reports. An extensive discussion of CCO interventions, barriers and next steps can be found in the Statewide PIP report, Appendix B.

Interventions. The CCOs developed interventions to address barriers and contributing factors identified from root cause and barrier analyses. All CCOs implemented prior-authorization processes and quantity limits as a first step in improving opioid safety, with many having done so before the start of this PIP. Other common interventions included:

- sending letters to providers and members about changes to opioid policies, community resources and alternative treatment options
- requiring taper plans for members with high opioid use
- conducting or sponsoring Pain/Opioid Summits and provider training
- identifying high opioid prescribers and providing education and problem-solving
- disseminating materials in different formats to the community about the risks of prescription opioids
- collaborating with other CCOs, local health departments and community-based organizations to coordinate efforts and prevent duplication

Almost all CCOs solicited the participation of substance use disorder organizations and staff in discussing strategies to increase access to MAT. Behavioral health staff were involved in training providers about substance use and how to have difficult conversations with members. A few CCOs conducted trainings for dental providers and included dental providers in the distribution of opioid use dashboards.

The most common barrier encountered in implementing the interventions was staff turnover. Other barriers included competing priorities, scheduling conflicts, difficulty coordinating with different departments, difficulty in developing accurate data reports, high costs of materials and inclement weather. Few CCOs reported having encountered provider resistance or noncompliance. In their progress reports, most CCOs described how they anticipated provider concerns and mitigated risks by implementing provider training and education.

Statewide PIP results

Study time periods.

- Baseline measurement: January 1–December 31, 2014
- First remeasurement: January 1–December 31, 2016
- Second remeasurement: January 1–December 31, 2017

CCOs, OHA and HealthInsight Oregon agreed on the date range for the first remeasurement period based on the expected date for many of the CCOs to begin implementing their interventions. A non-consecutive baseline measurement period was selected because a longer period of time would allow CCOs that had already worked on the study topic for several years more opportunity to demonstrate improvement in the study indicator.

At the time of this report, complete first remeasurement (calendar year 2016) results were not available due to lag in receipt of claims data.

Interpretation of results. The remeasurement period analyzed for the PIP report (December 1, 2015–November 30, 2016) is not strictly comparable to the baseline measurement period as it is not the 2016 calendar year. However, tentative conclusions can still be drawn about the data, as CCOs had not reported significant changes in interventions or barriers as of December 2016.

Data analyses showed that the percentage of enrollees aged 12 and older who filled opioid prescriptions for both ≥120 mg and ≥90 mg MED fell significantly ($p<.001$) between baseline and current remeasurement.

As shown in Figures 2 and 3, the study denominators for both metrics increased from December 2014 to March 2016 and then decreased steadily month-to-month through November 2016.

Figure 2. Aggregated Statewide Results for ≥120 mg MED Metric from Baseline to Remeasurement Period.

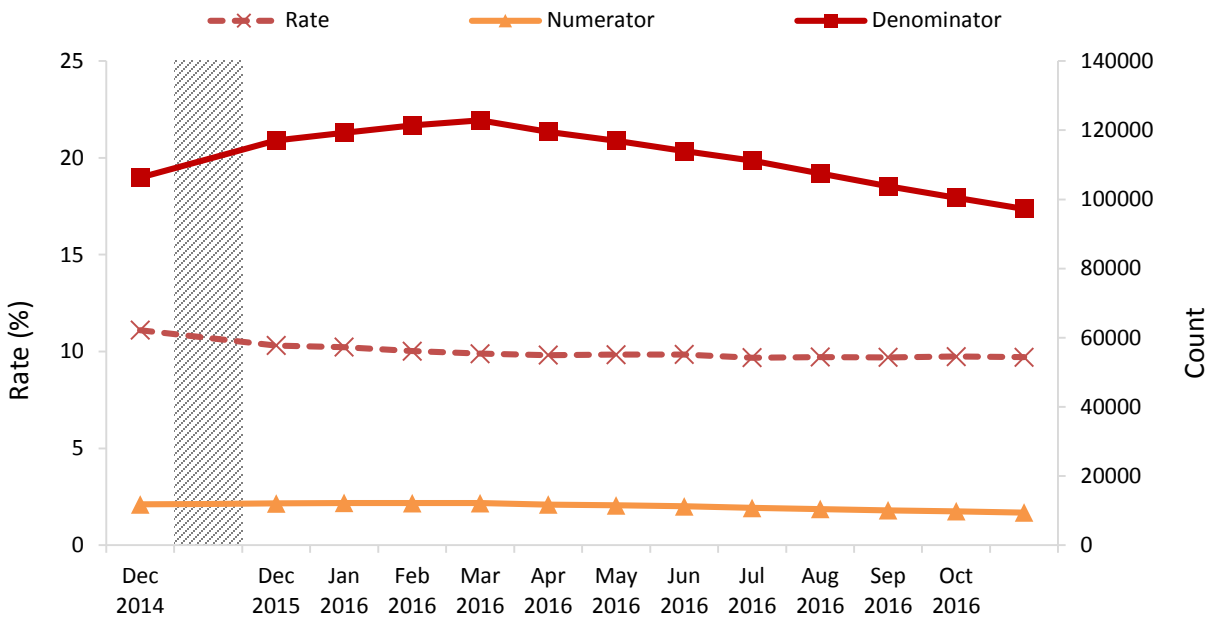
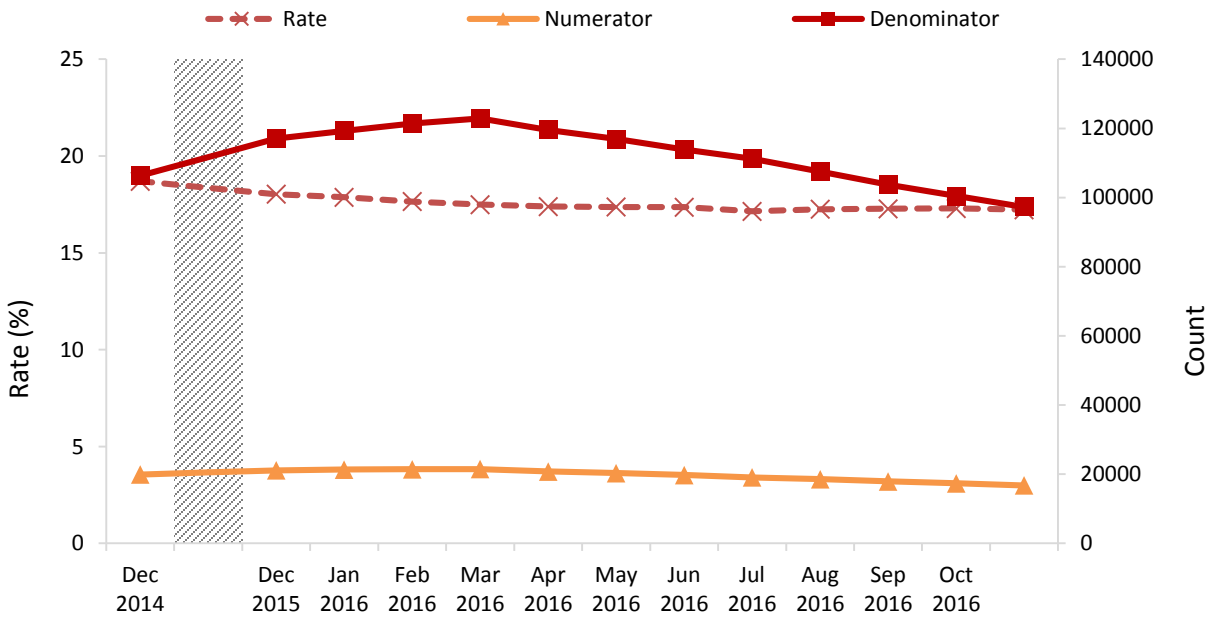


Figure 3. Aggregated Statewide Results for ≥90 mg MED Metric from Baseline to Remeasurement Period.



The increase in the aggregated study denominator from 2014 to 2015 can be accounted for by the increase in CCO enrollment and by the year-long (2015) incorporation of dental claims into CCO claims. It is not clear why the study denominator continued to increase until March 2016.

There was a notable decrease in the number of enrollees in the ≥120 mg MED and ≥90 mg MED aggregated study numerators from 2014 to 2015, followed by a very small monthly decrease through November 2016.

Data analyses of the two supplemental measures showed that the percentage of enrollees age 12 and older who filled opioid prescriptions for both ≥120 mg and ≥90 mg MED for consecutive 30 days or more fell significantly ($p<.001$) between baseline and current remeasurement. The supplemental measures displayed a trend similar to the study metrics, i.e., significant decrease in study denominator, slight decrease in the study numerators.

Because of the disproportionate decreases in the study denominator versus the numerators, it is important to examine both the counts as well as the rates when interpreting results, especially in the case of CCO-level data. For example, several CCOs saw a very small increase in both study metric rates from baseline to current measurement, yet data analyses showed a decrease in both the number of enrollees in their denominators and ≥120 mg MED and ≥90 mg MED numerators. The amount of opioids in circulation would be expected to decrease more quickly than the number of members being tapered off chronic doses of high opioids. A number of CCOs implemented taper plans of several months' duration that did not begin until late 2016, and the effect of those interventions might not be reflected in their rates until the second remeasurement year.

Additional analyses of the aggregated and CCO-level study data appear in the Statewide PIP report, Appendix B.

According to their January 2017 progress reports, most CCOs have succeeded in implementing interventions that address different aspects of the opioid problem in their communities. While it is reasonable to attribute improvement in the study indicators to CCO interventions, the degree to which CCO interventions are responsible for the change is not clear. Local, state and federal organizations have also implemented interventions as part of their own strategies to address opioid misuse and abuse, independent of the CCO-initiated interventions.

In addition to the effect of non-CCO interventions on study results, other limitations need to be considered. Medicaid claims do not capture cash payments by members for prescription opioids, and no readily available data exist for this subpopulation. Members might be included in the numerator because they appropriately received high doses of opioids for pain due to an active malignancy, but had not yet received exclusion diagnoses (e.g., palliative care). The study metrics address only a narrow aspect of the opioid problem (dosage thresholds and chronic high use) and do not reflect CCO progress on other and equally important opioid safety issues, such as co-prescribing with a benzodiazepine and the transition from naïve to chronic use.

Even taking the above limitations into account, the statistical tests, trends over time and individual CCO progress reports demonstrate improvement in the safety of opioid management at the state and CCO level. If CCOs continue to develop and implement intervention strategies as planned, improvement in both study indicators can be expected.

Future steps

1. HealthInsight Oregon will continue to offer technical assistance meetings to the CCOs on a quarterly basis or upon request.
2. HealthInsight Oregon will present Statewide PIP study results and facilitate a discussion of next steps at an upcoming QHOC meeting.
3. CCOs will continue to develop and modify interventions and to document progress in quarterly reports to OHA.
4. OHA will continue to provide each CCO with rolling monthly reports on both study indicators and the supplemental consecutive 30 days or more measures.

Recommendation

Based on the quarterly reports submitted by CCOs and the technical assistance meetings to date, HealthInsight Oregon recommends that OHA encourage CCOs to participate in technical assistance meetings with HealthInsight Oregon so that documentation issues, study modifications and/or problems with data can be addressed in a timely manner.

CCO-Specific PIPs and Focus Projects

Each CCO is required to provide quarterly reports on two additional PIPs and one focus project. In August 2016, HealthInsight began evaluating all CCO-specific PIPs and focus projects and providing assessments to OHA. OHA is responsible for providing direct technical assistance to CCOs.

Table 5 lists the topics of CCO-specific PIPs conducted in 2016, which sought to address various issues of health care access, timeliness and quality. The topics of these PIPs and of CCO focus projects are also shown in the individual CCO profiles in Appendix A.

Table 5. CCO-Specific PIP Topics and Objectives.

PIP Topic (CCO)	Objective
Addicted Newborns (UHA)	Increase the number of women receiving first trimester prenatal visits and drug screenings, and reduce the number of newborns born with substance issues.
Adolescent Well Care (PSCS-CG, PSCS-CO, YCCO, AllCare, JCC, EOCCO)	Increase the number of adolescents having an adolescent well-care visit during the measurement year. JCC is also measuring the number of adolescents receiving the alcohol and drug screening questionnaire.
Benzodiazepine and Opioid Co-Prescribing (WOAH)	Reduce the number of members receiving both opioid and benzodiazepine prescriptions.
COPD/Pulmonary Function Testing (CHA)	Increase the number of members with chronic obstructive pulmonary disease (COPD) who have had a pulmonary function test, a guideline requirement for this population.
Colorectal Cancer Screening (AllCare, PHJC)	Increase the number of members with a colorectal cancer screening test within the clinically recommended age group.
Dental Visit During Pregnancy (IHN, PSCS-CO , PSCS-CG)	Increase the percentage of pregnant members who have a dental visit.
Depression Screening (TCHP)	Increase identification and treatment of depression screening for adults in primary care by administering the PHQ-9 screening tool and tracking members with clinical-level results.
ED Utilization (UHA, WVCH, YCCO, IHN, JCC)	Reduce member use of the ED by increasing access to and use of primary care. YCCO is still at the stage of exploring reasons for high ED usage.
Effective Contraceptive Use (PSCS-CO, PSCS-CG, HSO, AllCare, WOAH)	Reduce unintended pregnancy in women of child-bearing age by increasing effective contraceptive use.
Foster Care/APC Collaborative (Health Share)	Design effective models of care for children in foster care so as to improve quality and utilization measures for these children.
Maternal and Perinatal Health (PHJC, EOCCO, JCC, FamilyCare, CHA)	Improve maternal and perinatal outcomes through case management, health education and outreach/incentives.
Mental Health 0–6 (EOCCO)	Increase the number of children age 0–6 who receive needed mental health services.
Patient-Centered Primary Care Home (WVCH, UHA, YCCO)	Increase the number of providers certified as PCPCHs and increase the percentage of enrollees affiliated with a PCPCH.
Reducing Hospital Readmissions (TCHP, WOAH, IHN)	Prevent inpatient readmission through improved discharge and transition planning and closer communication with primary care.
SBIRT (Adult)/CRAFFT (Adolescent) Substance Use Disorder Screening (CPCCO)	Increase the number of members age 12 years or older who are screened for substance abuse and the number of those identified and referred to substance use treatment.

PIP Topic (CCO)	Objective
Serious and Persistent Mental Illness/Metabolic Screening (FamilyCare)	Continues topic of the first Statewide PIP to increase screening rates for hyperlipidemia and diabetes among members with serious and persistent mental illness who are prescribed two indicator mental illness medications.
Substance Use During Pregnancy (Health Share)	Improve outcomes for pregnant, substance-using women and their babies.
Tobacco Use/Cessation (TCHP, FamilyCare, CPCCO, WVCH)	Reduce tobacco use prevalence among CCO members by increasing the use of tobacco cessation programs.
Trauma-Informed Care (CPCCO)	Conduct provider training to increase the number of providers who practice trauma-informed care.

GOBHI REVIEW RESULTS

GOBHI, a managed mental health organization (MHO), provides services through local community mental health programs (CMHPs) in Baker, Clatsop, Columbia, Douglas, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa and Wheeler counties.

GOBHI's governing board includes commissioners from Columbia, Umatilla and Union counties, plus provider and consumer representatives. Most MHO activities are delegated to the county mental health authorities, which receive a capitation payment to deliver services for enrollees.

Compliance follow-up review summary

In 2016, HealthInsight Oregon followed up on findings and recommendations of the 2014 and 2015 compliance reviews. The follow-up review found that GOBHI had made progress in addressing many findings that were carried over from 2012. Several findings from 2012 remained unresolved or only partially resolved. More work is needed to bring GOBHI into full compliance with its MHO contract and federal Medicaid regulations.

Delivery network

GOBHI lacks access to management reports to assess MHO enrollees' needs and expected service utilization. GOBHI submitted no documentation to demonstrate that it conducted assessments of network adequacy.

Policies and procedures

At the time of the 2015 review, many of GOBHI's policies and procedures were still in draft form. In 2016, GOBHI submitted many policies that were approved shortly before the follow-up review and had not yet been implemented. Only one of the policies submitted directly addressed MHO enrollees.

GOBHI reported that it had empowered its Quality Improvement Committee (QIC), rather than the MHO board of directors, to approve policies. The QIC's charter does not list approving policies and procedures among its duties. QIC minutes revealed that some policies discussed were actually EOCCO or CPCCO policies. The minutes documented that GOBHI staff had informed QIC members that GOBHI as an MHO is "held to the same standards."

- ***GOBHI needs to review all policies to determine whether they apply to MHO enrollees.***

Tracking of second opinions, seclusion and restraint and access to interpretation and materials in alternative formats and languages

OHA requires managed care plans to track this information and use it to inform assessments of network adequacy. GOBHI submitted an Excel spreadsheet as documentation of its tracking of these items, but the spreadsheet contained no data on seclusion and restraint use, second assessment denials, member grievances or requests for information in alternative formats during 2014–2015. GOBHI appeared to be tracking grievance codes for some items for which there are no grievance codes.

- ***GOBHI needs to develop effective mechanisms to track the required items for MHO enrollees.***

Oversight of delegated activities

GOBHI has created a delegation agreement for its providers to sign. This agreement refers to GOBHI's MHO contract, but the Statement of Work refers exclusively to CCO-related requirements. The document does not specify the activities GOBHI has delegated to the CMHPs for MHO enrollees.

- ***GOBHI needs to ensure that the CMHPs know what services are delegated, how GOBHI will track the CMHPs' performance of those activities and the steps GOBHI will take if the CMHPs do meet the performance expectations in the agreement.***

GOBHI plans to de-delegate certain functions. However, at the time of the follow-up review, only a few functions had been centralized. The MHO has made little progress in the oversight of delegated activities.

- ***GOBHI needs to conduct an annual evaluation of all delegated functions.***

Practice guidelines

GOBHI submitted a list of clinical practice guidelines that contained hyperlinks to websites. HealthInsight Oregon tested the links and found that many were broken or connected to a bookstore where one could buy the guideline. The title page for the recently adopted guideline for suicidality said the guideline "is more than 5 years old and has not yet been updated to ensure that it reflects

current knowledge and practice." In accordance with national standards, this guideline can no longer be assumed to be current.

- ***GOBHI is encouraged to review its practice guidelines to ensure that they are current, and implement a dissemination method.***

Oversight of quality management program

GOBHI's QIC includes a representative of the board of directors. According to the QIC minutes submitted, this representative reported board activities to the QIC. However, no documentation was submitted to demonstrate that this representative reported QIC activities to the board.

Board minutes documented oversight of GOBHI's CCO relationships, but not of the MHO contract or GOBHI's MHO quality management program.

- ***GOBHI needs to develop mechanisms that demonstrate oversight of the quality management activities of GOBHI as an MHO.***

Management data specific to MHO enrollees

GOBHI staff reported development of an information system that will produce performance reports. GOBHI lacks the ability to stratify its data to report on MHO enrollees. No data specific to MHO enrollees were submitted during the 2014 or 2015 reviews. GOBHI submitted one aggregate report of MHO grievances for the 2016 follow-up review.

At the time of review, GOBHI lacked data on access, utilization and quality of care delivered to MHO enrollees with SHCN.

- ***GOBHI needs to ensure the quality and appropriateness of services delivered to MHO enrollees.***

PIP validation summary

OHA requires GOBHI to conduct two PIPs of its choosing each year, one clinical and one nonclinical.

Following the 2015 review, HealthInsight Oregon (then Acumentra Health) recommended that GOBHI select two new PIP topics for 2016 that would target a significant number of MHO enrollees and could significantly affect enrollee

health, functional status or satisfaction. In response, GOBHI analyzed its MHO-only member population and identified the new topics listed below.

As of the 2016 review, GOBHI had not developed either PIP beyond identifying and justifying the study topic (Standard 1 of the review protocol). By the time of the 2017 review, GOBHI is expected to have completed Standards 2–5 (study design) and 8 (improvement strategies) and to have supplied partial information for Standards 6 (study results) and 7 (interpretation of results).

1. **Older Adult PIP**

   GOBHI's data review indicated underutilization of mental health services by adults over age 60. The MHO decided to focus this PIP on improving the service penetration rate for this population. GOBHI stated that its first step would be to identify the causes of low referrals and utilization. This topic clearly relates to quality of care for MHO enrollees since the target population does not appear to be receiving needed services. HealthInsight Oregon reviewed GOBHI's documentation and assigned a score of 85 (Substantially met) for Standard 1.

2. **Children 0–6 Years Old Primary Care PIP**

   GOBHI's data review indicated underutilization of services by young Hispanic children (0–6 years of age). This PIP will focus on improving the service penetration rate for young Hispanic children in Umatilla and Malheur counties, the counties with the highest percentage of GOBHI's target population. GOBHI documented the importance of the topic, its relevance to the local MHO population and the topic prioritization process. The MHO identified a possible root cause for lower access by this population and briefly described its selected intervention. HealthInsight Oregon assigned a score of 100 (Fully met) for Standard 1.

ISCA summary

The ISCA review focused on processes related to GOBHI's MHO population. GOBHI uses similar IT practices for some CCO activities, which are covered in the individual CCO reviews.

GOBHI is working toward NCQA certification with a target review date of summer 2017. At the time of the ISCA review, GOBHI was formalizing and aligning its policies and procedures to NCQA standards.

GOBHI has struggled to remediate issues identified in the ISCA reviews from year to year. The MHO has taken steps to address some issues, but many have remained unresolved for several years.

GOBHI has increased its staffing in the past two years, adding a new IT director and several additional IT staff members who have responsibilities not only for the MHO, but for other GOBHI lines of business.

Summary of data systems

GOBHI outsources claims processing, encounter verification and data submission, enrollment verification and fee-for-service payments to PH Tech, a third-party administrator. The ISCA review reflected GOBHI's internal reporting, PH Tech's data processing and reporting procedures and GOBHI's oversight and monitoring of PH Tech-contracted services.

GOBHI's staff has begun making authorization decisions in PH Tech's Community Integration Manager. Previously, GOBHI's CMHPs performed service authorizations.

GOBHI provides and hosts email services for its provider network. Provider agencies can choose to have a GOBHI email address or to have their domain hosted by GOBHI.

Data certification and submission

GOBHI's encounter data liaison signs the certification of claims and encounter data. PH Tech submits mental health and addiction data to OHA, and GOBHI receives a copy of the submitted data.

Reporting data

GOBHI staff maintains an internal data warehouse for reporting data, loading the reporting data from PH Tech. GOBHI receives enrollment updates daily. Claims and encounter data are loaded when received, often weekly or more frequently. GOBHI staff maintains and write reports from this database. GOBHI has hired a new person to develop the reporting capabilities.

GOBHI is working with Arcadia Solutions to implement a new data warehouse. GOBHI intends to supplement in-house reporting capabilities with Arcadia; this solution is not meant to replace the internal reporting capabilities. This hosted solution will receive data from GOBHI, PH Tech and GOBHI provider agencies.

GOBHI intends for this data warehouse to include not only claims and encounter data, but clinical data stored in the providers' EHR systems. GOBHI hopes this data warehouse will enhance capabilities to verify completeness of encounters and perform more timely clinical interventions or record reviews.

GOBHI's profile in Appendix A presents the MHO's scores on each section of the ISCA review protocol.

DISCUSSION AND OVERALL RECOMMENDATIONS

HealthInsight Oregon and the CCOs have completed the first three-year cycle of EQR reviews since the CCOs were formed. In total, the reviews have covered the CCOs' compliance with state and federal standards for Enrollee Rights, Grievance Systems, Certifications and Program Integrity and QA/PI; validation of CCO performance measures adopted by the state, including two full ISCA reviews of OHA and CCO information systems; and work the CCOs have performed as part of two Statewide PIPs.

These reviews have revealed many successes and challenges as the CCOs strive to transform the delivery of health care for a greatly expanded population of Medicaid recipients. Following the 2016 review, HealthInsight Oregon offers the following recommendations for OHA to help the CCOs address the program areas in greatest need of improvement.

Ongoing Service Integration

The overarching need for ongoing improvement is to finish integrating the required services into the CCO benefit package and delivery systems. CCOs have made substantial progress with mental health service integration and need to continue those efforts. Integration of substance abuse disorder treatment, dental and NEMT services is less complete.

The CCOs have made progress in integrating data on physical, behavioral and dental health services. However, more work is needed to ensure that CCOs can use the data to manage care for enrollees, including those with SHCN.

Moving forward, the CCOs need to continue to work on integrating all required services at the administrative and service delivery levels, and on integrating these services into the CCOs' electronic clinical data systems. CCOs should ensure that all providers and delegates are aware of the expectations for care integration, and that services delivered across the entire network are aligned with the CCOs' policies and procedures.

- ***OHA needs to continue to support the CCOs in developing integrated policies and procedures, data systems, network and capacity planning and care coordination for all required services.***

- ***OHA should encourage the CCOs to continue their efforts to integrate all service data into a single data repository for each CCO to enable better reporting on integrated care.***

Access to Care

During 2016, most CCOs did not monitor contractual requirements for provider network access. Some CCOs lacked system-wide mechanisms to monitor network capacity in order to identify service gaps or disparities. Few CCOs' policies and procedures for providing direct access to specialists addressed access to behavioral health and dental care specialists.

Most CCOs do not closely monitor the timeliness of access to routine, urgent and emergent mental health services, substance use disorder treatment, dental care or NEMT services. Although avoidable ED utilization has declined, most CCOs reported an increase in overall ED utilization from 2015 to mid-2016.

More work is needed to improve access to care in rural areas, and to improve processes for identifying and coordinating care for members with SHCN.

- ***OHA needs to provide the CCOs with clear direction on monitoring their provider network capacity to ensure timely access to required services for all members.***

Oversight of Delegated Functions

Though CCOs may subcontract many activities to outside entities, the CCO is responsible for all duties and responsibilities included in the managed care contract, and must monitor subcontractors' performance. Many CCOs lack mechanisms to monitor certain activities that are delegated to partners and providers. Continuing work is needed to ensure that delegated functions such as utilization management, care coordination and provider credentialing are performed as required by contract.

HealthInsight Oregon observed that the CCOs and their delegates handle and monitor physical health and mental health grievances inconsistently. In many instances the CCO's grievance policies and procedures had not been updated to apply to mental health and dental services. CCOs need to continue to work with their partners and delegates to ensure that the grievance system is implemented consistently across all service types.

- ***OHA needs to provide guidance to the CCOs on handling and monitoring of member grievances to ensure that grievances are gathered and reported consistently as expected.***

Most CCOs did not provide evidence of monitoring and overseeing their contracted or partner organizations' practices for encounter data submission and IT security.

- ***OHA needs to encourage the CCOs to develop processes for monitoring their providers to enforce contractual requirements for timely data submission, IT security and business continuity planning.***

Program Integrity

Many CCOs have effective compliance programs in place for monitoring internal and external risks. However, some CCOs incur significant risk by not screening key personnel monthly for exclusion from federal health care programs, not performing criminal background checks and not monitoring gifts, gratuities and vendor compensations and relationships.

- ***OHA needs to clarify its expectations for CCOs to screen key personnel for exclusion from federal health care programs, conduct criminal background checks and monitor for conflicts of interest to reduce CCOs' overall risk.***

Performance Measures

OHA has made substantial improvements in resolving concerns about the integrity and completeness of encounter data. However, HealthInsight Oregon remains concerned about the validity of the data OHA uses to calculate the CCO performance measures.

- ***OHA needs to clearly document the performance measure calculation process, including steps to ensure a complete data set, data flow among separate systems and the roles and responsibilities of external partners.***
- ***OHA should either conduct an EDV or require the CCOs or a third party to conduct an EDV, to ensure submission of complete and valid encounter data to OHA.***

Incentive measures are now reported according to member race and ethnicity as identified on the Medicaid enrollment forms. This is a positive step forward in addressing health equity. However, member race and ethnicity are not required

fields on the enrollment forms, so information is missing for a large proportion of Medicaid enrollees, rendering the stratified results unreliable.

- ***OHA should require race and ethnicity fields to be completed on Medicaid enrollment forms, and should require the CCOs to determine and report members' racial/ethnicity data as part of encounter data.***

Many CCOs lack adequate understanding of documentation of the different sources and flow of encounter data. Some CCOs continue to work on enhancing their documentation and processes for certifying encounter data.

- ***OHA needs to ensure that the CCOs implement a certification process to ensure the completeness, accuracy and truthfulness of all encounter data submitted by providers.***

Information System Security

OHA continues to expand and enhance its business continuity/disaster recovery (BC/DR) plan for the Medicaid Management Information System, which was still in draft form at the time of the ISCA review.

- ***OHA needs to implement its strategy to recover data in the event of a disaster. OHA should monitor and verify that the plan is tested at least every other year, reviewed at least every two years and updated when significant changes occur.***

OHA does not require the CCOs by contract to maintain BC/DR plans, without which the CCOs risk being unable to fulfill their contractual obligations. OHA noted that CMS has made a rule change requiring Medicare/Medicaid cost centers to conduct more effective BC/DR planning.

- ***OHA needs to ensure that:***
  - ***CCOs and their delegates have BC/DR plans in place that address all CCO activities and that the plans are tested annually or whenever a plan is updated***
  - ***the CCOs review and update their data security policies and procedures, and those of their delegates, at least every two years***

Provider Directories

CCOs continue working to develop integrated and accessible directories with practitioner-level details for all services. Many CCOs have posted directories on their websites, but the online directories often are incomplete, particularly for mental health and dental services. OHA requires directories to include certain information for all types of providers, including specialty, languages spoken and provider type. In addition, including the practitioner's gender in directories would improve members' ability to make informed choices.

- ***OHA needs to provide direction to the CCOs on ensuring that their provider directories are easily searchable and contain the required practitioner-level details.***
- ***OHA should modify the managed care contract to require CCO provider directories to include each practitioner's gender.***

APPENDIX A. CCO PROFILES

These profiles briefly describe each CCO's organizational structure and summarize the CCO's performance in the review areas covered by the 2016 EQR:

- Follow-up review of compliance with regulatory and contractual standards
- Statewide and CCO-specific performance improvement projects (PIPs)
- Information Systems Capabilities Assessment (ISCA)

High-level results are extracted from the reports of individual health plan reviews that HealthInsight Oregon delivered to OHA throughout 2016. HealthInsight Oregon calculated the scores for these activities using methodology based on the Centers for Medicare & Medicaid Services review protocols and approved by OHA.

Profiles are presented for the 16 CCOs and one managed mental health organization (GOBHI) that served Oregon Health Plan enrollees during 2016.

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AllCare Health Plan

Mid Rogue Independent Physician Association, doing business as AllCare Health Plan, contracts with OHA to provide physical, dental and behavioral health services for OHP members in Jackson, Josephine, Curry and Douglas counties. AllCare delegates mental health service delivery to Jackson County Mental Health, Curry Community Health and Options for Southern Oregon. The CCO delegates alcohol and drug treatment service delivery to OnTrack and Addictions Recovery Center; dental service delivery to Advantage Dental, Capitol Dental Care, Willamette Dental Group, Moda Health and La Clinica; non-emergent medical transportation (NEMT) to Ready Ride; provider credentialing to PrimeCare and NW Rehab Alliance; and encounter data processing to PH Tech.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with AllCare regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 2 and partially resolved 2 of the 4 findings from 2014.
- Of 20 recommendations in 2014, 6 were resolved, 10 were partially resolved and 4 were not resolved.
- The CCO resolved both of the 2 findings from 2015.
- Of 20 recommendations in 2015, 3 were resolved, 15 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Mailed co-branded letters (with logos of all CCOs in the letterhead) to all providers about the opioid policy guidelines
- Mailed co-branded letters and taper forms to providers with patients on high opioid doses about the need to develop taper plans
- Developing co-branded educational materials, including a video for staff education and a provider toolkit
- Developing co-branded letters and other materials to mail to members

Barriers:

- There was uncertainty as to who would own the rights to the co-branded video. It was decided that the Oregon Pain Guidance group would take ownership.
- Differences about how the toolkit would be distributed delayed implementation.

Next steps:

- Continue member education.
- Complete the staff educational video and begin dissemination.
- Continue to send taper agreement letters and track the number of plans received.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increasing the percentage of referrals of pregnant women to community substance abuse programs
- Increasing the percentage of member advance directives or Physician Orders for Life-Sustaining Treatment (POLST)

CCO Focus Area:

- Increasing PCPCH enrollment

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.9)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (2.8)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met (2.1)	Provider Data	Not met (1.8)
Administrative Data	Partially met (2.3)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: CCO monitoring of delegated IT activities

AllCare has developed a new delegation oversight and audit process to monitor IT security practices, policies and procedures of its delegates and partners. The process does not clearly define relationships between the IT and business sides of AllCare, nor the roles and responsibilities for different monitoring activities. AllCare expected the monitoring of delegates' and partners' IT security practices, policies and procedures to be in regular production rotation by late 2016. Through the delegation oversight and audit process, AllCare identified a business partner that lacked formal IT policies, procedures and processes. The business partner reported working to develop and formalize its IT policies, procedures and processes.

Finding #2: Business continuity/disaster recovery (BC/DR) plans and testing plans

AllCare reported that it was developing a CCO-level BC/DR plan and planned to create a testing strategy. The CCO has identified an alternate recovery site and is working to document this as part of its project to construct a new office building. Curry Community Health reported that it is working with a contractor to develop and implement a BC/DR plan and a testing plan. Development of this plan was expected to be completed in early 2017.

AllCare's provider agencies reported varied stages of BC/DR planning. One agency reported having an informal BC/DR plan but had not developed a testing plan or identified a recovery site. Another provider agency reported having a BC/DR plan but had not developed a testing plan.

Finding #3: Zero- and low-dollar claims expectations and monitoring process

AllCare reported that it does not monitor to ensure that all Medicaid claims are submitted to OHA. The CCO has begun educating providers on its expectations regarding zero- and low-dollar claims. PH Tech worked to clarify requirements to match the state expectations. At least one provider agency reported that it does not submit these type of claims or encounters. Curry Community Health reported that it monitors for zero-dollar claims but does not submit such claims.

Finding #4: Unclear if AllCare is notified when provider leaves Curry Community Health

Curry Community Health reported that it does not notify AllCare when a provider leaves the agency. AllCare has an informal process of reviewing the credentials of all providers listed in the CCO's provider directory, but the credential review would not ensure the accuracy of the provider directory.

Cascade Health Alliance (CHA)

CHA, a wholly owned subsidiary of Cascade Comprehensive Care, LLC (CCC), contracts with OHA to provide physical, behavioral and dental health services for OHP members in Klamath County. CCC, a local physician-owned organization, performs all administrative functions for the CCO. Dental care delivery for enrollees is delegated to Advantage Dental and Capitol Dental Care. CHA contracts with Klamath Basin Behavioral Health, Lutheran Community Services, Transformation Wellness Center and individual mental health practitioners to provide mental health and substance use disorder treatment. NEMT service management is delegated to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with CHA regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- CHA resolved 1 of the 6 findings from 2014 and partially resolved the other 5.
- The CCO resolved 7, partially resolved 8 and did not resolve 10 of the 25 recommendations from 2014.
- CHA resolved 2, partially resolved 1 and did not resolve 5 of the 8 findings from 2015.
- The CCO resolved 6, partially resolved 11 and did not resolve 23 of the 40 recommendations from 2015.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Integrate CHA's Pain Committee with Sky Lakes Medical Center to improve efficiency and reduce duplication
- Develop point-of-sale prior authorization guidelines for opioid prescriptions ≥ 90 mg MED
- Add non-opioid treatment options to formulary
- Add alternative treatment providers to network

Barriers:

- Lack of a full-time pharmacist has delayed integration efforts
- Difficulty finding alternative treatment providers to sign long-term contracts

Next steps:

- Once pain committees have been integrated, begin tracking pain contracts and tapering plans for members on ≥ 90 mg MED.
- Begin implementing point-of-sale prior authorization guidelines at Klamath Basin pharmacies.
- Negotiate short-term contracts with alternative service providers.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improve timeliness of prenatal care
- Increase percentage of members with chronic obstructive pulmonary disease who receive a pulmonary function test

CCO Focus Area:

- Improve patient access at the clinic level by reducing no-show appointments

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met with a finding (2.7)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met (2.4)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.9)
Security	Not met (1.7)	Provider Data	Fully met (2.8)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Fully met (2.8)

Key Findings and Areas for Improvement

Finding #1: Data-flow diagrams and documentation

CHA uses multiple data repositories to house claims and encounter data received from multiple partners. CHA sends eligibility data to Advantage Dental and Capitol Dental Care. The CCO uses multiple software packages in processing, authorizing, reporting and submitting claims/encounters to OHA. In the ISCA interview, CHA described sending all claims and encounter data to OHA, but the data-flow diagram CHA submitted did not confirm that process.

Finding #2: Monitoring

CHA lacked a formal process to monitor IT activities of its delegates or partners. Relationships between the IT and business sides of CHA were unclear; roles and responsibilities were not clearly defined for different monitoring activities. CHA has begun to determine how to monitor the security policies and practices of partners and delegates, and is evaluating how to conduct a review of a partner/delegate's IT security policies and practices before contracting with the partner/delegate. CHA is exploring how to expand its Admin Audit Tool and Dental Compliance and Delegated Activity Review documents and processes to monitor the IT security policies and practices of partners and delegates.

Finding #3: Business continuity/disaster recovery (BC/DR) plan

CHA has developed a BC/DR plan and continues to refine it. It was unclear whether this plan covers all CCO functions and services. CHA reported that it has not yet developed a testing plan.

Columbia Pacific CCO (CPCCO)

CPCCO, a wholly owned subsidiary of CareOregon, provides physical, behavioral and dental health services for OHP members in Columbia, Clatsop and Tillamook counties. The CCO has a management agreement with CareOregon to provide administrative and risk-associated services. CPCCO delegates behavioral health service delivery to GOBHI, which subcontracts with Tillamook Family Counseling Center, Clatsop Behavioral Healthcare and Columbia Community Mental Health Services. CPCCO contracts for dental services with Moda Health, Capitol Dental Care, Advantage Dental and Willamette Dental Group. CPCCO's utilization management functions are shared among CareOregon, GOBHI and the four dental organizations.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with CPCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 8 and partially resolved 5 of the 13 findings from 2014.
- Of 44 recommendations in 2014, 12 were resolved, 27 were partially resolved and 5 were not resolved.
- The CCO resolved 1 and did not resolve 2 of the 3 findings from 2015.
- Of 29 recommendations in 2015, 8 were resolved, 20 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- **Intervention #1:** Expanded the CCO's pain clinic model into each county served (total of 119 graduates)
- **Intervention #2:** Changing the prescribing patterns of local providers through clinician education and cultivation of a shared vision
- **Intervention #3:** Conducted North Coast Opioid Summit in April 2016. Participants represented regional clinics, local hospitals, drug courts, police departments, school staff and the community.

Barriers:

- Difficulty filling available pain clinic openings; CPCCO is working with private insurers to cover pain clinic services for all members.

Next steps:

- Continue with the pain clinic model, but work on raising community awareness about the service and identifying barriers to member participation.
- Continue developing or implementing the different strategies listed under Intervention #2.
- Evaluate the recent Opioid Summit and make decisions about next steps.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Tobacco cessation
- Timeliness of prenatal care

CCO Focus Area:

- Adverse childhood experiences/trauma informed care

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.0)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Partially met (2.3)
Security	Not met (1.5)	Provider Data	Partially met (2.4)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

CareOregon handles data submission for CPCCO. It was unclear how the data received from partner organizations would be monitored to ensure completeness and accuracy. CareOregon has some processes to check for expected/estimated volume and trends. It was unclear if those processes are used in the certification process. Currently, CareOregon staff sign the certification for the CCO.

Finding #2: CCO monitoring of delegated IT activities

CPCCO did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. During the interview, it was unclear who held the contracts and how many contracts were in place. The CCO provided no evidence of a process to monitor provider agencies' activities related to information systems. It was unclear how this function would be split between CCO staff and the CareOregon delegation team.

CareOregon's delegation team has conducted monitoring of some delegates' IT activities, but did not have a process for monitoring provider agencies. CareOregon reported that it is defining IT monitoring activities.

Finding #3: Lack of business continuity/disaster recovery (BC/DR) plan

CareOregon hired a disaster recovery expert to work on its disaster recovery plan, and had an early draft of the plan. CareOregon planned to continue working on this plan and develop a testing strategy during 2016.

Neither CPCCO nor CareOregon maintained a CCO-level BC/DR plan.

Finding #4: Provider directory

CPCCO has updated its provider directory since the previous review. However, the directory lists only facility-level information for mental health providers and does not provide practitioner details. It is unclear how a member would request non-emergent medical transportation services by using the CCO website.

CPCCO's website includes links to dental partners' websites. It appeared that most sites had practitioner-level details, but not all websites listed genders and languages spoken. Some websites may have had additional details, but links to individual practitioner information may have been broken. This process may be difficult for members to navigate.

Eastern Oregon CCO (EOCCO)

EOCCO provides physical, behavioral and dental health services to OHP members in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler counties. The CCO's daily operations are administered by GOBHI and Moda Health. GOBHI provides mental health services through contracts with providers, most of which are community mental health programs in its service area. Moda Health provides physical health, chemical dependency and vision services. EOCCO provides dental services through contracts with Advantage Dental, ODS Community Health and Capitol Dental Care. GOBHI administers the contract with Mid-Columbia Council of Governments for NEMT services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with EOCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 3 and partially resolved 4 of the 7 findings from 2014.
- Of 27 recommendations in 2014, 15 were resolved, 8 were partially resolved and 4 were not resolved.
- The CCO resolved all 3 findings from 2015.
- Of 16 recommendations in 2015, 4 were resolved, 11 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- **Community education:** The Regional Opioid Prescribing Group (ROPG) will conduct forums in Hermiston, Pendleton, Ontario and John Day, and plans to develop a patient resource library.
- **Community health worker (CHW) activities:** ROPG is developing ways to integrate opioid management into CHW training.
- **Provider education:** Deliver best-practice information and referral resources to help providers intervene with members on high opioid doses. Track buprenorphine rates to demonstrate changing prescribing practices and effectiveness of provider education.

Barriers:

- Changes in data analytics staffing; EOCCO is working with pharmacy to resolve the gap.
- Providers lack information and resources needed to manage chronic opioid users. EOCCO, through the ROPG, is developing interventions to address this barrier.

Next steps:

- Promote May 2016 pain management conference in Medford to the provider network.
- Distribute materials developed by Grande Ronde Regional and Baker City Saint Alphonsus clinics.
- Develop a list of regional pain schools and non-pharmacologic resource materials for providers.
- Recruit a non-physician behaviorist and a physical therapist representative to the ROPG.
- Provide education about buprenorphine to providers.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increase adolescent well visits
- Improve maternity and child health outcomes

CCO Focus Area:

- Increase rates of development screening for children 0–6 years old

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.5)	Enrollment Systems	Fully met (2.7)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.9)
Security	Partially met (2.1)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Business continuity/disaster recovery (BC/DR) plan

Moda Health has done some BC/DR planning but is reworking its activities. Testing was planned for summer 2016. There appears to be limited planning for loss of the key data center, but there are offsite data replicas. It was unclear if any BC/DR planning has occurred that includes the CCO partners or all CCO services.

GOBHI has a contingency policy in place, but it is high-level and focused on IT. GOBHI staff who assisted in testing this policy have a lot of historical knowledge, but the policy lacks sufficient information to enable other personnel without that knowledge to perform recovery tasks. GOBHI conducted a test scenario in August 2015; the plan was not updated after that test.

It was unclear how data flows through GOBHI's information systems and in what order information systems need to be restored in the event of a disaster to facilitate recovery of business operations.

GOBHI has many outsourced or cloud-based solutions. GOBHI's recovery strategy may need to document contact information and items needed to use those services.

Finding #2: Monitoring

GOBHI and Moda Health are developing a process for monitoring contracted and partner organizations' policies, procedures and practices related to information systems. GOBHI expected to implement monitoring by summer 2016. At the time of the review, GOBHI was hiring a person to work with contracted or partner organizations on compliance with contract requirements and security best practices.

Finding #3: Provider payment and updates process

GOBHI staff perform credentialing decisions for new provider contracts, and inform PH Tech of necessary updates and contracting rates. GOBHI has instructed PH Tech to track payment based on the facility's contracted rates. It was unclear if PH Tech could pay for an encounter conducted by a practitioner who has not completed GOBHI's credentialing process.

FamilyCare CCO

FamilyCare, Inc., a 501(c)(4) public benefit corporation, contracts with OHA to provide physical, behavioral and dental health services to OHP members in Multnomah, Clackamas, Washington and Marion counties. FamilyCare contracts with eight dental plans. FamilyCare contracts with CVS Caremark as its pharmacy benefit manager and with Access2Care for NEMT.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with FamilyCare regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 5 of the 12 findings from 2014.
- Of 11 recommendations in 2014, 5 were resolved, 5 were partially resolved and 1 was not resolved.
- The CCO resolved all 3 findings from 2015.
- Of 11 recommendations in 2015, 1 was resolved and 10 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Provider outreach: Initiated educational program with dental prescribers.
- Comprehensive/alternative pain services
- Provider education
- Conducted on-site visits to top prescribing clinics by medical directors
- Existing interventions: Continued to implement prior authorization and quantity limits policies and procedures
- Internal data development

Barriers:

- Mailing had been planned to begin earlier but was delayed by timing of internal staff education. Training has now been completed.
- Data needed to facilitate pilot programs were incomplete. FamilyCare is building dashboards to support data requests.
- On-site visits are time-consuming to plan, implement and follow up.
- Staffing changes in provider services create a barrier to on-site visits.
- Difficult to achieve clinic-oriented outreach when many providers are non-contracted and there is no clinic affiliation information.

Next steps:

- Begin mailing notifications to top prescribers. Continue providing reports to clinics, adapting elements of the reports to meet individual clinic needs. Increase the number of clinics to receive reports.
- Try to recruit a community provider to participate in a Project ECHO-like program.
- Analyze acute prescribing of high-dose opioids, focusing on urgent care, emergency department and post-surgical prescribing. Initial data suggest that acute prescribing might be more problematic for the CCO.
- Opioid workgroup will develop a program for alternative treatments for chronic pain management.
- Conduct data analyses of metric and interventions to determine effectiveness.
- Implement MED-based coding by 4th quarter 2016.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increasing colorectal cancer screening
- Increasing adolescent well-child visits

CCO Focus Area:

- Improving chronic conditions in the serious and persistent mentally ill population

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.8)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (2.8)
Security	Partially met (2.3)	Provider Data	Fully met (2.7)
Administrative Data	Partially met (2.4)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: CCO monitoring of delegated IT activities

FamilyCare reported that it does not conduct monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. FamilyCare has developed a Provider Office Site Review Checklist that includes reviewing the IT systems and policies and procedures used by a provider or other type of partner organization. The CCO submitted the new checklist for review after the ISCA interview.

FamilyCare plans to phase the new checklist into operations during regularly scheduled site visits to provider offices in late 2016 and 2017.

Finding #2 : Encounter data certification

PH Tech handles data submission for FamilyCare. PH Tech submits a copy of the CIM database, provider master database and various tables once a month. It was unclear if FamilyCare receives copies of the 837 files that PH Tech submits to OHA. FamilyCare is developing additional reports and processes to augment the current certification process used by the Claims Department assistant manager to sign the encounter data certification for the CCO.

Greater Oregon Behavioral Health, Inc. (GOBHI)

GOBHI, a managed mental health organization (MHO), manages the OHP mental health benefit in 22 rural Oregon counties and provides services through local community mental health programs. GOBHI's governing board includes county commissioners of Columbia, Umatilla and Union counties, provider network representatives and consumers. Most MHO activities are delegated to the county mental health authorities, which receive a capitation payment to deliver services for enrollees.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with GOBHI regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews. GOBHI had made progress in addressing many findings that were carried over from 2012, though several findings remained unresolved or only partially resolved. More work is needed to bring GOBHI into full compliance with its MHO contract and federal Medicaid regulations in the following areas:

- Delivery network
- Policies and procedures
- Tracking of second opinions, seclusion and restraint and access to interpretation and materials in alternative formats and languages
- Oversight of delegated activities
- Oversight of quality management program
- Practice guidelines
- Management data specific to MHO enrollees

Performance Improvement Projects (PIPs)

As of the 2016 review, GOBHI had not developed either PIP beyond identifying and justifying the study topic (Standard 1 of the review protocol). By the time of the 2017 review, GOBHI is expected to have completed Standards 2–5 (study design) and 8 (improvement strategies) and to have supplied partial information for Standards 6 (study results) and 7 (interpretation of results).

Older Adult PIP (score = 14 out of 85, Not met)

GOBHI's data review indicated underutilization of mental health services by adults over age 60. The MHO decided to focus this PIP on improving the service penetration rate for older adults. GOBHI stated that its first step would be to identify the causes of low referrals and utilization. This topic clearly relates to quality of care for MHO enrollees since the target population does not appear to be receiving needed services. HealthInsight Oregon reviewed GOBHI's documentation and assigned a score of 85 (Substantially met) for Standard 1.

Children 0–6 Years Old Primary Care PIP (score = 17 out of 85, Not met)

GOBHI's data review indicated underutilization of services by young Hispanic children (0–6 years of age). This PIP will focus on improving the service penetration rate for young Hispanic children in Umatilla and Malheur counties, the counties with the highest percentage of GOBHI's target population. GOBHI documented the importance of the topic, its relevance to the local population and the topic prioritization process. The MHO identified a possible root cause for lower access by this population and briefly described its selected intervention. HealthInsight Oregon assigned a score of 100 (Fully met) for Standard 1.

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.2)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (2.6)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.7)
Security	Not met (1.9)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.1)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

PH Tech handles data submission for GOBHI, sending reports to GOBHI of what the providers submit. GOBHI is using these reports in a specialized cleanup process and is trying to determine how to use these data and reports on an ongoing basis. GOBHI is working to evolve its processes to ensure data completeness and accuracy.

GOBHI signs the attestation that data are accurate based on PH Tech's data submission to OHA. GOBHI is working with PH Tech and providers on processes to ensure the completeness and timeliness of the data.

Finding #2: Monitoring

GOBHI is developing a process for monitoring contracted and partner organizations' policies, procedures and practices related to information systems. GOBHI expected to implement monitoring by summer 2016. At the time of the review, GOBHI was hiring a person to work with contracted or partner organizations on compliance with contract requirements and security best practices.

Finding #3: Provider payment and updates process

GOBHI staff perform credentialing decisions for new provider contracts that are added. Staff members inform PH Tech of necessary updates and contracting rates. GOBHI has instructed PH Tech to track payment based on the facility's contracted rates.

It was unclear if PH Tech could pay for an encounter with a practitioner who has not completed the GOBHI credentialing process. It was unclear if this process would need to change in March 2016 when NPI numbers for the rendering practitioner must be used. It was unclear how additional practitioners would be added to the provider directory.

Health Share of Oregon

Health Share contracts with OHA to provide physical, behavioral and dental health services to OHP members in Multnomah, Washington and Clackamas counties. The CCO contracts with 16 risk-accepting entities (RAEs). Activities delegated to RAEs include network planning, monitoring and maintaining access, credentialing, care coordination/case management, pharmacy benefit management, claims payment, customer service and utilization management. The CCO has workgroups and committees charged with fully integrating behavioral and physical health and dental services. The CCO retains adjudication of final appeals and oversight of QI activities.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with Health Share regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved all 4 findings from 2014.
- The CCO resolved all 20 recommendations from 2014.
- No findings arose from Health Share's 2015 compliance review.
- Of 12 recommendations in 2015, 10 were resolved and 2 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Patient education and engagement—distribute materials to members about the new opioid prescribing policy and need for tapering plans
- Provider education and engagement (e.g., learning collaborative, pain conference, continuing medical education)
- Expand access to effective alternatives (e.g., acupuncture, physical therapy, aqua therapy)
- Implement new opioid prescribing limits
- Increase actionable data
- Increase leadership priority and buy-in

Barriers:

- Kaiser Permanente (KP) nurses lacked tools or knowledge to hold difficult conversations with members. The nurses are receiving appropriate training.
- KP members have filed complaints about changes to the opioid prescribing guidelines.
- Challenging to develop a process of working with high opioid-prescribing providers and clinics that is sustainable and not punitive.
- Tuality Health Alliance (THA) is not receiving accurate pharmacy data.

Next steps:

- Health plan partners will continue existing interventions.
- One of Kaiser's clinics will test a review board model for new opioid starts.
- Providence Health Plan will reevaluate its Pathways to Treat provider tool, develop a regional case review process and reschedule the pain symposium.
- THA will meet face to face with providers about back pain coverage and opioid prescribing practices.
- Health Share will develop a dashboard to provide to each of its RAEs on a monthly basis.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving maternal and infant outcomes using a new model of care (Project Nurture)
- Designing and implementing foster care medical home models of care

CCO Focus Area:

- Improving rate of effective contraception use

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (3.0)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (2.8)	Vendor Data Integration	Partially met with a finding (2.6)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (3.0)
Security	Not met (1.8)	Provider Data	Partially met with a finding (2.8)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Business continuity/disaster recovery (BC/DR) plan

Health Share is developing a CCO-level BC/DR plan; CCO management was reviewing a draft plan at the time of the ISCA interview. CCO management expects to continue to define critical functions, systems and resources that need to be maintained in the event of a disaster.

Health Share reported that it has developed a plan for supporting the phone systems and network infrastructure during a disaster. The CCO is evaluating how the use of virtual workstations could facilitate disaster recovery and business continuity plans.

Finding #2: Monitoring of business partners and PH Tech

Health Share did not provide evidence of monitoring and oversight of PH Tech for processing of claims and encounter data.

Several of Health Share's business partners contract with PH Tech to process claims and encounter data. PH Tech submits claims and encounter data to Health Share on behalf of those business partners. It was unclear if Health Share would be able to ensure the completeness and accuracy of business partners' data submitted to the CCO by PH Tech based on the current level of monitoring.

InterCommunity Health Network (IHN)

IHN, a wholly owned subsidiary of Samaritan Health Services, contracts with OHA to provide physical, behavioral and dental health services for OHP members in Benton, Lincoln and Linn counties. IHN is managed by Samaritan Health Plan Operations (SHPO), and all CCO staff members are SHPO employees. IHN contracts with the three counties for behavioral health services, and with Advantage Dental, Capitol Dental Care, ODS Community Health and Willamette Dental Group to provide dental care for members.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with IHN regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 3 and partially resolved 4 of the 7 findings from 2014.
- Of 29 recommendations in 2014, 11 were resolved, 10 were partially resolved and 8 were not resolved.
- The CCO resolved 2 and partially resolved 2 of the 4 findings from 2015.
- Of 29 recommendations in 2015, 13 were resolved, 15 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Conduct general public and provider education
  - 16 urgent care providers received education from IHN's chief medical officer (CMO)
  - 57 providers were educated through the regional task force
  - 8 providers on Pharmacy and Therapeutics Committee received education
  - 151 providers attended the continuing medical education offering
  - 20 leaders attended training in managing chronic conditions
  - 70 members received direct education through a class led by the CMO
- Implement prescription opioid limits
  - 87 providers and 964 members were sent letters about the new policy

Barriers:

- None

Next steps:

- Continue current interventions.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospitalizations
- Deploying care teams to reduce emergency department utilization

CCO Focus Area:

- Improving the oral health of pregnant women

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.8)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met (2.4)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.0)
Security	Not met (1.8)	Provider Data	Partially met (2.4)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Lack of business continuity/disaster recovery (BC/DR) plan

IHN did not maintain a CCO-level BC/DR plan, though IHN's parent organization has a draft plan. IHN has a pilot project underway to develop a CCO-level plan based on the parent organization's plan. IHN planned to continue working on this plan and developing a testing strategy during 2016.

Finding #2: Historical gaps in mental health data

In September 2013, IHN began receiving mental health encounters directly from providers and county mental health facilities. The CCO no longer contracts with PH Tech to administer mental health data. Mental health claims and encounters from the first three to four months of CCO operations were not migrated into IHN's Facets system due to data integrity issues. At the time of the ISCA review, these data were not in a database and not available for reporting.

Jackson Care Connect (JCC)

JCC, a wholly owned subsidiary of CareOregon, contracts with OHA to provide physical, behavioral and dental health services for OHP members in Jackson County. JCC has an agreement with Jackson County Health and Human Services (JCHHS) to provide mental health services, and CareOregon provides physical health services. CareOregon performs many administrative and operational activities on the CCO's behalf. JCC delegates dental service delivery to Willamette Dental Group, Capitol Dental Care, Moda Health and Advantage Dental; and NEMT services to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with JCC regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 5, partially resolved 5 and did not resolve 5 of the 15 findings from 2014.
- Of 45 recommendations in 2014, 12 were resolved, 16 were partially resolved and 17 were not resolved.
- The CCO resolved 1, partially resolved 2 and did not resolve 1 of the 4 findings from 2015.
- Of 25 recommendations in 2015, 11 were resolved, 12 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- JCC-specific interventions
  - Use claims data to identify subgroups of opiate users and refine outreach to providers based on users' primary characteristics
  - Communicate to providers about lowering the medication limit; offer technical assistance by behavioral health and CCO medical director
- Joint interventions with regional collaborative: With other southern Oregon CCOs, develop joint strategies around community education, provider education, pain management modalities and medication-assisted treatment

Barriers:

- Inconsistencies between internal and OHA study metric data make it difficult to identify and understand the study population.
- Large number of pain specialists in the area is a disincentive for primary care providers to manage their own patients. Treatment of chronic pain by a specialist increases the fragmentation of patient care.
- Collaboration among CCOs has been difficult due to lack of time, physical distance between organizations, different operating structures.

Next steps:

- Continue to distribute quarterly reports on high opioid users to providers.
- JCC's behavioral health team, pharmacist and medical director will continue to reach out to providers and clinics with the most patients on a quarterly basis.
- JCC's pharmacist will begin to incorporate additional actionable data (patient lists) as they are received. Pharmacist will begin retrospective review of members previously identified as achieving MED goal, and will begin to provide tapering technical assistance to providers.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving prenatal and perinatal care
- Adolescent well care and behavioral health integration

CCO Focus Area:

- Focus on high utilizers

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.1)	Enrollment Systems	Partially met (2.4)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Partially met (2.4)
Security	Not met (1.6)	Provider Data	Partially met (2.4)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

CareOregon handles data submission for JCC. It was unclear how JCC would monitor data received from partner organizations to ensure completeness and accuracy. CareOregon has some processes to check for expected/ estimated volume and trends, but it was unclear if those processes are used in certification. Currently, CareOregon staff sign the certification for the CCO. The CCO is transitioning this function to CCO staff.

Finding #2: Monitoring

JCC did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. The 2015 Jackson County Utilization Management Team (JC-UMT) delegation oversight review included a health information system corrective action plan that has been completed. During the ISCA interview, it was unclear who held the contracts and how many contracts were in place. It was unclear how monitoring would be divided between CCO staff and the CareOregon team. CareOregon's delegation oversight unit conducted a review of JC-UMT but was in the process of adding organizations and IT monitoring.

Finding #3: Lack of business continuity/disaster recovery (BC/DR) plan

JCC did not maintain a CCO-level BC/DR plan. CareOregon hired a disaster recovery expert to work on its disaster recovery plan. CareOregon planned to continue working on this plan and developing a testing strategy in 2016.

Finding #4: JC-UMT enrollment checks

JC-UMT relies on providers to check eligibility before delivering services. JC-UMT checks eligibility at the time of authorization but not at the time of the claims payment. The JC-UMT profiler system does not have access to 834 enrollment data. There may be post-payment mechanisms that could reconcile some of these payments.

Finding #5: Provider directory

JCC has updated its provider directory since the previous review. JCC has a directory of physical health providers, but not of mental health or dental practitioners in Jackson County. It was unclear how a member might find mental health provider-level detail. Also, some views of the physical provider directory do not display gender or specialty, but those items are searchable.

JCC's provider directory shows dental agencies without practitioner-level information or DCO assignment information. The portal may confuse members because they can obtain practitioner-level information from the website, but then they must follow a link located in a separate area of the website for each contracted DCO.

PacificSource Central Oregon (PSCS-CO)

PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CO and PSCS-Columbia Gorge. PSCS-CO serves OHP members in Deschutes, Jefferson and Crook counties. Each CCO has its own governing council with oversight from a subsidiary board of directors. PacificSource contracts with Deschutes County Health Services for mental health services and substance use disorders; with Caremark for pharmacy benefit management; and with Advantage Dental, Capitol Dental Care, Willamette Dental Group and Moda Health for dental services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with PSCS-CO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO partially resolved both of the 2 findings from 2014.
- Of 20 recommendations in 2014, 14 were resolved, 5 were partially resolved and 1 was not resolved.
- The CCO partially resolved all 4 findings from 2015.
- Of 22 recommendations in 2015, 9 were resolved, 11 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Promote safer prescribing practices
  - Limit opioid dosing threshold to <120 mg MED
  - Reduce co-prescribing of opioids and benzodiazepines
- Increase prescription drug monitoring program (PDMP) enrollment and usage
  - Continue to implement pharmacy prior authorization process that requires attestation of PDMP enrollment

Barriers:

- Definition of target population is delayed as the issue of whether or not to include members on buprenorphine has not been decided.
- Creation of mailing processes has taken longer than expected due to multiple pre-approval processes and the need to create processes to accommodate new technology.
- Need to coordinate efforts of multiple entities around the PDMP to avoid burdening providers with multiple requests for their time.

Next steps:

- Finalize data analysis process and begin distributing accurate lists of members on ≥120 mg MED, regenerating old reports if revisions are necessary.
- Develop process to identify members who are co-prescribed opiates and benzodiazepines; provide lists of these members to providers on a monthly basis.
- Conduct PDMP training in May 2016.
- If Deschutes County receives grant to improve PDMP usage, work collaboratively with grant project staff.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving post-partum care
- Integrating chronic pain management into primary care

CCO Focus Area:

- Increasing preventive care to members with serious and persistent mental illness

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.4)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.4)
Security	Partially met (2.0)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

PH Tech is submitting final data directly to OHA, and PSCS-CO is not receiving a copy of the submitted data. The CCO stated it continues to monitor trends related to the encounter and claims data and is developing additional reports to more completely reflect all CCO services. After the PH Tech transition, PSCS-CO worked to determine what additional reports were needed to monitor the data submission process. These new and existing reports are being used to support the CCO's attestation process.

PacificSource Columbia Gorge (PSCS-CG)

PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CG and PSCS-Central Oregon. PSCS-CG serves OHP members in Hood River and Wasco counties. Each CCO has its own governing council with oversight from a subsidiary board of directors. PacificSource contracts with contracts with Mid-Columbia Center for Living for mental health services and substance use disorders; with Caremark for pharmacy benefit management; and with Advantage Dental, Capitol Dental Care, and Moda Health for dental services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with PSCS-CG regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO partially resolved both of the 2 findings from 2014.
- Of 21 recommendations in 2014, 14 were resolved, 6 were partially resolved and 1 was not resolved.
- The CCO resolved all 4 findings from 2015.
- Of 18 recommendations in 2015, 8 were resolved, 9 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Charter a Pain and Opioid Treatment Work Group to advise the CCO's Clinical Advisory Panel and disseminate recommendations to providers and members
- Promote safer prescribing practices
  - Adherence to a ≥ 120mg MED opiate limit
  - Avoidance of polypharmacy
- Increase prescription drug monitoring program (PDMP) enrollment and usage
  - CCO is developing a PDMP training

Barriers:

- Barriers to a successful community strategy:
  - Limited access to Suboxone prescribers
  - Limited treatment options for chronic pain members with "below the line" diagnoses
  - Competing demands and priorities for PCPs affects participation in workgroup
  - Strong member resistance to decreasing opioid limits
  - Providers lack experience with difficult patient conversations

Next steps:

- Pain and Opioid Treatment Work Group will meet monthly and develop interventions in accordance with their charter, including PDMP education and assistance to providers.
- Develop process to identify members who are co-prescribed opiates and benzodiazepines; provide lists of these members to providers on a monthly basis.
- Conduct PDMP training in May 2016.
- Continue to refine data analysis process.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving postpartum care
- Integrating chronic pain management into primary care

CCO Focus Area:

- Increasing preventive care to members with serious and persistent mental illness

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially Met (2.4)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.4)
Security	Partially met (2.0)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

PH Tech is submitting final data directly to OHA, and PSCS-CG is not receiving a copy of the data. The CCO stated that it continues to monitor trends related to encounter and claims data and is developing additional reports to more completely reflect all CCO services. After the PH Tech transition, PSCS-CG worked to determine which additional reports were needed to monitor the data submission process. These new and existing reports are being used to support the CCO's attestation process.

PrimaryHealth of Josephine County (PHJC)

PHJC, owned by Oregon Health Management Services (OHMS), provides physical, behavioral and dental health services for OHP members in Josephine County. OHMS sub-delegates mental health service delivery to Options for Southern Oregon; dental services to Capitol Dental Care, Advantage Dental, Willamette Dental Group, and Moda Health; and NEMT to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with PHJC regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 5, partially resolved 4 and did not resolve 1 of the 10 findings from 2014.
- Of 18 recommendations in 2014, 7 were resolved, 10 were partially resolved and 1 was not resolved.
- The CCO resolved 5 and partially resolved 2 of the 7 findings from 2015.
- Of 22 recommendations in 2015, 18 were resolved, 4 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Community education
- Support and assist providers in reducing prescription opioids
- Pain management modalities
  - CCO helped sponsor chronic pain group classes in Josephine County.
- Medication-Assisted Treatment (MAT)
  - CCO is working with Choices Counseling Center to open a MAT clinic.

Barriers:

- New limits might be a challenge and burden to PCPs that serve chronic pain patients
- Lack of alignment among CCOs regarding chronic pain management
- Previous pain resiliency pilot program lost funding due to low patient participation, low provider engagement and poor coordination with other resources
- Very few providers of buprenorphine in Josephine County

Next steps:

- Develop an educational video, culturally and linguistically appropriate member education materials and other messaging (social media, public service announcements, etc.).
- Develop small toolkit (including tapering agreement, schedule, letters and materials) primarily focused on benefit changes. Collaborate with drug detail representative to spread the policy message.
- Develop community-based meetings to discuss benefit changes and distribute toolkits.
- After review and analyses, recommend a model of care to inform Center of Excellence development.
- Collect data and information on the Josephine County pain classes and share with the larger group.
- Open MAT clinic in Grants Pass.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Design and implement a local medical maternal health home
- Reduce emergency department utilization by moderate utilizers

CCO Focus Area:

- Implement Mental Health First Aid in the community

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.9)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met with a finding (2.6)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met with a finding (2.6)	Provider Data	Fully met (2.9)
Administrative Data	Partially met (2.4)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Lack of integrated business continuity/disaster recovery (BC/DR) plan

PHJC developed a draft BC/DR plan and continues to refine it. PHJC is updating the plan to support virtualization of production servers. It was unclear whether this plan covers all CCO functions and services. PHJC has scheduled plan testing for 2017.

Finding #2: Informal process for monitoring data flow to ensure submission of all data

PHJC uses an informal process to monitor encounter trends for CCO services. The CCO should devote attention to capitated services due to the lack of incentive for an agency or partner organization to supply encounter data for these services. Monitoring for over- or underutilization of anticipated services will allow the CCO to address any issues early and minimize potential negative impacts on actuarial rates and performance measure calculations.

Finding #3: Monitoring IT policies and procedures of providers and other partner organizations

Intelligenz, on behalf of PHJC, has contracted with Amazon Web Services and PeHS for key production IT services and functions. Intelligenz submitted some IT policies and procedures, but it was unclear whether Intelligenz has developed or expanded its current policies, procedures and practices sufficiently to cover these new IT services and functions.

PHJC has developed a process for monitoring contracted and partner organizations' policies and procedures related to information systems. The CCO expected this monitoring process to be in full use sometime in 2017.

Finding #4: NEMT data not being submitted to OHA

As of the interview date, PHJC had not successfully submitted NEMT claims and encounter data to the state. PHJC is working with TransLink, its NEMT service provider, to resolve issues with submission of the 837 data.

Trillium Community Health Plan (TCHP)

TCHP, a wholly owned subsidiary of Centene Corp., contracts with OHA to provide physical, behavioral and dental health services for OHP members in Lane County and portions of other counties. Trillium Behavioral Health (TBH) provides behavioral health services for TCHP members. TCHP delegates to TBH the responsibility to establish and maintain the provider network needed to support behavioral services, utilization management, credentialing for behavioral health services and care coordination. TCHP provides dental services through contracts with Willamette Dental Group, Advantage Dental, Capitol Dental Care and Moda Health. NEMT services are delegated to RideSource.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with TCHP regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 3, partially resolved 1 and did not resolve 1 of the 5 findings from 2014.
- Of 25 recommendations in 2014, 10 were resolved, 10 were partially resolved and 5 were not resolved.
- The CCO partially resolved 1 and did not resolve 2 of the 3 findings from 2015.
- Of 18 recommendations in 2015, 5 were resolved, 7 were partially resolved and 6 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Clinical Advisory Panel adopted the Centers for Disease Control and Prevention (CDC) guidelines on opioid prescribing.
- Disseminate CDC guidelines to providers on laminated reference sheets.
- Conduct Living Well with Chronic Pain classes.

Barriers:

- Lack of staff delayed implementation of interventions.

Next steps:

- Once staff is hired and trained, implement interventions to offer and increase access to physical therapy or acupuncture and to behavioral health for managing chronic pain.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospital readmissions
- Improving depression screening

CCO Focus Area:

- Decreasing tobacco use during pregnancy

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (3.0)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.8)	Report Production/PM Reports	Fully met (2.9)
Security	Not met (1.9)	Provider Data	Fully met (2.8)
Administrative Data	Not met (1.6)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Business continuity/disaster recovery (BC/DR) plan

TCHP's BC/DR plan was being updated at the time of the ISCA review. Centene, the parent organization, has a BC/DR plan for its enterprise data center. TCHP plans to continue working on this plan and developing a testing strategy during 2016. TCHP submitted additional documentation detailing plans for updating the BC/DR plan and the expectation of testing the updated plan in the second quarter of 2017.

Finding #2: Monitoring

Centene is developing a new vendor oversight program that TCHP expects to use for monitoring and oversight of contracted and partner organizations' IT and security practices, procedures and policies. Centene is evaluating who will be the business owner for this process. It was unclear how TCHP will implement this program and communicate it to providers and other partner organizations.

Finding #3: Attestation process

It was unclear how TCHP monitors the submission of claims and encounter data by provider agencies. TCHP was not sure how the CCO and/or Centene would know if the volume of claims being submitted by providers was within expected norms. The onsite interview revealed that the TCHP staff member tasked with monitoring of data submission trends was unaware that NEMT claims and encounters had not been successfully submitted to OHA in several months.

Finding #4: NEMT data not monitored or submitted to OHA

TCHP contracts with RideSource (Lane Transit District) to provide NEMT services. TCHP reported that as of mid-September 2016, NEMT claims and encounter data had not been successfully submitted to OHA since the CCO's IT operations were migrated to Centene's corporate data center in June. Centene and TCHP were attempting to resolve these issues, resume regular submission of NEMT claims and encounter data to OHA and ensure that the backlogged claims are processed and submitted.

TCHP has not yet determined a strategy to monitor NEMT data for completeness. The ride vendor is responsible for ensuring that the transportation request has an associated appointment. The CCO needs to determine appropriate monitoring activities to ensure that transportation services have a corresponding encounter (e.g., a physician office visit).

Umpqua Health Alliance (UHA)

Douglas County Independent Practice Association *dba* UHA is the CCO for Douglas County. UHA contracts with Community Health Alliance (CHA) to provide mental health outpatient services; with ADAPT to provide substance use disorder treatment; with GOBHI to manage access to inpatient psychiatric services; with MedInsight for pharmacy benefits management; and with Advantage Dental and Willamette Dental Group for dental services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with UHA regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 5, partially resolved 5 and did not resolve 3 of the 13 findings from 2014.
- Of 35 recommendations in 2014, 9 were resolved, 6 were partially resolved and 20 were not resolved.
- The CCO partially resolved 3 and did not resolve 2 of the 5 findings from 2015.
- Of 26 recommendations in 2015, 2 were resolved, 11 were partially resolved and 13 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Monitoring of opioid policy, guidelines and adherence by CCO's Pain Committee
- Ongoing implementation of the prior authorization process
- Ongoing implementation of new opioid medication guidelines
- Ongoing provision of education and CME
- Ongoing case reviews conducted as needed
- Ongoing support for providers and clinics that have large drug-seeking patient populations

Barriers:

- Provider compliance with opioid policy guidelines: The Pain Committee chair and CCO pharmacist meet with individual providers who are "reticent to change."

Next steps:

- Continue existing interventions

CCO-Specific Project Topics

CCO-Specific PIPs:

- Identification of addiction issues in pregnancy
- Decreasing utilization of the emergency department

CCO Focus Area:

- Increasing PCPCH enrollment

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met with a finding (2.7)	Enrollment Systems	Partially met (2.4)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met with a finding (2.6)
Security	Partially met (2.1)	Provider Data	Fully met (2.9)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Attestation sign-off

UHA receives reports of the claims and encounter data that ABCT submits to OHA. UHA performs attestation based on those reports. It was unclear who would monitor data received from partner organizations to ensure data completeness and accuracy.

Finding #2: Disaster recovery planning

UHA has developed a business continuity/disaster recovery plan and continues to refine it. It was unclear whether this plan covers all CCO functions and services. UHA reported that it had not yet developed a testing plan.

Finding #3: Provider monitoring

No documentation was submitted showing that the delegate was monitoring providers. The CCO performs only limited monitoring of GOBHI's IT functions. The CCO lacked a formal process to monitor IT activities of its delegates or partners. Relationships between the IT and business sides of the CCO were unclear; roles and responsibilities were not clearly defined for different monitoring activities.

Finding #4: Provider is not verifying enrollment at time of service

One provider agency stated that it checks eligibility only when billing for the claim/encounter.

Finding #5: Enrollment data components received from OHA "unloadable" in Plexis CM

The daily 834 file received from OHA contained components that were unloadable into the Plexis CM system. It was unclear what UHA and ABCT were doing to resolve this situation.

Finding #6: Reconciliation issues due to full capitation payment not being received by CHA

CHA reported problems reconciling capitation payment for UHA members assigned to CHA. CHA reported that it receives a capitation payment without information on which member services the payment covers. UHA reduces CHA's capitation payment when a CHA-assigned member receives care from a non-CHA provider.

Western Oregon Advanced Health (WOAH)

Based in Coos Bay, WOAH provides physical, behavioral and dental health services to OHP members in Coos and Curry counties. Behavioral health services are delegated to Coos Health and Wellness, Curry Community Health and ADAPT. Advantage Dental is delegated to provide dental services, manage the dental network, conduct utilization review and provide training, credentialing and oversight of dental care providers. WOAH contracts with TransLink to provide NEMT services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with WOAH regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 2 of the 9 findings from 2014.
- Of 34 recommendations in 2014, 26 were resolved, 5 were partially resolved and 3 were not resolved.
- The CCO resolved 3 and partially resolved 1 of the 4 findings from 2015.
- Of 18 recommendations in 2015, 9 were resolved and 9 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Participated in a Heroin Town Hall organized by law enforcement in May 2016.
- Supporting the opening of an Opioid Treatment Program (OTP) in 2017; supporting the local Federally Qualified Health Center in developing its own office-based OTP.
- Working with Lines for Life to present an Opioid Summit in fall 2016.
- Facilitated regular meetings of a Community Opioid Guidance Group to promote communication and coordination among community partners and providers.
- Supported North Bend Medical Center (NBMC) to conduct quarterly education programs for providers in Coos and Curry counties.

Barriers:

- Provider resistance: Some providers feel the CDC opioid guidelines are not appropriate; others do not want to change treatment that appears to be “working” for their patients.
- Lack of prescribing providers: Patients report difficulty in finding providers willing to treat people on chronic opioids.
- Delay in receiving member-specific data has delayed member and provider outreach.
- Medication-Assisted Treatment access: The OTP will not be functional until early 2017.

Next steps:

- Continue to support NBMC quarterly education events.
- Begin planned regional collaborative interventions in October 2016.
- Conduct an Opioid Summit in fall 2016.
- Conduct a care manager conference to train care managers in motivational interviewing techniques and difficult conversation skills.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospital readmissions
- Reducing co-prescribing of benzodiazepines and opioids

CCO Focus Area:

- One Key Question implementation

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.7)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Partially met (2.4)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met (2.1)	Provider Data	Partially met with a finding (2.8)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Remote access

DOCS employees have remote user access when sharing hardware, saving data to local storage devices and remote printing. WOAH employees do not often handle protected health information (PHI) and other confidential data while working. Remote access that allows local printing and/or saving data to local storage increases the potential and associated risk of a breach of either PHI or confidential company data by allowing these data to be printed on devices that are not properly secured.

Finding #2: Lack of current policies and procedures

WOAH is developing a strategy to work with delegates and partners to create, maintain and update policies. The CCO will determine if some policies can be CCO-level and may not need to be duplicated by partners. WOAH has some policies in draft format, and delegates have some draft policies and policies in need of updates. WOAH plans to purchase, install and implement policy tracking software to better enable the CCO to maintain policies.

Finding #3: CCO monitoring of delegated IT activities

WOAH did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. Also, WOAH provided no evidence of processes to monitor provider agencies' activities related to information systems.

Finding #4: NEMT monitoring and data submission to OHA

As of the ISCA interview, NEMT encounter data had not yet been submitted to state. WOAH later reported that all backlogged NEMT encounter data were submitted to the state as required.

WOAH has not yet determined policies and procedures for monitoring NEMT data. The ride vendor is responsible for monitoring that the transportation request has an associated appointment. The CCO needs to determine monitoring practices and/or reports to ensure that transportation services have a corresponding service that has been delivered (e.g., a physician office visit).

Finding #5: Provider directory

WOAH has contracted with a new vendor to redesign and support its website. Members can now search on multiple provider attributes, but cannot search for specific types of behavioral health providers. Members are redirected to the dental provider network (DPN) websites for dental provider information, but members cannot search for specific types of dental health providers on the DPN websites. WOAH uses informal processes for adding providers to or removing providers from the provider directory.

Willamette Valley Community Health (WVCH)

WVCH contracts with OHA to provide physical, behavioral and dental health services for OHP members in Marion and Polk counties. WVCH delegates many day-to-day operational activities to Willamette Valley Provider Health Authority, such as utilization and medical management, care management, disease management and credentialing. WVCH delegates behavioral health service delivery to Mid-Valley Behavioral Care Network; customer service, claims processing and information systems to PH Tech; dental services to Moda Health, Capitol Dental Care, Advantage Dental and Willamette Dental Group; pharmacy services to MedImpact; and NEMT services to the Salem-Keizer Transit District.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with WVCH regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 2 of the 9 findings from 2014.
- Of 32 recommendations in 2014, 19 were resolved, 11 were partially resolved and 2 were not resolved.
- The CCO resolved 2, partially resolved 2 and did not resolve 1 of the 5 findings from 2015.
- Of 27 recommendations in 2015, 15 were resolved, 10 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Revise the CCO's preauthorization process with new criteria for prescribing opioids at >120 mg MED/day for new non-cancer pain
- Quantity and duration limits/tapering program: members on >120 mg; six-month taper for long-acting opioids, two-month taper for short-acting opioids
- Remove preauthorization criteria for physical and occupational therapy for members tapering off opioids and receiving an evaluation from pain management specialists

Barriers:

- Resistance by some physicians to using a pain contract. WVCH's Pharmacy and Therapeutics Committee will develop strategies to address this barrier.

Next steps:

- Continue the current interventions without changes.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Tobacco cessation and prevention
- Deploying care teams to improve care and reduce preventable or unnecessary utilization by "super users"

CCO Focus Area:

- Increasing the percentage of members assigned to a PCPCH

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.1)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.2)
Security	Not met (1.4)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.2)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

PH Tech is contracted to submit encounter data on behalf of WVCH. WVCH has increased the contractual expectations of PH Tech's role in this process. WVCH does not appear to be receiving copies of the 837 data submitted on its behalf. It was unclear how WVCH would monitor data received from partner organizations to ensure completeness and accuracy of the data. PH Tech has some processes to check for expected/estimated volume and trends. WVCH staff sign the certification documentation.

Finding #2: Business continuity/disaster recovery plan

WVCH has added to PH Tech's contract that it will participate in a recovery exercise later in 2016 to train all delegates regarding CIM and what to do if CIM is unavailable.

Many of the delegates have plans in draft form. WVCH is working to develop a strategy for the different plans and how they would interact or work together.

Finding #3: CCO monitoring of delegated IT activities

WVCH has begun the delegate monitoring process by understanding and augmenting contracted relationships. As part of this process, WVCH has started holding additional meetings to help communicate issues and work through roles and responsibilities. WVCH is planning to conduct additional oversight and monitoring in the future. WVCH has hired additional staff and is determining strategy and processes.

Finding #4: Provider directory

WVCH has updated its provider directory since the previous review. The CCO's website contains agency-level information for many types of services such as dental or mental health. WVCH has included updated information on how to access transportation services.

Yamhill Community Care Organization (YCCO)

YCCO, located in McMinnville, is a private not-for-profit organization, formerly a subsidiary of CareOregon. The CCO provides physical, dental and behavioral health services for OHP members in Yamhill County and parts of Polk, Marion and Washington counties. YCCO subcontracts with Yamhill County Health and Human Services to manage behavioral health services; with CareOregon to administer physical health services and provide administrative and management support; with Advantage Dental, Capitol Dental Care, and ODS Community Health for dental services; and with First Transit for NEMT services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with YCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 6, partially resolved 4 and did not resolve 2 of the 12 findings from 2014.
- Of 45 recommendations in 2014, 31 were resolved, 9 were partially resolved and 5 were not resolved.
- The CCO resolved 4, partially resolved 5 and did not resolve 2 of the 11 findings from 2015.
- Of 38 recommendations in 2015, 14 were resolved, 14 were partially resolved and 10 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Share CCO and provider-level trending data on opioid prescribing and ED utilization
- Implement community prescribing guidelines/ provider education on system resources, including prescription drug monitoring program (PDMP) registration, work flow, etc.
- Implement alternative payment model (APM), with add-on payments for practices with no members on >120 mg MED
- Community coordination/education
  - Created a Controlled Substance Quality Oversight Committee to assist providers
  - Community health workers conduct Living Well with Chronic Disease classes

Barriers:

- Little ability to access the PDMP program data. The CCO reached out to providers and asked them to report on their enrollment and use in day-to-day practice.

Next steps:

- Continue site visits and sharing data on chronic users and breakdown of various MED levels.
- Disseminate updated guidelines to providers; analyze data on the adoption of the guidelines.
- Explore how to promote the PDMP among providers not using the tool.
- Continue to evaluate APM strategies on a quarterly basis.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increase PCPCH enrollment
- Increase/improve adolescent well-care visits

CCO Focus Area:

- Reduce emergency department utilization

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.8)	Enrollment Systems	Fully met (2.9)
Staffing	Partially met (2.4)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.5)
Security	Not met (1.7)	Provider Data	Fully met (2.8)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Backup media improperly handled

YCCO is not encrypting backup media. The backup media are connected to a server in a small closet during the week. YCCO uses two USB external drives as backup media. Each Friday, a staff member brings the USB external drive back into YCCO's office and exchanges it with the external drive currently connected to the server. This staff member then takes the USB external drive removed from the server to staff member's personal residence.

Finding #2: Monitoring

YCCO did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. YCCO provided no evidence of a process to monitor provider agencies' activities related to information systems. It was unclear how this function would be split between CCO staff and the CareOregon delegation team.

Appendix B: Oregon Statewide Performance Improvement Project (PIP) on Opioid Safety: Reducing Prescribing of High Morphine Equivalent Doses

Prepared by HealthInsight Oregon

Standard 1: Study Topic

Standard 1 establishes the importance of the study topic in general; presents local data to demonstrate that the topic applies to a large or high-risk portion of the Medicaid population and will have a significant impact on enrollee health, functional status, or satisfaction; and demonstrates that a systematic selection and prioritization process, that includes opportunities for input by enrollees and providers, was used in choosing the topic.

Status of PIPs in Oregon

OHA's contract with coordinated care organizations (CCOs), as negotiated with the Centers for Medicare & Medicaid Services, requires CCOs to conduct three PIPs and one focus study that target improving care in at least four of seven quality improvement (QI) areas. OHA determined that one of the PIPs would be conducted as a statewide collaborative on the integration of physical health and behavioral health, and in accordance with the 2012 CMS PIP protocol. The first Statewide PIP (2013–2015) addressed monitoring for diabetes in people with schizophrenia or bipolar disorder. The second Statewide PIP focuses on improving the safety of prescription opioid management.

HealthInsight Oregon, the state's external quality review organization, is responsible for facilitating and documenting the 10 PIP validation standards adapted from federal guidelines. The CCOs are responsible for developing interventions that meet the needs of their local communities and documenting their efforts in quarterly reports to OHA.

Topic Overview

Opioid abuse and misuse is a major public health problem in the United States. Federal and state health agencies, medical provider organizations, health care researchers and the Veterans Administration have been galvanized to address the opioid epidemic in response to public testimonies, provider concerns and alarming national statistics. The United States accounts for only 4.6% of the world's population, yet the country uses 99% of the world's supply of hydrocodone and 83% of the world's oxycodone.[1]

[1] Report of the International Narcotics Control Board for 2007. https://www.incb.org/documents/Publications/AnnualReports/AR2007/AR_07_English.pdf. Accessed January 12, 2016.

Data collected at a national level reveal that from 1999 through 2006, opioid-analgesic deaths increased about 18% on average. The rate stabilized from 2006 to 2011, then began to decline in 2012.[2] A recent report by the Centers for Disease Control and Prevention (CDC) indicates that the decline has not been sustained. Data show that although overdose deaths due to natural and semisynthetic opioids (which include most of the prescribed opioid pain relievers) remained similar from 2012 to 2013, there was a 9% increase from 2013 to 2014.[3]

Overdose and death are not the only adverse effects of the abuse and misuse of prescription opioids. CDC estimated that prescription opioid abuse costs (e.g., lost workplace productivity, medical treatment and criminal justice costs), totaled about $55.7 billion in 2007.[4]

Studies by Washington State and New York State demonstrated that the Medicaid population is disproportionately affected by the opioid epidemic. In Washington, a Medicaid enrollee was 5.7 times more likely to die due to prescription opioid overdose than a person not enrolled in Medicaid.[5] A similar increased death rate among Medicaid enrollees was observed in New York from 2003 to 2012.[6] In response to the particular vulnerability of the Medicaid population, CMS issued a bulletin describing Medicaid pharmacy benefit management and naloxone provision strategies states could employ to reduce opioid-related overdose deaths.[7]

As part of a national initiative to address the opioid problem, CDC awarded 16 states (including Oregon) grants to assist those states in their efforts to prevent opioid misuse and overdose. In addition, CDC issued opioid prescribing guidelines for primary care providers in early 2016. Although state, regional and professional guidelines and resource guides have been published, the CDC guidelines are the first set of standards

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[2] Chen LH, Hedegaard H, Warner M. Drug-poisoning Deaths Involving Opioid Analgesics: United States, 1999–2011. NCHS Data Brief No. 166, September 2014. http://www.cdc.gov/nchs/data/databriefs/db166.pdf.

[3] Centers for Disease Control and Prevention. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. *MMWR*, December 18, 2015. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm64e1218a1.htm?s_cid=mm64e1218a1_e. Accessed January 12, 2016.

[4] Centers for Disease Control and Prevention. Injury Prevention & Control: Prescription Drug Overdose. http://www.cdc.gov/drugoverdose/data/overdose.html. Accessed February 17, 2016.

[5] Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. *MMWR.* 2009; 58:1171-1175.

[6] Sharp MJ, Melnik TA. Poisoning deaths involving opioid analgesics-New York State, 2003–2012. *MMWR.* 2015; 64:377–380.

[7] Centers for Medicare & Medicaid Services. CMS Informational Bulletin: Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-02-02-16.pdf. Accessed February 17, 2016.

on prescription opioids from a federal agency. Among other recommendations, CDC proposed that providers should avoid increasing opioid dosages to ≥90 mg/day morphine milligram equivalent (MME)/day and "carefully reassess benefits and risks" when increasing opioid dosages to ≥50 MME[8] . Other guidelines (Washington State, Medicare) have established a target of <120 mg/day MED.

In March 2016, President Obama addressed the National Prescription Drug Abuse and Heroin Summit in Atlanta and announced a series of public and private sector initiatives aimed at stemming prescription opioid abuse and the heroin epidemic. Among other actions, the federal government will increase the number of patients for whom a provider can prescribe buprenorphine from 100 to 200; award funding to 271 community health centers and 11 states to expand access to medication-assisted treatment (MAT); provide funding for states to buy and distribute naloxone, a drug used to reverse opioid overdose, and to train first-responders in its use; and create a federal interagency task force on mental health and substance use disorder parity.[9]

Oregon

Statewide, Oregon had the highest rate of nonmedical use of prescription opioids for people age 18 years and older in 2011–2012, according to the National Survey on Drug Use Health. Oregon tied for second place in 2012–2013.[10]

Data collected by state and federal agencies reveal the extent of the opioid epidemic in Oregon:

- In 2013, the number of deaths due to drug overdose exceeded that of motor vehicles among people 25 to 64 years of age. Half of the drug overdose deaths were related to prescription drugs, and more than 70% of the prescription drug overdoses involved opioids.[11]
- The rate of opioid hospitalizations in Oregon increased from 2.6 per 100,000 in 2000 to 10.0 per 100,000 in 2013, according to the Oregon Public Health Division (PHD).[12]

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[8] Centers for Disease Control and Prevention. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. *MMWR*, March 18, 2016. Accessed at: http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

[9] White House press release: Fact Sheet: Obama Administration Announces Additional Actions to Address the Prescription Opioid Abuse and Heroin Epidemic. March 29, 2016. Accessed at: https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-address.

[10] National Survey on Drug Use Health. Available at www.icpsr.umich.edu/icpsrweb/ICPSR/series/64.

[11] Oregon Health Authority, Public Health Division. Injury and Violence Prevention Program. Prescription Drug Poisoning/Overdose in Oregon. http://www.orpdmp.com/PDO_2015v04242015.pdf. Accessed February 17, 2016.

[12] See note 9 above.

- Unintentional and undetermined prescription opioid poisoning death rates followed a similar trend, increasing from 1.4 per 100,000 in 2000 to 6.5 per 100,000 in 2006. In 2012, the rate was 4.2 per 100,000.[13]
- The PHD reported that while the prescription drug poisoning/overdose death rates in 2013 and 2014 had declined to about 4.0 per 100,000, the 2013 rate was still 2.8 times higher than in 2000.[14]
- Recent CDC data showed an increase in all drug overdose deaths in Oregon: from 11.3 deaths per 100,000 persons in 2013 to 12.8 deaths per 100,000 persons in 2014. Since the CDC data do not distinguish between deaths due to heroin and those due to natural and semisynthetic opioids (associated with the more commonly prescribed opioid pain relievers), further analyses are needed to determine if there is consistency between the national and state data.

In terms of the Medicaid population, an exploratory data analysis for this PIP by OHA's Office of Health Analytics demonstrated that of 170,000 adults age 18 years or older on Medicaid, 35,749 (21% of the total population) received six or more prescriptions for opioid pain relievers in calendar year 2014. The percentage of the CCO adult population receiving six or more prescriptions ranged from 8.0% to 31.1% per CCO.

Recognizing the alarming trend in prescription opioid misuse and abuse, the State of Oregon and health professionals and organizations have taken steps to address the problem, including but not limited to the following initiatives.

- The Oregon Legislature established a Prescription Drug Monitoring Program (PDMP) in 2009. The PDMP, which became operational in 2011, is intended to assist health care providers in providing better patient care by helping providers identify risks associated with controlled drug dispensing and use.
- In 2011, a managed care organization, Doctors of the Oregon Coast South (DOCS), selected the topic of opioid prescribing for a PIP after reviewing alarming pharmacy data. Opioid prescribing continued to be a focus for improvement even after DOCS merged with other partners to create the Western Oregon Advanced Health CCO.
- In 2011, Dr. Jim Shames, medical director of Jackson County Health and Human Services, along with several CCOs (AllCare, Jackson Care Connect) and

[13] Oregon Health Authority, Center for Prevention & Health Prevention. Injury & Violence Prevention section. Drug Overdose Deaths, Hospitalizations, Abuse & Dependency among Oregonians. http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/oregon-drug-overdose-report.pdf. Accessed February 17, 2016.

[14] Oregon Health Authority, Public Health Division. Injury and Violence Prevention Program. Prescription Drug Poisoning/Overdose in Oregon. http://www.orpdmp.com/PDO_2015v04242015.pdf. Accessed February 17, 2016.

interested health care professionals, formed the Oregon Pain Group (OPG) to address the growing negative impact of prescription opioids in southern Oregon. OPG has identified and developed patient and provider materials and guides (including an Opioid Prescribers Guideline), hosts annual pain conferences and maintains a website for health care professionals and patients (http://www.oregonpainguidance.com/).

- In 2012 and 2013, the Prescription Drug Task Force, appointed by Governor John Kitzhaber, hosted meetings for stakeholders interested in developing and implementing a prescription drug strategy. Interested stakeholders formed the Oregon Coalition for Responsible Use of Meds, whose mission is to "prevent overdose, misuse and abuse of amphetamines and opioids, both prescription and illicit."[15]
- In 2014, the Healthy Columbia Willamette Collaborative convened a workgroup to develop opioid prescribing standards. The workgroup represented four Portland area public health departments (Clackamas, Multnomah and Washington counties, OR, and Clark County, WA), safety net clinics, two CCOs (FamilyCare and Health Share of Oregon), local hospitals and professional organizations. After nearly a year's work, the workgroup released the Portland Metro Regional Safe Opioid Prescribing Standards in December 2015.
- After reviewing the existing research on back pain treatments, including surgery and opioids, OHA's Health Evidence Research Commission presented a revised back pain guideline to the Quality and Health Outcomes Committee (QHOC) meeting in February 2015. Key changes in the treatment of back pain included limiting coverage on the prescription of opioids and adding coverage for non-opioid therapies such as physical therapy, chiropractic, acupuncture and massage. The new guidelines were scheduled for implementation on January 1, 2016, but implementation was delayed until July 2016.
- In 2015, the PHD received a Prescription Drug Overdose Prevention for States grant from CDC. The purpose of the grant was to help states enhance their PDMPs and work with communities, health systems and providers to develop and implement interventions to prevent prescription drug overdose. As part of this effort, the PHD developed a toolkit to help CCOs develop a more comprehensive approach to reducing opioid overdose and misuse (https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/reducing-opioid-overdose-cco-guide.pdf).

[15] Oregon Coalition for Responsible Use of Meds. http://orcrm.org. Accessed January 12, 2016.

- In November 2016, the Oregon Opioid Prescribing Guidelines Task Force, representing the PHD, CCOs, physical health, mental health, oral health and addiction medicine professional organizations, pharmacists, federally qualified health centers and other opioid task forces, adopted the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain as "the foundation for opioid prescribing for Oregon" and provided additional recommendations to address Oregon-specific issues.[16]

Topic Selection and Prioritization

At the April 2015 QHOC meeting, QI directors and managers divided into small groups to begin preliminary discussions about topics for the second Statewide PIP (start date July 1, 2015). The following topics garnered the most support: opioid management, maternal medical home, tobacco prevalence and cessation, effective contraceptive care and assessments for children in DHS custody. Following the discussion, Lisa Bui, OHA's QI director, sent an online survey to all CCOs asking them to rank the above list according to their top three preferences.

HealthInsight Oregon encouraged, but did not require, CCOs to solicit stakeholder input. It is not clear what, if any, influence enrollees had in prioritizing the topic. The overwhelming majority of CCOs selected the topic of opioid management as their first preference. The selection of opioid management as a topic for the second Statewide PIP received final approval by the OHA Quality Council in June 2015.

Standard 2: Study Question

Standard 2 presents a study question that provides a clear framework for data collection, analysis, and interpretation. The study question should refer to the proposed intervention, a study population (denominator), what is being measured (a numerator), a metric (e.g., average, percentage), and a direction of desired change.

All participating CCOs conduct the PIP with the same topic, indicators and objectives, but may have different interventions. Consequently, the interventions are not defined in the study questions.

Two study questions were developed after finalization of the study metric:

> Study question #1: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥120 mg MED on at least one day within the measurement year?*

[16] Oregon Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications. https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf. Accessed on January 30, 2017.

Study question #2: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥90 mg MED on at least one day within the measurement year?*

Standard 3: Study Population

Standard 3 provides a brief description of the study population; lists all inclusion and exclusion criteria for the study population, including enrollment criteria; and provides definitions and data sources, including codes and calculations. If a sample is selected, the sampling methods will be described.

This PIP targets adult and adolescent OHP members who have at least one prescription for an opioid pain reliever filled within the measurement year. The study includes all qualified members and does not require sampling.

Study Population (Denominator) Inclusion Criteria and Definitions

- *OHP enrollment (Medicaid/CHIP-enrolled):* Enrolled in Medicaid or CHIP at the time of service. The study population includes enrollees with dual eligibility in Medicaid and Medicare and enrollees in CHIP who meet the rest of the study criteria.
- *Continuous enrollment*: The 2015 HEDIS specifications define enrollment as continuous enrollment with only one enrollment gap allowed of no more than 45 days during the measurement year.
- *Adults and adolescents*: Medicaid enrollees ≥12 years of age on the final day of the measurement year. Data will be analyzed and reported according to the following stratifications: 12–17, 18+ and total.
- *Opioid pain reliever:* All medications covered under the OHA therapeutic class 40: narcotic analgesics. Using the therapeutic class to define opioids allows for year-to-year variation as NDC codes and medication formulations change. Cough and cold medications are "under the line" (i.e., not covered by OHA) and are not included in the definition. A table of the individual codes for drugs in this class is available as a separate document from HealthInsight Oregon or tOHA's Office of Health Analytics.

Denominator Exclusion Criteria

- *Neoplasm-related pain/end of life care/palliative care/hospice*: The use of high doses of opioids under these circumstances is appropriate, and members who are identified as meeting this criterion according to relevant medical claim codes will be excluded from the study denominator.

According to the Washington State Agency Medical Directors' Group, "In the absence of 'red flags' for malignancy, simple exacerbations of chronic pain in the [cancer] survivor may be treated in a manner similar to chronic non-cancer pain."[17] A cancer diagnosis is not considered to be an exclusion criterion. As "red flags" cannot be identified through claims data, it is likely there will be a small number of members with active malignancy who have a cancer diagnosis but have not yet received an end of life/palliative care/hospice diagnosis.

See Attachment A for a list of the relevant denominator exclusion codes.

- *Buprenorphine:* Buprenorphine, alone or in combination with naloxone, is a semi-synthetic partial opioid agonist. The U.S. Food and Drug Administration has approved transmucosal, film and sublingual buprenorphine products for the treatment of opioid use disorder (MAT). MAT drugs are excluded from the therapeutic class 40 narcotic analgesic drug list, so members on these medications ONLY are excluded from the denominator as they do not need to be targeted for MME reduction interventions.

  Buprenorphine transdermal patches and injections are not approved for use in MAT, and are included in the therapeutic class 40 narcotic analgesic drug list. OHA data analysis from July 2016 revealed that 0.04% of opioid medication claims for the study population were for buprenorphine, and those claims were for transdermal buprenorphine patches (Butrans®).

Standard 4: Study Indicator

Standard 4 provides a definition of the numerator (what is being measured) and the denominator; defines key terms; describes the target goal; discusses the basis for adopting the indicator as a valid proxy for enrollee outcomes, satisfaction, or quality of care; lists all inclusion and exclusion criteria for the numerator (what is being measured), including enrollment criteria; and provides definitions and data sources, including codes and calculations.

Statewide PIP metric: Percentage of OHP enrollees age 12 years and older who filled prescriptions for opioid pain relievers of ≥120 mg MED on at least one day, and the percentage of enrollees with ≥90 mg MED on at least one day during the measurement year.

[17] Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain. 3rd Edition, June 2015. http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf.

Metric Selection

Following the topic confirmation, HealthInsight Oregon conducted a literature review and identified a list of potential metrics for a Statewide PIP on the management of opioid prescription drugs. The list was reviewed by the Office of Health Analytics, several members of the HealthInsight Oregon PDMP research team and the Healthy Columbia Willamette Collaborative opioid monitoring workgroup. The documents were discussed by the medical directors at the July 2015 QHOC meeting, and were evaluated in more depth by the Quality and Performance Improvement (QPI) workgroup in the afternoon QHOC session. The QPI workgroup selected the following three metrics for further consideration:

1. Percentage of individuals on opioid doses ≥120 mg MED per day
2. Proportion of individuals with overlapping prescriptions for opioids and benzodiazepines
3. Percentage of adolescents and adults, previously naïve to opioid pain reliever utilization, who became chronic users of opioid pain relievers (this metric is used by the Minnesota Department of Human Services and is referenced in this report as "the Minnesota metric")[18]

Following the QPI workgroup, HealthInsight Oregon, OHA and the Office of Health Analytics met to discuss the metric specifications for each of the three metrics, and developed a list of clarifications that needed to be presented to the larger group for final decisions. A handout of issues needing clarification, along with a table of individuals with opioid prescriptions for calendar year 2014 (analyzed according to CCO, age and 6+ prescriptions), was distributed at the September 2015 QHOC meeting. Discussions at the medical director or QPI sessions produced no consensus on metric selection. Copies of the three metric technical specifications, along with a list of pros/cons gathered from past discussions, were emailed to CCO medical directors and QI managers, along with a survey asking each of the 16 CCOs to submit a single vote for one of the three metrics. These are the survey results:

- Metric #1 – 9 votes
- Metric #2 – 2 votes
- Metric #3 – 5 votes

This information, along with feedback from the PHD and the CCO Pharmacy Directors workgroup, was presented to OHA leadership. At OHA's request, the Office of Health Analytics conducted data analyses of each CCO's Medicaid populations using the

[18] Schiff, J. Analysis of Opioid Utilization CYs 2011–2014. Minnesota Department of Human Services, Office of the Medical Director. August 20, 2015.

Minnesota metric eligibility criteria to determine the metric's feasibility. The analyses demonstrated that four CCOs had numerators of less than 40, and another two CCOs had numerators less than 50. Although OHA leadership was interested in the Minnesota metric, the small study populations presented a barrier to implementation, as was demonstrated in the first Statewide PIP on diabetes monitoring in the SPMI population. Instead, OHA leadership selected the ≥120 mg MED metric as the Statewide PIP metric and decided to investigate other avenues for a metric focused on naïve to chronic users, such as review by the OHA Scoring and Metrics Committee.

Once a decision was made to monitor the management of opioid pain relievers by measuring a dosing threshold, concerns were raised about the dosing threshold level itself. While experts agree that there is a dose-related risk for overdose and adverse effects,[19] at the time the PIP metric definitions were discussed at QHOC, they had not achieved consensus on a dosage limit performance measure. During that time, CDC had invited subject matter experts and the public to review and comment on a draft Guideline for Prescribing Opioids for Chronic Pain. The draft CDC guidelines recommended a dosing threshold of ≤90 mg MED per day.[20] The 2015 edition of the Washington State Interagency Guideline on Prescribing Opioids for Pain included a recommendation from the 2010 edition that prescribers avoid prescribing opioids >120 mg/day MED without first consulting with a trained pain specialist. Citing studies from the literature,[21,22] the Washington guideline emphasized that "there is no completely safe opioid dose."[23]

Data provided by the Office of Health Analytics revealed that CCOs that had worked on opioid prescribing issues for several years had significantly lower percentages of members on ≥120 mg MED per day than did organizations just beginning work in this area. Experienced CCOs expressed concern that given the lower percentages, it would be difficult to demonstrate improvement over a short period of time. After discussion of additional pros and cons of different dosage levels at the November QHOC meeting, HealthInsight Oregon surveyed CCOs as to their study metric dosage threshold preference. Each of the 16 CCOs was asked to select only one option. The results of the

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[19] Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain. 3rd Edition, June 2015. http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf.

[20] Centers for Disease Control and Prevention. Draft CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. http://www.regulations.gov/#!documentDetail;D=CDC-2015-0112-0002. Accessed January 12, 2016.

[21] Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* 2010.

[22] Fulton-Kehoe D, Garg RK, Turner JA, et al. Opioid poisonings and opioid adverse effects in workers in Washington State. *Am J Ind Med*. 2013.

[23] See note 15.

survey are as follows (PacificSource–Central Oregon and PacificSource–Columbia Gorge voted as a single CCO):

- ≥ 90 mg MED – 7
- ≥100 mg MED – 1
- ≥120 mg MED – 7

Several CCOs that supported the ≥120 mg MED threshold noted that they had already begun educating providers and implementing interventions based on that threshold assumption. The survey results, along with CCO comments, were presented to a OHA Quality Directors Committee meeting. The committee decided that this PIP should measure both the 90 mg and the 120 mg thresholds.

While data will be collected on both numerators (≥120 mg and ≥90 mg MED/day) at the statewide level, CCOs have the option of collecting data internally on either or both of the metrics. Because CCOs differ significantly in terms of study baseline rates (percentage of members with opioid doses ≥120 mg MED/day or ≥90 mg MED/day) and existing implementation strategies, target goals will be established at the CCO level.

Study Numerators

Numerator inclusion criteria and definitions:

- Study eligible (meet the denominator definitions)
- *90 mg and 120 mg MED per day:* Daily MED is calculated as drug strength multiplied by quantity divided by days' supply, multiplied by the conversion factor identified by CDC (the table of morphine equivalent conversion factors is available as a separate document from the Office of Health Analytics). MED will be calculated per filled prescription, applied to the date range according to the fill date and days' supply and then summed for patient total. Any overlapping prescriptions should be summed on each day of overlap.

Any enrollee in the denominator who filled prescriptions for opioid pain relievers of ≥120 mg MED or ≥90 mg MED for one day during the measurement year will be included in the numerators.

Standard 5: Data Collection and Data Analysis Plan

Standard 5 describes data collection and data validation procedures, including a plan for addressing errors and missing data, and presents a clear data analysis plan, including time frames for the measurement and intervention periods and an appropriate statistical test to measure differences between the baseline and remeasurement periods.

Data Collection

OHA uses an encrypted system of web-based electronic mailboxes to receive Medicaid claims and encounter data from CCOs. This system ensures that data transfers are consistent with HIPAA confidentiality provisions. The state then uses the Medicaid Management Information System (MMIS) claims adjudication engine to process the CCO encounter data.

From MMIS, data are transferred to the Decision Support Surveillance and Utilization Review System (DSSURS), where it is organized to facilitate reporting and other data extraction. The Office of Health Analytics pulls data from DSSURS, applies the continuous enrollment and exclusion criteria and then calculates the study indicators for the measurement periods and for monthly reports to each CCO. Data are reported to the CCOs in a rolling 12-month format and according to age group (12–17, 18+ and both age groups).

In addition to study indicator data, OHA analyzes and reports the number and percentage of the members in the study denominator who have opioid prescriptions of 90 mg MED and 120 mg MED for at least 30 consecutive days. A report on consecutive 30-day opioid use at 90 mg MED and 120 mg MED was generated at the beginning of this PIP to alleviate CCO concerns that the study numerator results were artificially inflated due to technicalities, such as overlapping prescriptions.

CCOs are expected to track the study indicators internally. OHA has offered all CCOs technical assistance for collecting data and applying the technical metric specifications.

Data Verification and Validation

At the end of the remeasurement period, OHA allows for a 90-day period to receive all CCO claims (a 90-day period to collect and process claims is routine practice). OHA then calculates the study data and posts member-level data on each CCO's secure FTP site. CCOs are asked to review the information and send any revisions/questions to the designated OHA contact, who works with the Office of Health Analytics to evaluate the CCO queries.

Quality management personnel at each CCO are responsible for reviewing and comparing OHA monthly reports against their own data reports to reconcile any discrepancies. Before submitting data to the state, CCOs perform automated edits and

validation checks to ensure completeness and correctness of submitted claims. Currently, there is no contractual requirement for the CCOs to perform encounter data validation in accordance with the CMS standards for that activity.

Study Time Periods

- **Baseline measurement:** January 1–December 31, 2014
- **First remeasurement:** January 1–December 31, 2016
- **Second remeasurement:** January 1–December 31, 2017

CCOs, OHA and HealthInsight Oregon agreed on the date range for the first remeasurement period based on the expected date for many of the CCOs to begin implementing their interventions. A non-consecutive baseline measurement period was selected because a longer period of time would allow those CCOs that had worked on the study topic for several years more opportunity to demonstrate improvement in the study indicator.

The study results for each study indicator at the statewide level will be tested for a statistically significant difference between baseline and remeasurement periods using a one-tailed chi-square test (appropriate for categorical data with a directional hypothesis) with a probability level of $p \leq .05$.

Standard 6: Study Results

Standard 6 presents results according to the data analysis plan, including the study indicator, the original data used to compute the indicator, and a statistical test to measure differences between the baseline and remeasurement periods; and discusses any other data analyses for factors that may affect the study results.

Study results are reported according to study metric threshold and in the following order.

- Aggregated statewide numerator, denominator and calculated indicator for baseline and current measurement
- Results of statistical tests
- Table of aggregated statewide numerator by age
- Graph of the aggregated statewide numerators, denominators and rates from 2014 (baseline) to the current measurement period
- Graph of the individual CCO rates from 2014 to the current measurement period

≥120 mg MED Metric Results

Table 1 shows the baseline and last remeasurement period results for the ≥120 mg MED metric.

Table 1. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥120 mg MED on at least one day during the measurement year.

Study indicator	Baseline January 1–December 31, 2014	Current December 1, 2015– November 30, 2016
Numerator	11,945	9518
Denominator	112,768	101,800
Calculated indicator	10.6%	9.3%

The chi-square test yielded a result of 91.8 with 1 degree of freedom, with a one-tailed *p* value of <0.001, indicating a statistically significant difference between the percentage of enrollees age 12 years and older who filled opioid prescriptions for at least ≥120mg MED at baseline and current remeasurement.

Table 1a shows the 120 mg study metric data according to age group

Table 1a. Aggregated statewide results: Number of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥120 mg MED on at least one day during the measurement year according to age group

Age group	Baseline January 1–December 31, 2014	Current December 1, 2015– November 30, 2016
12–17 years	142	77
18+ years	11803	9441
Total	11945	9518

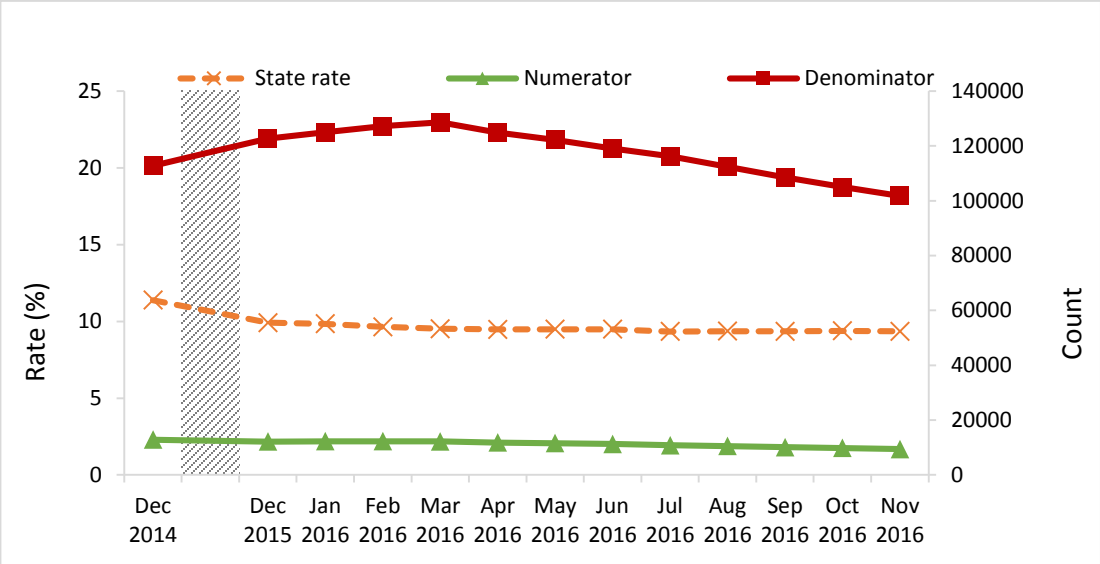
The number of enrollees age 12–17 who filled an opioid prescription ≥120mg MED on at least one day during the measurement period decreased by approximately 50% from baseline to current remeasurement, compared to the 18+ age group, which decreased by 20% in the same period.

The graphs of the statewide and CCO study results include calendar year 2015, even though that year is not included as a measurement period in the data analysis plan. Study indicator data from January 1 to December 31, 2015, are presented in order to

better analyze trends and understand the relationship between CCO interventions and the study results.

Figure 1 shows the aggregated statewide results for the 120mg MED metric over time.

Figure 1. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥120 mg MED on at least one day during the measurement year over time.

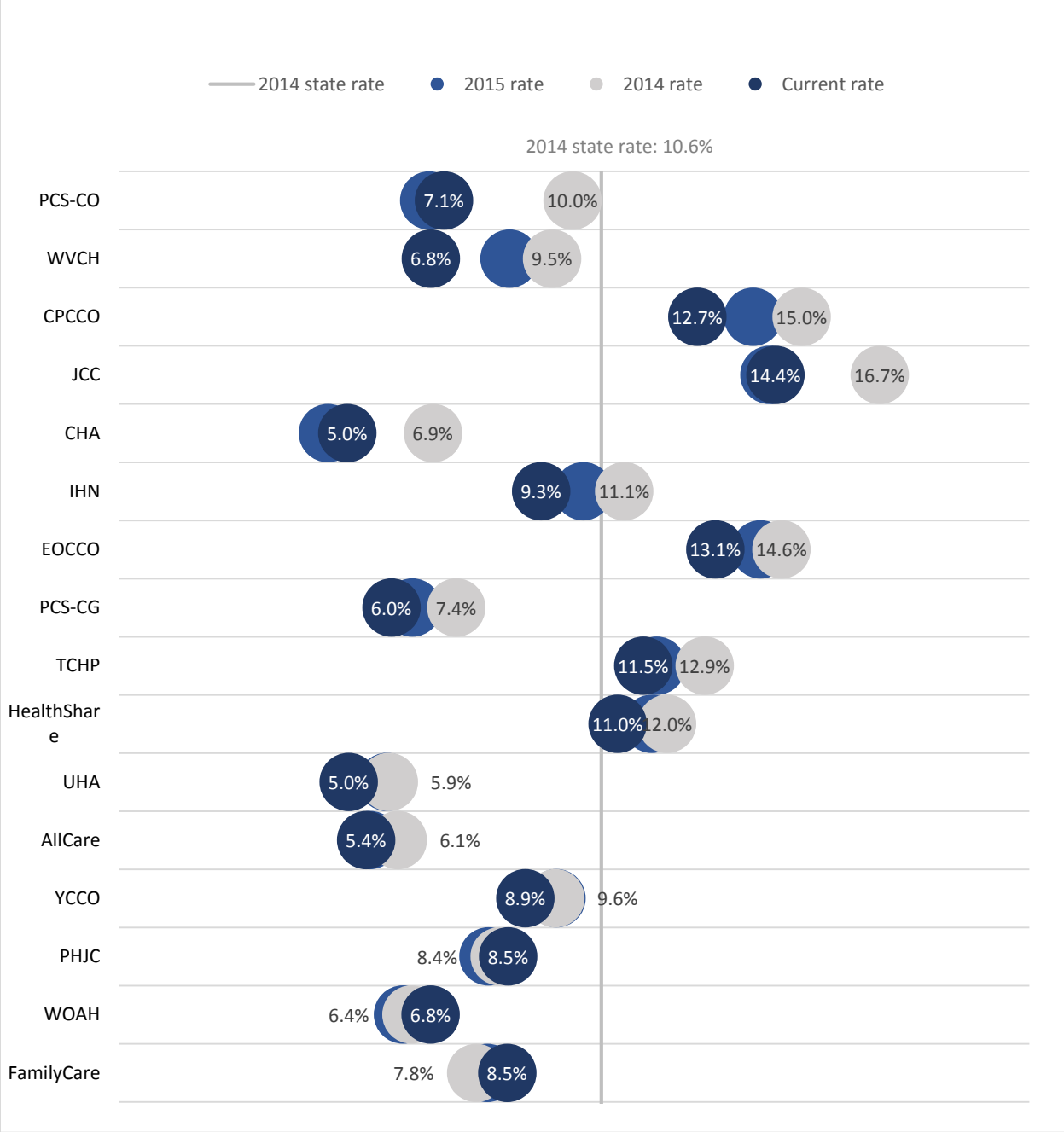


The study denominator increased over time until March 2016, when it dropped steadily until the current measurement. Although difficult to discern because of the scale of the graph, the study numerator also increased from 2014 to 2015, then decreased slightly and steadily over time. The statewide rate showed an initial decrease from 2014 (10.6%) to 2015 (9.9%) and then continued to decrease slightly over 2016.

The above tables and graphs provide information on the aggregated study results. It is important to examine CCO-level as well as statewide results to get a more accurate understanding of the prescription opioid problem in Oregon.

Figure 2 shows CCO progress on the 120 mg MED metric over time. CCOs are ordered from top to bottom according to the amount of progress from baseline to current measurement. Note: the figure does not display 2015 rate data labels.

Figure 2. CCO progress on ≥120 mg MED study metric from baseline to current remeasurement.



≥90 mg MED Metric Results

Table 2 shows the baseline and last remeasurement results for the ≥90 mg MED metric.

Table 2. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥90 mg MED on at least one day during the measurement year.

Study indicator	Baseline January 1–December 31, 2014	Current December 1, 2015– November 30, 2016
Numerator	20,235	16,974
Denominator	112,768	101,800
Calculated indicator	17.9%	16.7%

The chi-square test yielded a result of 78.4 with 1 degree of freedom, with a one-tailed *p* value of <0.001, indicating a statistically significant difference between the percentage of enrollees age 12 years and older who filled opioid prescriptions for at least ≥90 mg MED at baseline and current remeasurement

Table 2a shows the 90 mg study metric data according to age group

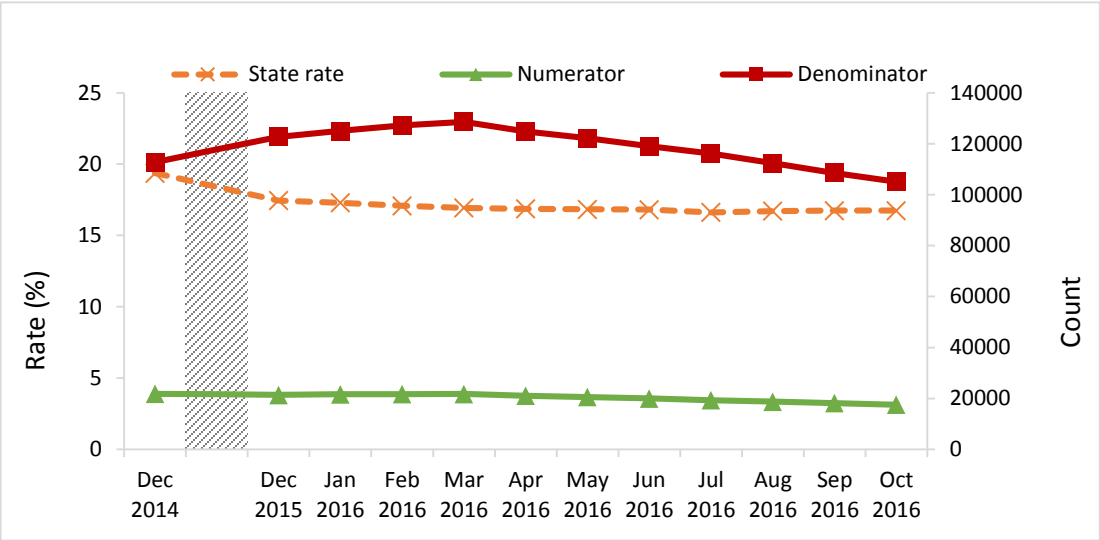
Table 2a. Aggregated statewide results: Number of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥90 mg MED on at least one day during the measurement year according to age group.

Age group	Baseline January 1–December 31, 2014	Current December 1, 2015– November 30, 2016
12–17 years	354	220
18+ years	19,881	16,754
Total	20,235	16,794

As with the 120mg metric, the 12–17 year old group showed more improvement over time than the older group in reducing the numbers of enrollees with opioid prescriptions of ≥90 mg MED for any day in the measurement period. Compared to the 120 mg metric results, the decreases were not as large (approximately 40% for the 12–17 year old group; approximately 15% for the 18+ year old group).

Figure 3 shows the aggregated statewide results for the 90 mg MED metric over time.

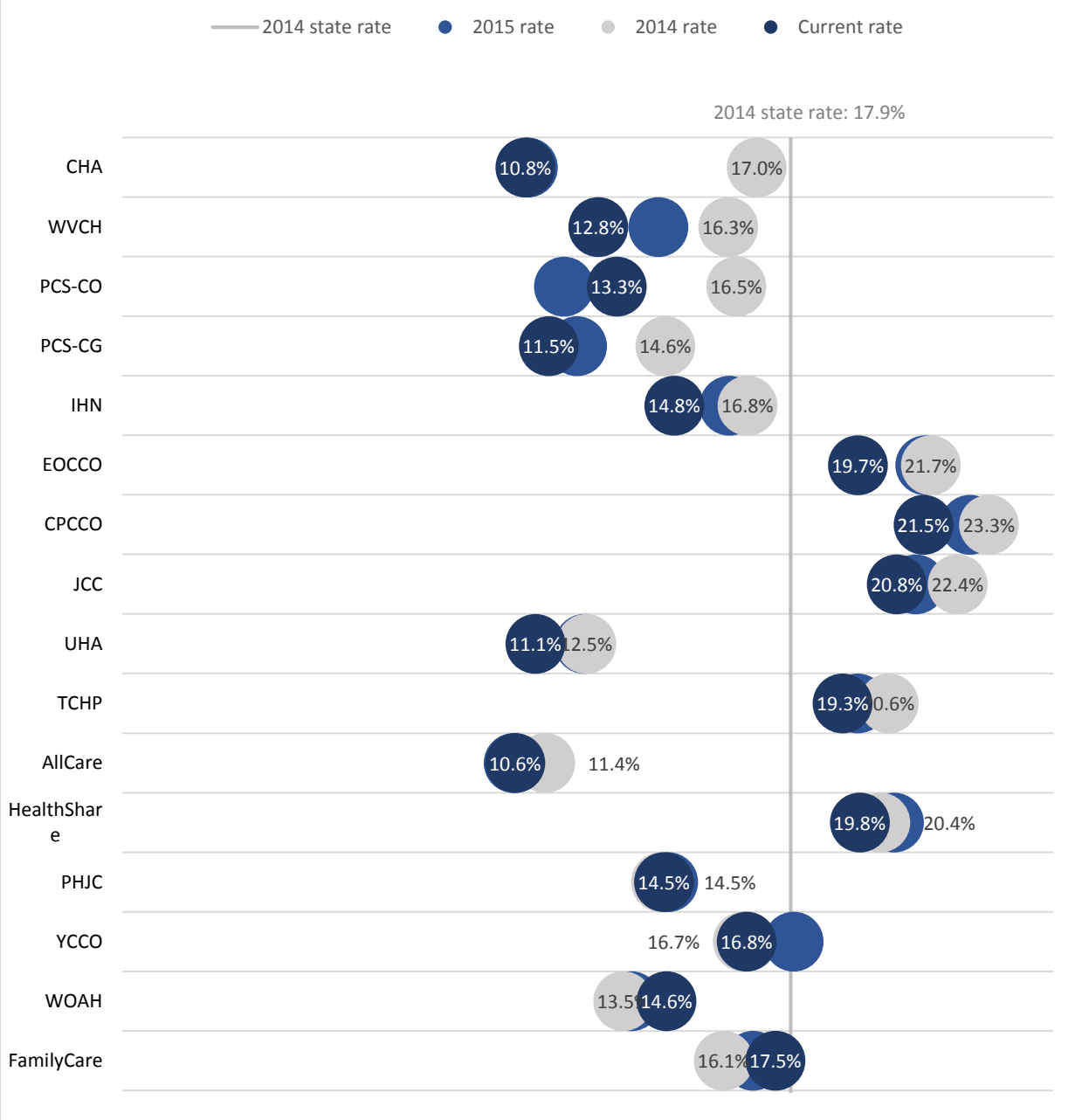
Figure 3. Aggregated statewide results: Number and percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥90 mg MED on at least one day during the measurement year.



As with the 120 mg MED metric results, the study numerator and rate decreased slightly from baseline to current measurement.

Figure 4 shows CCO progress on the 90 mg MED metric over time. CCOs are ordered from top to bottom according to the amount of progress from baseline to current measurement. Note: the figure does not display 2015 rate data labels.

Figure 4. CCO progress on ≥90 mg MED study metric from baseline to current remeasurement.



Additional Analyses

Demographic analyses of the statewide study baseline denominator and chronic high user numerator populations indicate that Latino/Hispanic, Asian and Race/ethnicity unknown enrollees are underrepresented in the numerator, while Caucasian/white enrollees are overrepresented. The complete analysis appears in Attachment E.

OHA provided CCOs with data on the percentage of OHP members on ≥120 mg and ≥90 mg for 30 or more consecutive days. The additional analyses were provided to help CCOs identify their chronic user populations.

Tables 3 and 4 compare baseline and remeasurement results for high chronic users.

Table 3. Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥120 mg MED for consecutive 30 days or more within the measurement year.

Study indicator	Baseline January 1–December 31, 2014	Current remeasurement December 1, 2015– November 30, 2016
Numerator	3,129	2.019
Denominator	112,768	101,800
Calculated indicator	2.8%	2.0%

Table 4 Aggregated statewide results: Percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for ≥90 mg MED for consecutive 30 days or more within the measurement year.

Study indicator	Baseline January 1–December 31, 2014	Current remeasurement December 1, 2015– November 30, 2016
Numerator	4,448	3,239
Denominator	112,768	101,800
Calculated indicator	3.9%	3.2%

Statistical tests indicate a statistically significant difference between the percentage of OHP enrollees age 12 years and older who filled opioid prescriptions for at least 120 mg and 90 mg MED for 30 consecutive days or more at baseline and at current remeasurement.

Figures 5 and 6 show CCO progress over time on the supplemental measures. Note: the figures do not display 2015 rate data labels.

Figure 5. ≥120 mg MED for consecutive 30 days metric by CCO over time.

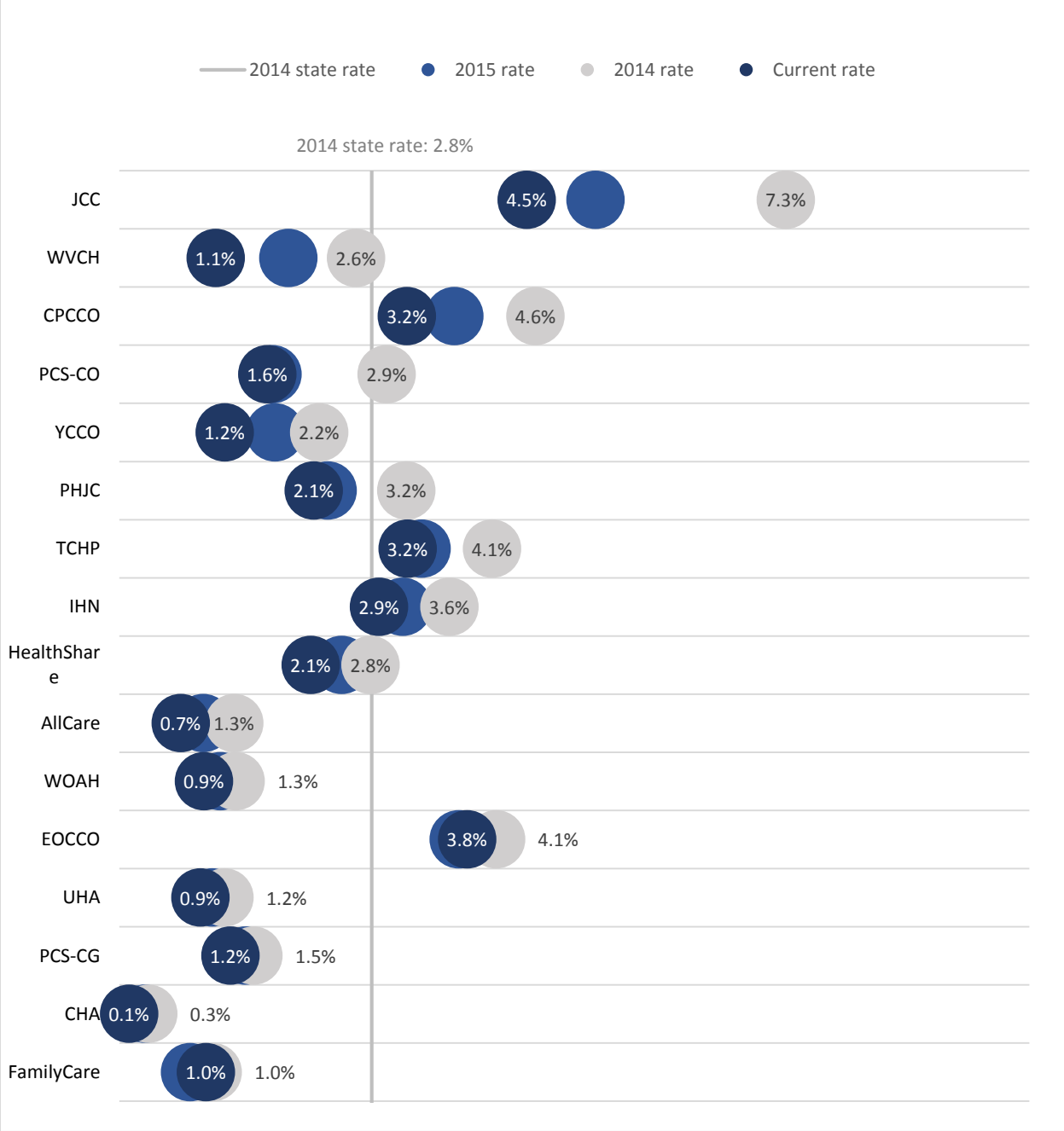
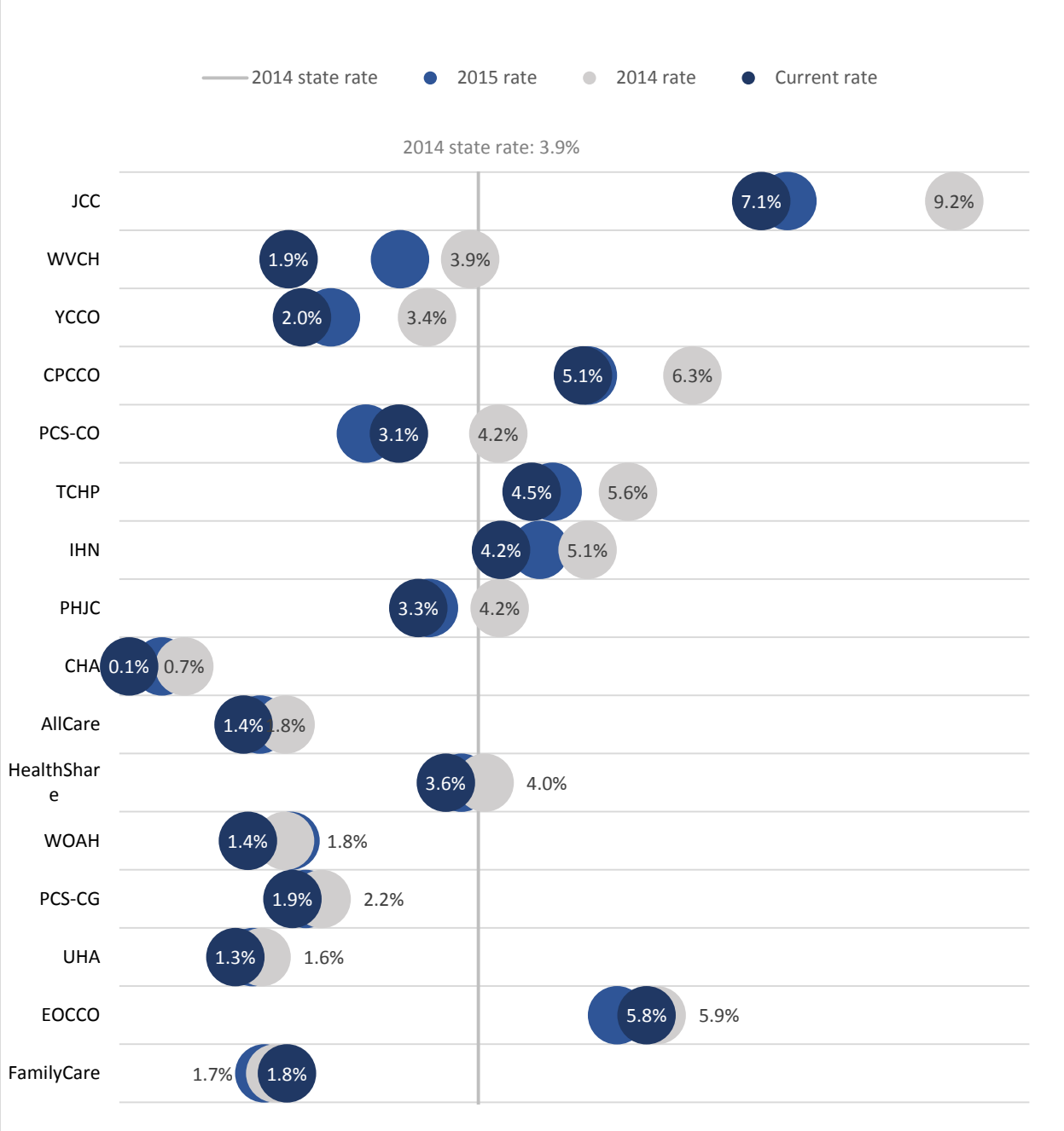


Figure 6. ≥90 mg MED for consecutive 30 days metric by CCO over time.



Standard 7: Interpretation of Results

Standard 7 lists any changes to the study design and discusses the effect of those changes on the comparability of data and interpretation of results; describes any factors that threaten the internal or external validity of the study; discusses whether the intervention was implemented as planned; describes any improvement in enrollee health, functional status, or satisfaction and accomplishment of target goals; discusses how the intervention influenced the results; discusses lessons learned during the PIP process; draws a conclusion about the study results based on the above factors; and describes next steps for the study.

No changes have been made to the study design at the time of this report.

The following factors need to be considered when interpreting the study results.

Data validity and limitations:

- At the time of this report, OHA was only able to provide study data through November 30, 2016, due to a 90-day claims lag. The current measurement period (December 1, 2015–November 30, 2016) overlaps the previous measurement period (calendar year 2015) by one month and omits data from the month of December 2016. Discussions with CCOs revealed no major events in December 2016 that would significantly reverse the trends of the previous 11 months. While the current measurement is not strictly comparable to the baseline measurement period (calendar year 2014), tentative conclusions can be drawn.
- The baseline (calendar year 2014) and first remeasurement period (calendar year 2016) are not contiguous, leaving calendar year 2015 unaccounted for. However, this project is not a strictly before-after comparison, as at least four CCOs had implemented prior authorization and quantity limits for opioids and provider education for several years prior to the study baseline. Collection and analyses of an additional data point (calendar year 2015) will better demonstrate any trends and help rule out statistical regression as a threat to validity.
- The study data are aggregated across 16 CCOs, but as noted above, a number of CCOs had implemented interventions aimed at improving the opioid problem in their communities, resulting in significantly lower than average study metrics at baseline. To gain a better understanding of the actual progress on this measure, it will be necessary to analyze the individual CCO study results alongside the aggregated study indicators.
- Although patients with a diagnosis for palliative care, hospice or end-of-life care are excluded from the denominator, patients with a diagnosis of cancer are not. It is likely that a small number of members with active malignancy who had not yet received an exclusion diagnosis will be included in the numerator.

- The single end-of-measurement period data do not reflect ongoing improvement efforts. Members who were tapered off of high-dose opioids during the measurement year still appear in the numerator, and the intervention success will not be evident until the following measurement year data collection. However, OHA is analyzing and reporting study indicator data on a rolling 12-month basis, and displaying the data in time-series graphs more accurately reflects the effect of intervention strategies.
- Members might be included in the numerator for administrative reasons (one-day overlap in prescriptions) that do not reflect the member's ongoing opioid use. However, this PIP is focused on opioid safety, and even one day at 120 mg MED or 90 mg MED puts members at risk. Their inclusion in the numerator, therefore, is appropriate.
- CCO Medicaid claims do not capture cash payments by members for prescription opioids. It is not clear to what extent the exclusion of cash purchases of opioids affect the study numerators and denominator. At least one CCO (Cascade Health Alliance) has identified the cash purchase of opioids as a significant contributing factor to its local opioid problem.
- The topic of opioid safety is complex, and the study metrics address only one safety aspect (high dosages and chronic high use). CCO efforts around other and equally important opioid safety issues, such as co-prescribing and the transition from naïve to chronic use, are not reflected in the study metrics.

Possible confounding factors:

- Other local and state organizations (see Standard 1) have implemented interventions as part of their own strategies to address opioid misuse and abuse, independent of the CCO-initiated interventions, which could have contributed to a decrease in the remeasurement study indicator results. Nationally, CDC released its final Guideline for Prescribing Opioids for Chronic Pain in March 2016. These guidelines and the media attention surrounding their release could have influenced provider prescribing practices, separate from any local CCO-initiated interventions.
- The delay in the implementation of OHA's back and spine policy guidelines (originally scheduled to begin January 1, 2016, but implemented July 1, 2016) disrupted CCOs' plans to develop and fund non-opioid therapies, and could have had a negative impact on improvement in the study indicators in the first remeasurement period. However, the restrictions on opioid treatment for enrollees with newly diagnosed back and spine conditions (seven days'

medication at a time, no medication coverage after 90 days), might have had an effect on the number of opioids in circulation (study denominator).

Results of the statistical analyses showed statistically significant differences between baseline and current remeasurement periods for both study indicators as well as for the supplemental consecutive 30 day measures.

Analysis of performance by percentage without taking frequencies into account provides an incomplete picture. As shown in the Standard 6 graphs and tables, the number of enrollees in the statewide and CCO study denominators decreased at a more rapid rate than the study numerators (see Attachment D for CCO-level data). Even though their numbers decreased, some CCOs saw little change or even an increase in their study metric rates over time. The amount of opioids in circulation would be expected to decrease more quickly than the number of members being tapered off chronic doses of high opioids. A number of CCOs implemented taper plans of several months' duration that did not begin until late 2016. It is not clear whether or not the decrease in opioids in circulation is appropriate. CCOs have reported that they plan to monitor provider refusals to prescribe opioids. No quantitative or qualitative results regarding this topic were documented in quarterly progress reports.

There was a notable increase in the total (both age groups) statewide and CCO study denominators from 2014 to 2015, with a smaller increase in both numerators. However, in the 12–17 year old group, there was a consistent decrease in the denominator from 2014 to 2015 and from 2015 to 2016 (see Attachment C). The increase in the adult denominators and numerators can be accounted for by the increase in CCO enrollment (from 707,458 as of 1/15/14 to 916,127 as of 1/15/15)[24] and by the complete incorporation of dental claims into CCO claims report (CCOs began incorporating dental claims at different times throughout 2014; 2015 was the first entire year of integrated claims). It is not clear why the overall denominators and numerators increased to their highest point in March 2016, and then began to decrease.

As seen in Figures 2 and 4, baseline study metrics varied widely among CCOs. For the 120 mg MED metric, baseline rates ranged from 5.9% (Umpqua Health Alliance) to 16.7% (Jackson Care Connect). For the 90 mg MED metric, baseline rates ranged from 11.4% (AllCare) to 23.3% (Columbia Pacific CCO).

CCOs also varied as to their percentages of high chronic users (enrollees in the study denominator on 30 consecutive days or more of opioid dosages ≥120 mg MED or ≥90 mg MED) at baseline and in their progress over time.

[24] Accessed at: https://www.oregon.gov/oha/healthplan/DataReportsDocs/April%202016%20Mental%20Health%20Service%20Delivery%20by%20Rate%20Group.pdf.

Tracking and monitoring of data from CCO progress reports demonstrates successful implementation of interventions. CCOs are continuing to develop and implement interventions around pain management and buprenorphine prescribing training for providers, opioid risks and alternative pain treatment education for members and the community, increasing access to MAT and increasing member utilization of non-opioid treatments and services, including pain programs/classes. Although local, state and federal organizations have implemented interventions as part of their own strategies to address opioid misuse and abuse, independent of the CCO-initiated interventions, it is reasonable to attribute some, if not most, of the improvement in the study indicator to CCO efforts. If the CCOs continue to develop and implement their intervention strategies as planned, improvement in both study indicators (continued downward trend as demonstrated in the graphs) can be expected.

In the process of working on this project, CCOs have realized other benefits. The four CCOs that formed the regional collaborative developed a model of collaboration that could be used to address other common problems and gaps. Participation by community-based groups, public health and law enforcement in the development and implementation of PIP strategies has strengthened those relationships. Siloes between physical health, behavioral health and oral health continue to be breached through interventions (such as Meet and Greet and Community of Practice dinner events), utilization of behavioral health staff in educating providers and collaboration with substance use organizations (in increasing access to MAT).

A few CCOs that have achieved and maintained lower rates of enrollees on high doses of prescription opioids have expanded their efforts to address opioid use by pregnant women and co-prescribing of opioids and benzodiazepines.

Standard 8: Improvement Strategies

Standard 8 describes and documents the implementation of the intervention(s) and discusses the basis for adopting the intervention; how the intervention can be reasonably expected to result in measurable improvement; the cultural and linguistic appropriateness of the intervention; a tracking and monitoring plan (providing evidence of how the intervention was or will be implemented as planned); barriers encountered during implementation of the intervention and how they were addressed; and how the intervention will be adapted, adopted, or abandoned.

Each CCO has been tasked with developing, implementing and documenting an improvement strategy to address the statewide study topic of improving the safety of opioid management. Because they differ significantly in terms of geography, level of integration of physical, mental and oral health systems, previous attempts in addressing this topic and population size, the CCOs were advised to develop strategies for this PIP in a manner that met the needs of their local communities. HealthInsight Oregon

provided the CCOs with the criteria and scoring matrix for this standard, as well as ongoing technical assistance.

OHA required that CCOs submit quarterly reports documenting their progress on the Statewide PIP, beginning with the January 2016 quarterly report. Following completion of the first remeasurement period (12/31/16) and based on their January 31, 2016, quarterly report submission, each CCO received an evaluation (met/partially met/not met) for the degree of completeness, clarity and consistency in addressing each of the Standard 8 criteria. See Attachment F for an explanation of the Standard 8 criteria. HealthInsight Oregon developed evaluation reports and sent them to the CCOs for review. All CCOs had the option of either accepting their initial evaluation or resubmitting their Standard 8 documentation for re-evaluation. See Attachment G for the final overall Standard 8 criteria evaluations for each CCO.

Following is a summary of CCO documentation of each of the Standard 8 criteria.

a. Root cause analysis or QI process used to select the intervention

As one of their first steps in the QI process, CCOs participated in or developed opioid/pain taskforces or workgroups. These groups included different internal representatives (leadership, providers, QI improvement and behavioral staff) and representatives from community organizations, public health departments, addiction and drug treatment centers, law enforcement and Community Advisory Councils. Soliciting the input from such a diverse group of involved stakeholders helped CCOs develop a thorough understanding of the barriers and contributing factors to the opioid problem in their communities. Many CCOs also conducted data analyses of their study population, looking at factors such as race, ethnicity, gender, age, location and prescription opioid dosage.

Root cause barriers to improving/factors contributing to the opioid problem described by CCOs were associated with the following categories.

Member factors:

- ignorance of the risks of prescription opioids and pain management options
- lack of available non-opioid alternative treatments
- manipulation of providers and CCO processes in order to obtain opioids.

Provider factors:

- confusion about CCO prescription opioid guidelines
- lack of knowledge about prescription opioid risks, MAT and non-opioid treatment options
- underutilization of the PDMP
- reluctance to engage members in difficult conversations

Organizational factors:

- absence of formal pharmacy benefits/prescribing guidelines
- lack of alternative non-opioid treatments and service policies and processes
- lack of resources to assist providers in managing chronic pain patients

In addition, several CCOs identified contributing factors specific to their situation. Four southern Oregon CCOs, whose coverage areas and contracted providers overlap with each other, formed a regional collaborative to address "CCO shopping" by members seeking desired benefits and frustration by providers over multiple different guidelines and processes. The proliferation of non-contracted pain clinics in one small area in southern Oregon resulted in a significant number of members in both the covering and adjacent CCO receiving opioids from providers resistant to CCO policies and processes.

Rating: All 16 CCOs received a "met" rating rating for this criterion.

b. Brief description of the intervention(s)

In their reports, CCOs described interventions developed and implemented by their CCO alone, in collaboration with other CCOs and with other organizations (clinics, law enforcement and community-based organizations).

Prior to the start of the first remeasurement period (January 1, 2016), almost all CCOs had implemented prior authorization (PA) processes and quantity limit (QL) guidelines to address the opioid problem in their communities. Fourteen CCOs defined quantity limits by dosage, while two CCOs limited prescribers as to number of capsules/tablets. Most CCOs' PA criteria included documentation of a pain contract/agreement and a tapering plan. One CCO required providers to sign a certificate attesting to their agreement with CCO policy and fulfillment of mandated criteria. Following CDC's recommendation to limit opioid dosages to less than 90 mg MED and the adoption of that recommendation by the Oregon Opioid Prescribing Guidelines Task Force, most CCOs revised, or at the time of this report were in the process of revising, their PA and QL guidelines to align with this threshold.

Other common intervention themes included:

- Provider training/education: Education about opioid-related topics was provided at clinic site visits, hospital grand rounds, clinic continuing medical education and Pain/Opioid Summits. The topics covered CCO policy and guidelines, current literature on opioid risks, alternative non-

opioid treatments, available resources, MAT, how to use the PDMP and how to have difficult conversations with patients about opioids. CCOs also informed providers about PA process and guideline changes through individual letters and provider newsletters. Many CCOs had developed opioid dashboards (including an overview of prescribing patterns, member demographics, etc.) that were distributed to all primary care providers or clinics.

- Member education: Members were educated about the risks of opioids and CCO policies and guidelines through individual letters, newsletter articles, videos in clinic and hospital waiting rooms and community forums.
- Targeted interventions with members and providers: Most CCOs analyzed data to identify top opioid prescribers and members receiving ≥120 mg MED or ≥90 mg MED. Top prescribers received a letter (with information about guidelines and resources) and often a visit by the medical director and/or pharmacist to determine how the provider could achieve compliance. CCOs sent letters to members on high doses of opioids about CCO policies and guidelines, the need to develop a taper plan with their provider and the availability of alternative non-opioid treatments and resources.
- Alternative therapies: CCO strategies regarding alternative non-opioid treatments and services focused on alternative or complementary services, non-opioid pain medication and pain management programs.

  While a few CCOs had offered alternative treatment (acupuncture, chiropractic, massage) and behavioral health services to members with chronic pain, most plans delayed implementation of this intervention until final approval of OHA's Guideline note 60 in July 2016. Guideline note 60 encourages the use of non-opioid treatments for back and spine pain by providing coverage for up to 30 visits per year of any combination of physical/occupational therapies, chiropractic or osteopathic manipulation and acupuncture, cognitive behavioral therapy and non-opioid medications. At the time of this report, CCOs were still refining their benefit policies, developing credentialing procedures for non-licensed providers, organizing lists of available local alternative providers and negotiating contracts for service.

In addition to treatment services, most CCOs documented efforts to expand pharmacy benefit coverage to cover non-opioid medications, such as gabapentin, non-steroidal anti-inflammatories, lidocaine, etc.

Another non-opioid pain management resource promoted to both providers and members was pain management classes/programs. Some CCOs developed and conducted their own programs, while others made referrals to existing community programs.

- Medication-assisted treatment (MAT): All CCOs were either developing or had implemented strategies to increase access to MAT, including provider education about the role of MAT, provider training on acquiring the license necessary to prescribe MAT, identifying MAT providers in the community, working with other organizations to implement opioid treatment programs and developing a hub-and-spoke MAT model.
- Collaboration with community organizations: Several CCOs reported working with local law enforcement or community organizations on initiatives to increase medication disposal sites and with local pharmacists to increase prescribing of naloxone. CCOs also collaborated with community organizations in sponsoring community education events

Four CCOs (AllCare, Jackson Care Connect, PrimaryHealth of Josephine County, and Western Oregon Advanced Health), formed a regional collaborative and created an umbrella advisory PIP group and multiple workgroups to address common concerns in an organized and consistent manner. To date, the collaborative has developed standardized member and provider letters (which included all four CCO logos in the header and signed by all four CCO medical directors), member and staff educational materials and tapering forms and a staff/provider training video.

In terms of the integration of physical, behavioral and oral health, almost all CCOs solicited the participation of substance use disorder organizations and staff in discussing strategies to increase access to MAT. Behavioral health staff were involved in training providers about substance use and how to have difficult conversations with members. A few CCOs conducted trainings for dental providers and included dental providers when distributing opioid use dashboards.

Rating: Twelve CCOs received a “met” and four CCOs received a “partially met” rating for this criterion. CCOs that received a partially met rating did not provide clear and complete documentation of interventions.

c. How the intervention could be expected to improve the study indicator

CCOs responded to this question by using narrative, diagrams or cross-references to explain and illustrate how the interventions addressed factors identified in their root cause analyses. A few CCOs provided details as to how some interventions were evidence-based or implemented standard-of-care practices.

Rating: Fifteen CCOs received a "met" and one CCO received a "partially met." The CCO that received a partially met rating did not clearly link interventions to root cause barriers and factors.

d. Cultural and linguistic appropriateness of the intervention

CCOs described their local study populations as majority Caucasian and English-speaking, and many noted that their demographics reflected national statistics. CCOs highlighted factors that they had identified in their root cause analyses: mental illness/substance use, location (urban/rural/frontier) and lower socio-economic status/illiteracy.

In discussing this topic, almost all CCOs mentioned the existence of general organizational policies and procedures regarding equity, such as the availability of interpreters, staff training in diversity, etc. Some CCOs provided specific examples of how interventions were modified to address study population characteristics, e.g., conducting pain programs in different locations to lessen the burden on rural members, soliciting input from Hispanic organizations on how best to engage Hispanic members, including chronic disease management or information on mental illness in training modules.

Rating: Nine CCOs received a "met" and seven CCOs received a "partially met" rating for this criterion. CCOs that received a partially met rating discussed cultural and linguistic appropriateness only from an organizational level and were asked to provide examples specific to the PIP study population.

e. Tracking and monitoring plans and results

By the end of the first remeasurement period, CCOs were expected to have not only developed tracking and monitoring plans, but also to have produced and presented the results of those plans.

CCOs were given the option of reporting on either or both of the study indicators. Four CCOs chose to report on the 90 mg MED metric, six CCOs reported on the 120 mg MED metric and five CCOs reported data for both metrics. One CCO provided no data for either study metric. About half of the

CCOs presented measurement plans that included internally derived study indicator data as well as other CCO-selected performance measures.

In terms of tracking the effective implementation of interventions, CCOs presented data on summit/grand rounds/training program attendance, number of mailings to providers and members, number of received taper plans, number of clinic/site visits, number of providers licensed to prescribe buprenorphine, number of opioid treatment programs and number of clinics receiving additional payments for meeting performance thresholds. Some CCOs also described plans to link medical director or pharmacy director visits to high prescribers or to link training attendance to changes in prescribing patterns. HealthInsight Oregon has encouraged CCOs to link the effective implementation of interventions to changes in prescribing or member dosages.

In general, CCOs were less successful at providing results to demonstrate the effectiveness of alternative therapy interventions. One CCO was working with Oregon State University to assess all of its pain management strategies, but at the time of this report, had not yet received its evaluation. Another CCO provided data on pain program referrals, attendance and graduation rates over the past year. No CCO reported on the number of members who received alternative services (chiropractic, acupuncture, massage, etc.) or any changes in opioid dosage or use following treatment.

In situations where CCOs did not have direct responsibility for intervention implementation (e.g., community-based interventions), tracking and monitoring results were often not available.

Rating: Seven CCOs received a "met," eight CCOs received a "partially met" and one CCO received a "not met" rating for this criterion. CCOs that received a partially met rating did not provide a specific metric improvement target or complete metric data. One CCO did not provide any study metric data and received a rating of not met.

f. Barriers encountered during the implementation of the interventions and how they were addressed

Overall, the CCOs did a good job of documenting the barriers they encountered during implementation of their interventions. A number of CCOs continued to experience turnover of leadership, QI and data analytic staff, resulting in delayed development and implementation of intervention strategies and in lack of available study indicator or intervention effectiveness data.

Reported barriers also included competing priorities, scheduling conflicts, difficulty coordinating with different departments, difficulty in developing accurate data reports, high costs of materials and inclement weather.

Very few CCOs reported provider resistance or noncompliance as a barrier. Most CCOs anticipated provider concerns and mitigated risks by implementing multiple interventions focused on provider training and education.

Rating: Fifteen CCOs received a "met" and one CCO received a "partially met" rating. The CCO that did not identify or fully identify as barriers the problems described in progress reports received a lower rating.

g. Next steps: how the intervention(s) will be adapted, adopted or abandoned

Most CCOs had a well-established vision of the next steps for their intervention strategies. All CCOs were continuing with the interventions described in their intervention strategies table, sometimes with some minor modifications. The four CCOs in the regional collaborative are continuing to explore how they can best pool their resources.

Rating: Fifteen CCOs received a "met" and one CCO received a "partially met" rating for this criterion. The CCO that did not fully capture next steps that were alluded to in the intervention strategies and tracking monitoring sections of their reports received a lower rating.

Strengths and Opportunities for Improvement

Generally, HealthInsight Oregon has seen improvement in the CCOs' documentation of the Standard 8 criteria and their understanding of QI concepts since the implementation of the previous Statewide PIP. Most CCOs did a good job of conducting data and barrier analyses linking the analyses to expected improvement in the study indicator, developing interventions to address aspects of the opioid problem and describing any barriers encountered in the implementation of those interventions.

Regarding individual Standard 8 criteria, the cultural and linguistic appropriateness and tracking and monitoring criteria were the most challenging for CCOs. In their initial submissions, almost all CCOs described general CCO-level linguistic and health disparity policies and processes, but few provided examples of how interventions were developed or modified to meet the specific needs of the study population. About half of the CCOs either did not provide an improvement target for their selected study metric or did not provide baseline and quarterly data for one of the study metrics. It is possible that the lower ratings for these two criteria reflect lack of documentation rather than lack of actual implementation.

Standard 9: Repeated Measurement of the Study Indicator

Standard 9 provides study results for two measurement periods, including the study indicator, original data used to compute the indicator, and a statistical test of group differences; provides any other data analyses for factors that may affect the study results; and discusses how the intervention, consistency of methodology, and any confounding factors affected the study results in the second remeasurement period.

This standard will not be completed until after the second remeasurement.

Standard 10: Sustained Improvement

Standard 10 discusses whether or not goals were met and sustained; whether improvement in the study indicator, as well as in enrollee health, functional status, or satisfaction was achieved; discusses lessons learned for the PIP and the system as a whole; and reports next steps.

This standard will not be completed until after the second remeasurement.

Statewide PIP, Attachment A: Denominator Exclusion Codes

Diagnoses and CPT codes related to end-of-life care, palliative care or hospice care		
DX		
V66	Convalescence and palliative care	
V667	Encounter for palliative care	
Z515	Encounter for palliative care	
CPT		
4350F	Cnslng Provided Symp Mngmnt	Counseling Provided On Symptom Management, End Of Life Decisions, And Palliation (Dem)
4553F	Pt Asst Re End Life Issues	Patient Offered Assistance In Planning For End Of Life Issues (Als)
99377	Hospice Care Supervision	Physician Supervision Of Patient Hospice Services, 15-29 Minutes Per Month
99378	Hospice Care Supervision	Physician Supervision Of Patient Hospice Services, 30 Minutes Or More Per Month
D9110	Tx Dental Pain Minor Proc	Palliative (Emergency) Treatment Of Dental Pain-Minor Procedures
G0065	Physician Supervision Of A Hospice Patient	Physician Supervision Of A Hospice Patient
G0151	Hhcp-Serv Of Pt,Ea 15 Min	Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting, Each 15 minutes
G0152	Hhcp-Serv Of Ot,Ea 15 Min	Services Performed By A Qualified Occupational Therapist In The Home Health Or Hospice Setting, Each
G0153	Hhcp-Svs Of S/L Path,Ea 15mn	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Or Hospice Setting,
G0154	Hhcp-Svs Of Rn,Ea 15 Min	Direct Skilled Nursing Services Of A Licensed Nurse (Lpn Or Rn) In The Home Health Or Hospice Setting

Diagnoses and CPT codes related to end-of-life care, palliative care or hospice care		
G0155	Hhcp-Svs Of Csw,Ea 15 Min	Services Of Clinical Social Worker In Home Health Or Hospice Settings, Each 15 Minutes
G0156	Hhcp-Svs Of Aide,Ea 15 Min	Services Of Home Health/Hospice Aide In Home Health Or Hospice Settings, Each 15 Minutes
G0157	Hhc Pt Assistant Ea 15	Services Performed By A Qualified Physical Therapist Assistant In The Home Health Or Hospice Setting
G0158	Hhc Ot Assistant Ea 15	Services Performed By A Qualified Occupational Therapist Assistant In The Home Health Or Hospice Set
G0182	Hospice Care Supervision	Physician Supervision Of A Patient Under A Medicare-Approved Hospice (Patient Not Present) Requiring
G0337	Hospice Evaluation Preelecti	Hospice Evaluation And Counseling Services, Pre-Election
G8768	Doc Med Reas No Lipid Profle	Documentation Of Medical Reason(S) For Not Performing Lipid Profile (E.G., Patients With Palliative
G8892	Doc Med Reas No Ldl-C Test	Documentation Of Medical Reason(S) For Not Performing Ldl-C Test (E.G. Patients With Palliative Goal
G9380	Off Assis Eol Iss	Patient Offered Assistance With End Of Life Issues During The Measurement Period
G9381	Doc Med Reas No Offer Eol	Documentation Of Medical Reason(S) For Not Offering Assistance With End Of Life Issues (Eg, Patient
G9382	No Off Assis Eol	Patient Not Offered Assistance With End Of Life Issues During The Measurement Period
G9433	Death, Nhres, Hospice	Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The M
G9433	Death, Nhres, Hospice	Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The M
HC100	Omap: Nf Hospice Care	Omap: Nf Hospice Care
Q5001	Hospice Or Home Hlth In Home	Hospice Or Home Health Care Provided In Patient'S Home/Residence

Diagnoses and CPT codes related to end-of-life care, palliative care or hospice care		
Q5002	Hospice/Home Hlth In Asst Lv	Hospice Or Home Health Care Provided In Assisted Living Facility
Q5003	Hospice In Lt/Non-Skilled Nf	Hospice Care Provided In Nursing Long Term Care Facility (Ltc) Or Non-Skilled Nursing Facility (Nf)
Q5004	Hospice In Snf	Hospice Care Provided In Skilled Nursing Facility (Snf)
Q5005	Hospice, Inpatient Hospital	Hospice Care Provided In Inpatient Hospital
Q5006	Hospice In Hospice Facility	Hospice Care Provided In Inpatient Hospice Facility
Q5007	Hospice In Ltch	Hospice Care Provided In Long Term Care Facility
Q5008	Hospice In Inpatient Psych	Hospice Care Provided In Inpatient Psychiatric Facility
Q5009	Hospice/Home Hlth, Place Nos	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (Nos)
Q5010	Hospice Home Care In Hospice	Hospice Home Care Provided In A Hospice Facility
S0255	Hospice Refer Visit Nonmd	Hospice Referral Visit (Advising Patient And Family Of Care Options) Performed By Nurse, Social Work
S0257	End Of Life Counseling	Counseling And Discussion Regarding Advance Directives Or End Of Life Care Planning And Decisions, W
S0271	Home Hospice Case 30 Days	Physician Management Of Patient Home Care, Hospice Monthly Case Rate (Per 30 Days)
S5150	Unskilled Respite Care /15m	Unskilled Respite Care, Not Hospice; Per 15 Minutes
S5151	Unskilled Respitecare /Diem	Unskilled Respite Care, Not Hospice; Per Diem
S9126	Hospice Care, In The Home, P	Hospice Care, In The Home, Per Diem
T2042	Hospice Routine Home Care	Hospice Routine Home Care; Per Diem
T2043	Hospice Continuous Home Care	Hospice Continuous Home Care; Per Hour
T2044	Hospice Respite Care	Hospice Inpatient Respite Care; Per Diem
T2045	Hospice General Care	Hospice General Inpatient Care; Per Diem
T2046	Hospice Long Term Care, R&B	Hospice Long Term Care, Room And Board Only; Per Diem

Statewide PIP, Attachment B: Buprenorphine Products

HICL Sequence Number	Generic Drug Name	Route Administered Code & Description	Included in Opioid PIP?	Review by Nicole O'Kane, PharmD, Clinical Director, HealthInsight Oregon
10731	ACAMPROSATE CALCIUM	PO - ORAL	No	Not opioid
23438	BUPRENORPHINE	TD - TRANSDERM	YES	Exclude from MAT Definition (treats chronic pain)
1762	BUPRENORPHINE HCL	IJ - INJECTION	YES	Exclude from MAT Definition (treats chronic pain)
1762	BUPRENORPHINE HCL	MC - MISCELL	No	Possibly MAT
1762	BUPRENORPHINE HCL	SL - SUBLINGUAL	No	Likely MAT
24846	BUPRENORPHINE HCL/NALOXONE HCL	SL - SUBLINGUAL	No	Likely MAT
529	DISULFIRAM	MC - MISCELL	No	Not opioid
529	DISULFIRAM	PO - ORAL	No	Not opioid
35611	METHYLNALTREXONE BROMIDE	SQ - SUB-Q	No	Not opioid. Exclude from MAT Definition (treats opioid constipation)
36577	MORPHINE SULFATE/NALTREXONE	PO - ORAL	YES	Exclude from MAT Definition (treats chronic pain)
33364	NALTREXONE	MC - MISCELL	No	Not opioid
1875	NALTREXONE HCL	MC - MISCELL	No	Not opioid
1875	NALTREXONE HCL	PO - ORAL	No	Not opioid
33782	NALTREXONE MICROSPHERES	IM - INTRAMUSC	No	Not opioid

Statewide PIP, Attachment C: Study Denominator by Age Group and CCO over Three Time Periods

Among OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever within the measurement year.									
	12–17 years old			18+ years old			Both age groups (Total)		
CCO	CY 2014	CY 2015	12/1/2015 - 11/30/2016	CY 2014	CY 2015	12/1/2015 - 11/30/2016	CY 2014	CY 2015	12/1/2015 - 11/30/2016
AllCare	331	309	280	6240	6428	5510	6571	6737	5790
CHA	95	77	89	1167	2062	1768	1262	2139	1857
CPCCO	209	171	131	3792	3850	3128	4001	4021	3259
EOCCO	431	369	305	5512	6176	5321	5943	6545	5626
FAMILYCARE	621	574	415	11058	13433	10716	11679	14007	11131
FFS	498	463	313	8638	5917	5023	9136	6380	5336
HEALTH SHARE	1538	1330	1027	26214	28850	22948	27752	30180	23975
IHN	480	396	308	7819	8305	6628	8299	8701	6936
JCC	240	195	157	3488	3837	3373	3728	4032	3530
PSCS-Central Oregon	475	399	303	6993	7462	6168	7468	7861	6471
PSCS-Columbia Gorge	82	74	60	1143	1292	1047	1225	1366	1107
PHJC	68	77	47	1391	1451	1170	1459	1528	1217
Trillium	665	614	443	12861	13538	11428	13526	14152	11871
UHA	189	152	140	3711	3676	3231	3900	3828	3371
WOAH	144	126	104	2986	3115	2585	3130	3241	2689
WVCH	643	633	582	9313	10781	9799	9956	11414	10381
YCCO	242	176	154	2627	2748	2435	2869	2924	2589
SUM OF CCOS	**6453**	**5672**	**4545**	**106315**	**117004**	**97255**	**112768**	**122676**	**101800**

For CY 2014 Data extraction date: 12/28/2015
For CY 2015: Data extraction date: 9/28/2016
For 12/1/15-11/30/16 Data extraction date: 3/16/2017 indicates change over period 1/1/16-11/30/16

Statewide PIP, Attachment D: Study Numerators by Age and CCO over Three Time Periods

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥120 mg MED on at least one day.												
CCO	**12–17 years**			**18+ years**			**Both groups (Total)**			**Rate for both groups**		
	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16
AllCare	6	3	4	396	368	310	402	371	314	6.1%	5.5%	5.4%
CHA	7	2	1	80	96	92	87	98	93	6.9%	4.6%	5.0%
CPCCO	7	2	1	593	558	413	600	560	414	15.0%	13.9%	12.7%
EOCCO	10	6	7	855	916	730	865	922	737	14.6%	14.1%	13.1%
FAMILYCARE	10	9	8	906	1124	941	916	1133	949	7.8%	8.1%	8.5%
FFS	4	10	3	894	549	407	898	559	410	9.8%	8.8%	7.7%
HEALTH SHARE	40	28	22	3300	3504	2604	3340	3532	2626	12.0%	11.7%	11.0%
IHN	10	5	3	911	882	640	921	887	643	11.1%	10.2%	9.3%
JCC	7	1	3	616	575	506	623	576	509	16.7%	14.3%	14.4%
PSCS-CO	8	1	3	545	505	384	553	506	387	7.4%	6.4%	6.0%
PSCS-CG	1	0	0	121	93	79	122	93	79	10.0%	6.8%	7.1%
PHJC	0	0	1	122	124	103	122	124	104	8.4%	8.1%	8.5%
Trillium	14	22	11	1726	1649	1356	1740	1671	1367	12.9%	11.8%	11.5%
UHA	3	5	3	228	220	167	231	225	170	5.9%	5.9%	5.0%
WOAH	3	3	2	198	199	182	201	202	184	6.4%	6.2%	6.8%
WVCH	10	8	3	937	971	708	947	979	711	9.5%	8.6%	6.8%
YCCO	6	6	5	269	275	226	275	281	231	9.6%	9.6%	8.9%
SUM OF CCOS	**142**	**101**	**77**	11803	**12059**	**9441**	**11945**	**12160**	**9518**	**10.6%**	**9.9%**	**9.3%**

For denominators and extraction dates, see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥90 mg MED on at least one day.												
CCO	**12–17 years**			**18+ years**			**Both groups (Total)**			**Rate for both groups**		
	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16
AllCare	7	10	5	739	698	605	746	708	643	11.4%	10.5%	10.4%
CHA	13	5	5	202	228	197	215	233	203	17.0%	10.9%	10.3%
CPCCO	16	5	1	915	910	698	931	915	739	23.3%	22.8%	21.3%
EOCCO	32	21	10	1258	1390	1098	1290	1411	1160	21.7%	21.6%	20.5%
FAMILYCARE	40	35	27	1846	2337	1929	1886	2372	2006	16.1%	16.9%	16.7%
FFS	25	29	16	1574	1000	776	1599	1029	842	17.5%	16.1%	15.7%
HEALTH SHARE	89	82	57	5559	6171	4688	5648	6253	4938	20.4%	20.7%	20.2%
IHN	21	18	10	1372	1400	1019	1393	1418	1049	16.8%	16.3%	14.4%
JCC	12	4	4	824	855	729	836	859	736	22.4%	21.3%	20.5%
PSCS-CO	26	18	15	1063	942	726	1089	960	797	14.6%	12.2%	11.8%
PSCS-CG	2	2	2	200	160	145	202	162	152	16.5%	11.9%	13.6%
PHJC	1	3	2	210	221	175	211	224	184	14.5%	14.7%	14.7%
Trillium	39	53	38	2744	2741	2256	2783	2794	2378	20.6%	19.7%	19.1%
UHA	6	8	9	480	467	366	486	475	390	12.5%	12.4%	11.5%
WOAH	7	8	10	414	435	379	421	443	412	13.5%	13.7%	14.7%
WVCH	27	18	10	1593	1625	1320	1620	1643	1349	16.3%	14.4%	13.0%
YCCO	16	14	10	462	513	424	478	527	450	16.7%	18.0%	16.6%
SUM OF CCOS	**354**	**304**	**215**	19881	**21093**	**16754**	**20235**	**21397**	**17586**	17.9%	17.4%	16.7%

For denominators and extraction dates, see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥120 mg MED consecutive 30 days or more.												
CCO	**12–17 years**			**18+ years**			**Both groups (Total)**			**Rate for both groups**		
	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16
AllCare	0	1	0	83	61	39	83	62	39	1.3%	0.9%	0.7%
CHA	0	0	0	4	6	2	4	6	2	0.3%	0.3%	0.1%
CPCCO	0	0	0	183	148	103	183	148	103	4.6%	3.7%	3.2%
EOCCO	1	0	0	245	244	215	246	244	215	4.1%	3.7%	3.8%
FAMILYCARE	0	0	0	120	109	106	120	109	106	1.0%	0.8%	1.0%
FFS	0	0	0	258	154	91	258	154	91	2.8%	2.4%	1.7%
HEALTH SHARE	0	0	0	766	737	504	766	737	504	2.8%	2.4%	2.1%
IHN	0	0	0	301	271	198	301	271	198	3.6%	3.1%	2.9%
JCC	0	0	0	273	211	158	273	211	158	7.3%	5.2%	4.5%
PSCS-CO	0	0	0	110	109	79	110	109	79	1.5%	1.4%	1.2%
PSCS-CG	0	0	0	36	23	18	36	23	18	2.9%	1.7%	1.6%
PHJC	0	0	0	46	35	26	46	35	26	3.2%	2.3%	2.1%
Trillium	0	0	0	554	470	376	554	470	376	4.1%	3.3%	3.2%
UHA	0	0	0	45	39	30	45	39	30	1.2%	1.0%	0.9%
WOAH	0	0	0	40	36	25	40	36	25	1.3%	1.1%	0.9%
WVCH	0	0	0	259	212	110	259	212	110	2.6%	1.9%	1.1%
YCCO	0	0	0	63	50	30	63	50	30	2.2%	1.7%	1.2%
SUM OF CCOS	1	**1**	**0**	3128	**2761**	**2019**	3129	**2762**	**2019**	2.8%	**2.3%**	**2.0%**

For denominators and extraction dates, see Attachment C.

Number and percentage of OHP enrollees age 12 years and older who had at least one prescription for an opioid pain reliever who filled prescriptions totaling ≥90 mg MED consecutive 30 days or more.												
CCO	**12–17 years**			**18+ years**			**Both groups (Total)**			**Rate for both groups**		
	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16	CY 2014	CY 2015	12/1/15 - 11/30/16
AllCare	0	1	0	120	103	79	120	104	79	1.8%	1.5%	0.1%
CHA	0	0	0	9	10	2	9	10	2	0.7%	0.5%	5.1%
CPCCO	0	0	0	252	207	166	252	207	166	6.3%	5.1%	5.8%
EOCCO	1	0	0	350	358	326	351	358	326	5.9%	5.5%	1.8%
FAMILYCARE	0	0	0	200	223	205	200	223	205	1.7%	1.6%	3.1%
FFS	0	0	0	412	245	168	412	245	168	4.5%	3.8%	3.6%
HEALTH SHARE	0	0	0	1114	1135	860	1114	1135	860	4.0%	3.8%	4.2%
IHN	0	0	0	427	402	291	427	402	291	5.1%	4.6%	7.1%
JCC	0	0	0	342	296	249	342	296	249	9.2%	7.3%	1.9%
PSCS-CO	0	0	0	166	161	123	166	161	123	2.2%	2.0%	3.1%
PSCS-CG	0	0	0	51	37	34	51	37	34	4.2%	2.7%	3.3%
PHJC	0	0	0	61	52	40	61	52	40	4.2%	3.4%	4.5%
Trillium	0	0	0	756	674	538	756	674	538	5.6%	4.8%	1.3%
UHA	0	0	0	61	56	43	61	56	43	1.6%	1.5%	1.4%
WOAH	0	0	0	57	61	38	57	61	38	1.8%	1.9%	1.9%
WVCH	0	0	0	384	352	193	384	352	193	3.9%	3.1%	2.0%
YCCO	0	0	0	97	68	52	97	68	52	3.4%	2.3%	**3.2%**
SUM OF CCOS	1	**1**	**0**	4447	**4195**	79	4448	**4196**	79	3.9%	**3.4%**	0.1%

For denominators and extraction dates, see Attachment C.

Statewide PIP, Attachment E: Study Demographics

Number of enrollees age 12 years and older who had least one prescription for an opioid pain reliever filled within the baseline measurement year by race and ethnicity.					
Denominator	**Hispanic/ Latino**	**Non-Hispanic/ Non-Latino**	**Unknown**	**Cross Ethnicity**	**% of denominator**
African American	162	4589	46	4797	4.25%
American Indian or Alaskan Native	122	1414	24	1560	1.38%
Asian	120	1566	23	1709	1.52%
Caucasian/White	4943	80,800	1326	87,069	77.21%
Native Hawaiian/Pacific Islander	27	248	0	275	0.24%
Hispanic	25	0	18	43	
Other Race or Ethnicity	874	1826	37	2737	2.43%
Unknown	4611	9827	140	14,578	12.93%
Total	**10,884**	**10,0270**	**1614**	**112,768**	

Percentage of denominator who are Hispanic = 9.65%.

Data extraction date: 12/28/2015, Office of Health Analytics, OHA.

Number of enrollees in the study baseline denominator with at least 30 consecutive days with ≥120 mg MED/day by race and ethnicity.					
Numerator: ≥120mg MED/day for 30 days or more	**Hispanic/ Latino**	**Non-Hispanic/ Non-Latino**	**Unknown**	**Cross Ethnicity**	**% of numerator**
African American	2	90	0	92	2.94%
American Indian or Alaskan Native	4	51	0	55	1.76%
Asian	0	10	0	10	0.32%
Caucasian/White	61	2609	18	2688	85.91%
Native Hawaiian/Pacific Islander	0	5	0	5	0.16%
Hispanic	0	0	0	0	0.0%
Other Race or Ethnicity	20	25	1	46	1.47%
Unknown	40	191	2	233	7.45%
Total	**127**	**2981**	**21**	**3129**	

Percentage of denominator who are Hispanic = 4.10%.

Data extraction date: 12/28/2015, Office of Health Analytics, OHA.

Statewide PIP, Attachment F: Standard 8 Scoring Criteria

8.1 Has the CCO described:

a. The root cause analysis or quality improvement process used to understand the problem/gap and serve as the basis for adopting interventions.
   - Part 1 should include: presentation of local data that was analyzed to determine root cause(s); listing or discussion or root causes or contributing factors to the problem/gap; and list of stakeholders involved in the decision-making process.
   - *Note: Analyses should be consistent with interventions (e.g., if provider training is an intervention strategy, provider lack of knowledge should be listed in the root cause analysis).*

b. The intervention strategies as they have been developed or implemented:
   - Part 1 should include information on start dates, staff roles and tools or instruments used.
   - Progress report should include updates on activities on existing interventions, including lack of new activities; new interventions (interventions developed after Part 1 submission) should include information on start dates, staff roles and tool/instruments used.
   - *Note: This information can be reported in the additional information section of the progress report.*

c. Why the interventions could be expected to improve the study indicator.
   - Part 1 should include a description on how each intervention addresses causes/barriers identified in the root cause analysis and is a system intervention.
   - Part 1 should include a description on how other factors (e.g., evidence-based research, clinical knowledge, previous success, and continuous quality tracking and modification process) increase the likelihood of intervention effectiveness and therefore improvement in the study indicator.
   - Progress report should include descriptions of interventions developed after the Part 1 submission and an explanation of why those new interventions can be expected to improve the study indicator.
   - *Note: This information can be reported in the "additional information" section of the progress report.*

d. Cultural and linguistic appropriateness (CLA) of the interventions
   - Part 1 should include an explanation of how the interventions will address racial, ethnic and/or linguistic differences in the CCO study population.
   - Part 1 should explain how the interventions will address broader cultural considerations relevant to the CCO study population, such as socioeconomic status, geographic location (urban vs. rural living), literacy status, serious and persistent mental illness, etc.
   - Progress report with descriptions of new interventions should include an explanation of their cultural and linguistic appropriateness. This information should be included in the "additional information" section on page 3.
   - *Note: Cultural and linguistic appropriateness considerations should be consistent with the root cause, demographic and barrier analyses (e.g., if analyses indicate that rural environment is a contributing factor/barrier, the CLA discussion should include an explanation as to how that will be taken into account when developing and implementing interventions).*

e. Tracking and monitoring plans and results/intervention effectiveness
   - Part 1 should describe plans to collect study indicator and implementation effectiveness data.
   - Progress report should include study indicator data over time in the outcome table.
   - Progress report should include information on the # or % of study eligible enrollees reached by the interventions (when applicable*).*
   - Progress report (under the intervention effectiveness column) should include data (quantitative or qualitative) to demonstrate whether or not each intervention was implemented successfully
   - Graphs, run charts and tables can be used to further illustrate tracking and monitoring results.
   - *Note: CCOs should demonstrate that between all of the different interventions, they have covered the entire study population and not just "cherry-picked" sub-populations.*
   - *Note: Graphs and tables should be labelled and consistent with the narrative.*

f. Barriers:
   - Progress report should include information on factors/events/situations that negatively affected the development and implementation of the interventions, where applicable.

- Progress report should include a description of how barriers were addressed (or could not be addressed).
- *Note: The reported barriers should be consistent with next steps/intervention status (e.g., if an intervention is modified or abandoned, there should be a corresponding discussion of barriers in the barriers column*).

g. Next steps:
   - Progress report should include information on the status of each intervention (i.e., how the intervention was continued, adapted, abandoned or adopted).
   - *Note: Intervention status should be consistent with any tracking and monitoring data and reported barriers.*

Statewide PIP, Attachment G: Results of First Remeasurement Standard 8 Rating by CCO

M = Met **P** = Partially met **N** = not met

CCO	Root cause			Description interventions			How improves the indicator			Cultural/linguistic appropriateness			Tracking and monitoring			Barriers			Next steps		
	M	**P**	**N**	**M**	**P**	**N**	**M**	**P**	**N**	**M**	**P**	**N**	**M**	**P**	**N**	**M**	**P**	**N**	**M**	**P**	**N**
AllCare	1				1			1		1				1		1			1		
CHA	1			1			1			1				1		1			1		
CPCCO	1			1			1			1				1		1			1		
EOCCO	1			1			1			1				1		1			1		
FamilyCare	1			1			1				1		1			1			1		
Health Share	1			1			1				1			1		1			1		
IHN	1			1			1			1			1			1			1		
JCC	1			1			1				1		1			1			1		
PSCS-CO	1				1		1				1			1		1			1		
PSCS-CG	1				1		1				1			1		1			1		
PHJC	1			1			1				1		1			1			1		
TCHP	1				1		1				1				1		1			1	
UHA	1			1			1			1				1		1			1		
WOAH	1			1			1			1			1			1			1		
WVCH	1			1			1			1			1			1			1		
YCCO	1			1			1			1			1			1			1		
Sum	**16**	**0**	**0**	**12**	**4**	**0**	**15**	**1**	**0**	**9**	**7**	**0**	**7**	**8**	**1**	**15**	**1**	**0**	**15**	**1**	**0**

Appendix C: Results of State-Level ISCA Review

In 2016, HealthInsight Oregon conducted a full ISCA review of OHA's data management and reporting systems through interviews with key staff and review of system documentation.

The ISCA review found that OHA continues efforts to strengthen its infrastructure and IT processes and procedures by performing daily backups of Medicaid data and replicating the backups to an offsite location. OHA reported continuing efforts to expand server, database and storage capability to handle workload increases due to Medicaid expansion. CCOs reported that OHA continues to improve the integrity of member eligibility data sent to the CCOs. OHA also continues working to address issues related to:

- maintenance and ongoing support for Medicaid Management Information System (MMIS) hardware and software
- expanding the teams responsible for processing, reviewing and auditing the CCOs' claims and encounter data
- inconsistencies in data submission by the CCOs
- regular review and updating of policies, procedures and business continuity/disaster recovery (BC/DR) plans

Table C-1 reports OHA's scores for each major category of the ISCA review, along with recommendations for improvement.

Oregon's MMIS receives encounter data from the CCOs, their dental provider networks (DPNs) and their third-party administrators (TPAs). MMIS houses data for all encounters, including pharmacy, dental and vision services. Electronic Data Interchange processes run a series of edits to accept, pend or reject claims before data are imported into MMIS. Rejected claims are not imported and are not tracked by OHA. OHA sends a "999" acknowledgement file to the submitter of claims. CCOs do not necessarily receive copies of the 999 files for claims and encounters submitted on their behalf by DPNs and/or TPAs.

DSSURS is the data warehouse for the main reporting database for MMIS. Medicaid data are loaded into DSSURS by an Extract, Transform and Load process on a weekly basis. Hewlett-Packard (HP) creates PDF-formatted reports for OHA based on MMIS data, using the COLD tool.

HP manages and supports multiple key systems for OHA but is not authorized to make financial decisions on behalf of OHA. HP manages the software and hardware for MMIS, DSSURS and the provider portal. The servers supporting these systems are located in the state data center. OHA has completed the technology refresh project started in 2014. As part of this project, hardware was replaced, virtualized or upgraded to support the increase in MMIS activity due to Medicaid expansion.

OHA staff use SQL and SAS software to calculate the incentive performance measures, based on data from DSSURS. OHA contracts with Providence's Center for Outcomes Research and Education (CORE) to validate the code used to calculate the performance measures that use encounter data. OHA's Health Analytics team sends a subset of data to CORE, depending on the measure year. As of the ISCA review, CORE also managed performance data reporting on behalf of Health Share of Oregon CCO.

OHA continues to work with CORE to enhance reporting related to performance measure calculation and data detail for each CCO.

OHA continues to formalize its system development practices (processes for planning, creating, testing and deploying information systems, software and/or reports) for the incentive performance measures. Data accuracy is delegated to the CCOs and their TPAs. OHA continues to refine and enhance its version control and peer review processes for internally developed reports such as performance measures.

Table C-1. State-Level ISCA Review: Strengths and Recommendations
Information Systems (data flow) – Partially met (2.5)
Recommendations
Version control OHA does not use version control software or processes. Instead, staff renames previous versions of files or programs, and edits new copies as needed. OHA uses informal version control for DSSURS and Health Analytics group reports and output. Version control software can improve the ability to identify changes and return to previous versions of files if needed, and automates revision history. • OHA should develop and implement a formal version control process for Medicaid data reporting. • OHA should explore options and implement enterprise version-control management software for its Medicaid reporting.
Finding #1: 999 files not being sent to the CCOs OHA sends a 999 file to the submitter of claims/encounter data confirming receipt of the data file and the transaction status of claims/encounters in the data file. It was unclear whether the CCOs receive copies of the 999 files when claims and/or encounters are submitted on their behalf by other organizations. A CCO will not know the status of claims and/or encounters submitted if the CCO does not receive either the 999 file or the information contained within the file. • OHA should evaluate providing 999 files to the CCOs for any encounters submitted to OHA for members assigned to a CCO. • OHA needs to add language to the CCO contract requiring CCOs to require copies of all 999 files related to encounter data submitted to OHA, regardless of who submits the encounter data.
Data flow for reporting OHA submitted limited documentation explaining how different types of data are received from the CCOs, processed, integrated and submitted to CMS. Such documentation could help OHA monitor various data sources. • OHA needs to develop an integrated data flow diagram that describes the data process for all encounters received from CCOs. The diagram should include receipt of encounter data, reporting solutions and submission to CMS. This documentation should be stored and/or communicated in a manner that is easily accessible to staff members who need it.
Staffing (claims and encounters, authorization) – Fully met (3.0)
Recommendations
None
Configuration Management (hardware systems) – Fully met (3.0)
Recommendations
None

Security (incident management, risk management) – Partially met (2.4)

Recommendations

Need process for monitoring subcontractor's BC/DR plan

OHA outsources MMIS support, maintenance and design to HP. The ISCA interview revealed that OHA lacked processes for monitoring HP's BC/DR plan for OHA's MMIS system.

- OHA should work with HP to develop formal documentation of the configuration, maintenance processes, support procedures and BC/DR plan for OHA's MMIS.

Finding #2: BC/DR plan in progress

OHA continues to expand and enhance its BC/DR plan, which is still in draft form. OHA is working on an internal Continuity of Operations Plan and a stop-gap recovery plan with HP. OHA scheduled a test of the current plan in January 2017, with a pre-test in late 2016.

- OHA needs to implement a strategy to recover data in the event of a disaster.
- OHA needs to determine the level of detail necessary to include in the plan to enable a skilled IT person to recover or assist with resuming operations in a timely manner.
- OHA should monitor and verify that the plan is tested at least every other year, reviewed at least every two years and updated when significant changes occur.

Mobile device policies

OHA lacks policies and procedures for mobile device management. OHA needs to control the configuration, encryption and data being accessed by mobile devices.

- OHA should establish mobile device management policies and procedures to ensure that mobile devices are configured, maintained and controlled to safeguard sensitive data.

Administrative Data (claims and encounter data) – Partially met (2.1)

Recommendations

Race/ethnicity data not required

OHA reported that CCOs are not required to supply members' race/ethnicity data. If the race/ethnicity field is blank on a claim/encounter, OHA assigns a value of "unknown" to this field. 42 CFR §438.10(c)(3) requires CCOs to provide written materials that are critical to obtaining services, including provider directories, enrollee handbooks, appeal and grievance notices and denial and termination notices, in the prevalent non-English languages in the CCO's service area. It is unclear how either OHA or the CCOs would be aware of prevalent non-English languages in the CCOs' service areas without members' racial/ethnicity data.

- OHA needs to determine and specify the prevalent non-English languages for all CCO service areas.
- OHA should include language in the CCO contract requiring that the CCOs determine and report, as part of the encounter data, a member's racial/ethnicity data.

Finding #3: CCO contract requirements for BC/DR plans

OHA does not require the CCOs to maintain BC/DR plans or plans for testing BC/DR plans. Without sufficient and effective BC/DR plans, CCOs risk being unable to fulfill their contractual obligations. OHA noted that CMS has made a recent rule change requiring Medicare/Medicaid cost centers to conduct more effective BC/DR planning. OHA reported that its Health Systems Division is evaluating the

implications of this rule change and has assembled a team to work with partner organizations and CCOs to determine how to monitor for compliance, when monitoring will begin and how assistance will be provided to the CCOs.

- OHA needs to add language to the CCO contract requiring the CCOs and their subcontractors to maintain working BC/DR plans.
- OHA needs to develop a process to evaluate the CCOs' BC/DR plans and BC/DR plan testing on a regular basis.

Monitoring process for data completeness

OHA reported that it is unaware whether the CCOs require subcontractors to submit all claims and/or encounters, including zero-dollar claims, to OHA and/or the CCOs. OHA is evaluating whether it needs to establish policies and procedures to ensure that all CCO subcontractors are aware of and complying with OHA's expectations to submit complete claims and/or encounters. PH Tech has been working to clarify requirements to match the state expectations.

- OHA should inform all CCOs and their subcontractors that zero- or low-dollar claims must be submitted to OHA.
- OHA should develop a process to monitor Medicaid claims being submitted to OHA.

Finding #4: CCOs not performing encounter data validation (EDV)

OHA does not require CCOs to perform EDV to validate their encounter data against clinical records, nor does OHA conduct EDV on data submitted by the CCOs. OHA continues to evaluate who should perform this activity.

- OHA should develop and implement an EDV process or require the CCOs to regularly conduct EDV to compare a sample of the state's encounter data with clinical records. This process could be conducted by OHA, the CCOs or a third party.

Trust in NEMT payment vs. encounter data

OHA has developed procedures to evaluate non-emergent transportation (NEMT) potential encounters versus actual NEMT encounters submitted by the CCOs. OHA reported being concerned that it is not receiving all NEMT encounter data. OHA said it was unclear if the payments being made for NEMT services are correct and supported by the NEMT encounter data submitted by the CCOs to OHA.

- OHA should communicate its expectations and requirements concerning the submission and validation of complete, timely and accurate NEMT data.

Enrollment Systems (Medicaid eligibility downloads) – Fully met (2.9)

Recommendations

Need method for members to update their enrollment information in a timely manner

Multiple CCOs reported issues arising from member-supplied enrollment data not matching MMIS-supplied enrollment data. OHA's process for updating member enrollment information requires that the member submit a completed MSC 2094 form. OHA then has 60 days to respond after receiving the member's request. OHA may extend the time to respond by an additional 30 days, but must inform the member of the extension and reason for the delay.

This method of updating member enrollment data requires the CCOs to maintain multiple copies of member data. The CCOs must keep a copy of the enrollment information that the member provides the CCO and a copy of the 834 enrollment data. Multiple CCOs reported issues when mailing important

information to members for whom the 834 enrollment data were not current, causing mail to be returned or delivered to someone other than the member. OHA reported that it is working on a process to make it easier for members to update their enrollment data via electronic or other means.

- OHA needs to move forward with efforts to streamline the process for updating member enrollment data so that the data can be processed in a timely manner.

Vendor Data Integration and Ancillary Systems – Fully met (3.0)

Recommendations

None

Report Production and Integration and Control of Data for Performance Measure Reporting – Partially met (2.4)

Recommendations

Documentation of MMIS data extraction

OHA did not submit documentation detailing how data used for reporting are extracted from the data repositories and archived.

- OHA needs to fully document the processes used to create, store, access and restore from encounter data archives.
- OHA needs to develop an integrated data flow diagram that describes the archiving process for encounter data used for reporting.

Peer review practices

Performance measure report writing and program development processes and practices appear not to require peer reviews. Peer review is conducted informally and inconsistently when reports and/or programs are created or modified. OHA lacks a formal peer review and approval process for programming data report production to validate data accuracy and completeness before production.

- OHA needs to develop a formal process for peer review of report and data extract production.

Need formal process for sign-off on calculations used in performance metric dashboard

OHA described the current process for verification and acceptance of the performance measure data as being based on a verbal consensus arrived at during OHA management meetings by comparing OHA's performance measures with CORE's performance metric calculations.

- OHA needs to document and formalize its process to verify the accuracy of the performance metric dashboard data.

Provider Data (compensation and profiles) – Fully met (3.0)

Recommendations

None

Meaningful Use of Electronic Health Records – Fully met (3.0)

Recommendations

None

APPENDIX A. CCO PROFILES

These profiles briefly describe each CCO's organizational structure and summarize the CCO's performance in the review areas covered by the 2016 EQR:

- Follow-up review of compliance with regulatory and contractual standards
- Statewide and CCO-specific performance improvement projects (PIPs)
- Information Systems Capabilities Assessment (ISCA)

High-level results are extracted from the reports of individual health plan reviews that HealthInsight Oregon delivered to OHA throughout 2016. HealthInsight Oregon calculated the scores for these activities using methodology based on the Centers for Medicare & Medicaid Services review protocols and approved by OHA.

Profiles are presented for the 16 CCOs and one managed mental health organization (GOBHI) that served Oregon Health Plan enrollees during 2016.

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AllCare Health Plan

Mid Rogue Independent Physician Association, doing business as AllCare Health Plan, contracts with OHA to provide physical, dental and behavioral health services for OHP members in Jackson, Josephine, Curry and Douglas counties. AllCare delegates mental health service delivery to Jackson County Mental Health, Curry Community Health and Options for Southern Oregon. The CCO delegates alcohol and drug treatment service delivery to OnTrack and Addictions Recovery Center; dental service delivery to Advantage Dental, Capitol Dental Care, Willamette Dental Group, Moda Health and La Clinica; non-emergent medical transportation (NEMT) to Ready Ride; provider credentialing to PrimeCare and NW Rehab Alliance; and encounter data processing to PH Tech.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with AllCare regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 2 and partially resolved 2 of the 4 findings from 2014.
- Of 20 recommendations in 2014, 6 were resolved, 10 were partially resolved and 4 were not resolved.
- The CCO resolved both of the 2 findings from 2015.
- Of 20 recommendations in 2015, 3 were resolved, 15 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Mailed co-branded letters (with logos of all CCOs in the letterhead) to all providers about the opioid policy guidelines
- Mailed co-branded letters and taper forms to providers with patients on high opioid doses about the need to develop taper plans
- Developing co-branded educational materials, including a video for staff education and a provider toolkit
- Developing co-branded letters and other materials to mail to members

Barriers:

- There was uncertainty as to who would own the rights to the co-branded video. It was decided that the Oregon Pain Guidance group would take ownership.
- Differences about how the toolkit would be distributed delayed implementation.

Next steps:

- Continue member education.
- Complete the staff educational video and begin dissemination.
- Continue to send taper agreement letters and track the number of plans received.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increasing the percentage of referrals of pregnant women to community substance abuse programs
- Increasing the percentage of member advance directives or Physician Orders for Life-Sustaining Treatment (POLST)

CCO Focus Area:

- Increasing PCPCH enrollment

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.9)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (2.8)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met (2.1)	Provider Data	Not met (1.8)
Administrative Data	Partially met (2.3)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: CCO monitoring of delegated IT activities

AllCare has developed a new delegation oversight and audit process to monitor IT security practices, policies and procedures of its delegates and partners. The process does not clearly define relationships between the IT and business sides of AllCare, nor the roles and responsibilities for different monitoring activities. AllCare expected the monitoring of delegates' and partners' IT security practices, policies and procedures to be in regular production rotation by late 2016. Through the delegation oversight and audit process, AllCare identified a business partner that lacked formal IT policies, procedures and processes. The business partner reported working to develop and formalize its IT policies, procedures and processes.

Finding #2: Business continuity/disaster recovery (BC/DR) plans and testing plans

AllCare reported that it was developing a CCO-level BC/DR plan and planned to create a testing strategy. The CCO has identified an alternate recovery site and is working to document this as part of its project to construct a new office building. Curry Community Health reported that it is working with a contractor to develop and implement a BC/DR plan and a testing plan. Development of this plan was expected to be completed in early 2017.

AllCare's provider agencies reported varied stages of BC/DR planning. One agency reported having an informal BC/DR plan but had not developed a testing plan or identified a recovery site. Another provider agency reported having a BC/DR plan but had not developed a testing plan.

Finding #3: Zero- and low-dollar claims expectations and monitoring process

AllCare reported that it does not monitor to ensure that all Medicaid claims are submitted to OHA. The CCO has begun educating providers on its expectations regarding zero- and low-dollar claims. PH Tech worked to clarify requirements to match the state expectations. At least one provider agency reported that it does not submit these type of claims or encounters. Curry Community Health reported that it monitors for zero-dollar claims but does not submit such claims.

Finding #4: Unclear if AllCare is notified when provider leaves Curry Community Health

Curry Community Health reported that it does not notify AllCare when a provider leaves the agency. AllCare has an informal process of reviewing the credentials of all providers listed in the CCO's provider directory, but the credential review would not ensure the accuracy of the provider directory.

Cascade Health Alliance (CHA)

CHA, a wholly owned subsidiary of Cascade Comprehensive Care, LLC (CCC), contracts with OHA to provide physical, behavioral and dental health services for OHP members in Klamath County. CCC, a local physician-owned organization, performs all administrative functions for the CCO. Dental care delivery for enrollees is delegated to Advantage Dental and Capitol Dental Care. CHA contracts with Klamath Basin Behavioral Health, Lutheran Community Services, Transformation Wellness Center and individual mental health practitioners to provide mental health and substance use disorder treatment. NEMT service management is delegated to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with CHA regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- CHA resolved 1 of the 6 findings from 2014 and partially resolved the other 5.
- The CCO resolved 7, partially resolved 8 and did not resolve 10 of the 25 recommendations from 2014.
- CHA resolved 2, partially resolved 1 and did not resolve 5 of the 8 findings from 2015.
- The CCO resolved 6, partially resolved 11 and did not resolve 23 of the 40 recommendations from 2015.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Integrate CHA's Pain Committee with Sky Lakes Medical Center to improve efficiency and reduce duplication
- Develop point-of-sale prior authorization guidelines for opioid prescriptions ≥ 90 mg MED
- Add non-opioid treatment options to formulary
- Add alternative treatment providers to network

Barriers:

- Lack of a full-time pharmacist has delayed integration efforts
- Difficulty finding alternative treatment providers to sign long-term contracts

Next steps:

- Once pain committees have been integrated, begin tracking pain contracts and tapering plans for members on ≥ 90 mg MED.
- Begin implementing point-of-sale prior authorization guidelines at Klamath Basin pharmacies.
- Negotiate short-term contracts with alternative service providers.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improve timeliness of prenatal care
- Increase percentage of members with chronic obstructive pulmonary disease who receive a pulmonary function test

CCO Focus Area:

- Improve patient access at the clinic level by reducing no-show appointments

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met with a finding (2.7)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met (2.4)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.9)
Security	Not met (1.7)	Provider Data	Fully met (2.8)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Fully met (2.8)

Key Findings and Areas for Improvement

Finding #1: Data-flow diagrams and documentation

CHA uses multiple data repositories to house claims and encounter data received from multiple partners. CHA sends eligibility data to Advantage Dental and Capitol Dental Care. The CCO uses multiple software packages in processing, authorizing, reporting and submitting claims/encounters to OHA. In the ISCA interview, CHA described sending all claims and encounter data to OHA, but the data-flow diagram CHA submitted did not confirm that process.

Finding #2: Monitoring

CHA lacked a formal process to monitor IT activities of its delegates or partners. Relationships between the IT and business sides of CHA were unclear; roles and responsibilities were not clearly defined for different monitoring activities. CHA has begun to determine how to monitor the security policies and practices of partners and delegates, and is evaluating how to conduct a review of a partner/delegate's IT security policies and practices before contracting with the partner/delegate. CHA is exploring how to expand its Admin Audit Tool and Dental Compliance and Delegated Activity Review documents and processes to monitor the IT security policies and practices of partners and delegates.

Finding #3: Business continuity/disaster recovery (BC/DR) plan

CHA has developed a BC/DR plan and continues to refine it. It was unclear whether this plan covers all CCO functions and services. CHA reported that it has not yet developed a testing plan.

Columbia Pacific CCO (CPCCO)

CPCCO, a wholly owned subsidiary of CareOregon, provides physical, behavioral and dental health services for OHP members in Columbia, Clatsop and Tillamook counties. The CCO has a management agreement with CareOregon to provide administrative and risk-associated services. CPCCO delegates behavioral health service delivery to GOBHI, which subcontracts with Tillamook Family Counseling Center, Clatsop Behavioral Healthcare and Columbia Community Mental Health Services. CPCCO contracts for dental services with Moda Health, Capitol Dental Care, Advantage Dental and Willamette Dental Group. CPCCO's utilization management functions are shared among CareOregon, GOBHI and the four dental organizations.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with CPCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 8 and partially resolved 5 of the 13 findings from 2014.
- Of 44 recommendations in 2014, 12 were resolved, 27 were partially resolved and 5 were not resolved.
- The CCO resolved 1 and did not resolve 2 of the 3 findings from 2015.
- Of 29 recommendations in 2015, 8 were resolved, 20 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- **Intervention #1:** Expanded the CCO's pain clinic model into each county served (total of 119 graduates)
- **Intervention #2:** Changing the prescribing patterns of local providers through clinician education and cultivation of a shared vision
- **Intervention #3:** Conducted North Coast Opioid Summit in April 2016. Participants represented regional clinics, local hospitals, drug courts, police departments, school staff and the community.

Barriers:

- Difficulty filling available pain clinic openings; CPCCO is working with private insurers to cover pain clinic services for all members.

Next steps:

- Continue with the pain clinic model, but work on raising community awareness about the service and identifying barriers to member participation.
- Continue developing or implementing the different strategies listed under Intervention #2.
- Evaluate the recent Opioid Summit and make decisions about next steps.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Tobacco cessation
- Timeliness of prenatal care

CCO Focus Area:

- Adverse childhood experiences/trauma informed care

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.0)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Partially met (2.3)
Security	Not met (1.5)	Provider Data	Partially met (2.4)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

CareOregon handles data submission for CPCCO. It was unclear how the data received from partner organizations would be monitored to ensure completeness and accuracy. CareOregon has some processes to check for expected/estimated volume and trends. It was unclear if those processes are used in the certification process. Currently, CareOregon staff sign the certification for the CCO.

Finding #2: CCO monitoring of delegated IT activities

CPCCO did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. During the interview, it was unclear who held the contracts and how many contracts were in place. The CCO provided no evidence of a process to monitor provider agencies' activities related to information systems. It was unclear how this function would be split between CCO staff and the CareOregon delegation team.

CareOregon's delegation team has conducted monitoring of some delegates' IT activities, but did not have a process for monitoring provider agencies. CareOregon reported that it is defining IT monitoring activities.

Finding #3: Lack of business continuity/disaster recovery (BC/DR) plan

CareOregon hired a disaster recovery expert to work on its disaster recovery plan, and had an early draft of the plan. CareOregon planned to continue working on this plan and develop a testing strategy during 2016.

Neither CPCCO nor CareOregon maintained a CCO-level BC/DR plan.

Finding #4: Provider directory

CPCCO has updated its provider directory since the previous review. However, the directory lists only facility-level information for mental health providers and does not provide practitioner details. It is unclear how a member would request non-emergent medical transportation services by using the CCO website.

CPCCO's website includes links to dental partners' websites. It appeared that most sites had practitioner-level details, but not all websites listed genders and languages spoken. Some websites may have had additional details, but links to individual practitioner information may have been broken. This process may be difficult for members to navigate.

Eastern Oregon CCO (EOCCO)

EOCCO provides physical, behavioral and dental health services to OHP members in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler counties. The CCO's daily operations are administered by GOBHI and Moda Health. GOBHI provides mental health services through contracts with providers, most of which are community mental health programs in its service area. Moda Health provides physical health, chemical dependency and vision services. EOCCO provides dental services through contracts with Advantage Dental, ODS Community Health and Capitol Dental Care. GOBHI administers the contract with Mid-Columbia Council of Governments for NEMT services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with EOCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 3 and partially resolved 4 of the 7 findings from 2014.
- Of 27 recommendations in 2014, 15 were resolved, 8 were partially resolved and 4 were not resolved.
- The CCO resolved all 3 findings from 2015.
- Of 16 recommendations in 2015, 4 were resolved, 11 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- **Community education:** The Regional Opioid Prescribing Group (ROPG) will conduct forums in Hermiston, Pendleton, Ontario and John Day, and plans to develop a patient resource library.
- **Community health worker (CHW) activities:** ROPG is developing ways to integrate opioid management into CHW training.
- **Provider education:** Deliver best-practice information and referral resources to help providers intervene with members on high opioid doses. Track buprenorphine rates to demonstrate changing prescribing practices and effectiveness of provider education.

Barriers:

- Changes in data analytics staffing; EOCCO is working with pharmacy to resolve the gap.
- Providers lack information and resources needed to manage chronic opioid users. EOCCO, through the ROPG, is developing interventions to address this barrier.

Next steps:

- Promote May 2016 pain management conference in Medford to the provider network.
- Distribute materials developed by Grande Ronde Regional and Baker City Saint Alphonsus clinics.
- Develop a list of regional pain schools and non-pharmacologic resource materials for providers.
- Recruit a non-physician behaviorist and a physical therapist representative to the ROPG.
- Provide education about buprenorphine to providers.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increase adolescent well visits
- Improve maternity and child health outcomes

CCO Focus Area:

- Increase rates of development screening for children 0–6 years old

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.5)	Enrollment Systems	Fully met (2.7)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.9)
Security	Partially met (2.1)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Business continuity/disaster recovery (BC/DR) plan

Moda Health has done some BC/DR planning but is reworking its activities. Testing was planned for summer 2016. There appears to be limited planning for loss of the key data center, but there are offsite data replicas. It was unclear if any BC/DR planning has occurred that includes the CCO partners or all CCO services.

GOBHI has a contingency policy in place, but it is high-level and focused on IT. GOBHI staff who assisted in testing this policy have a lot of historical knowledge, but the policy lacks sufficient information to enable other personnel without that knowledge to perform recovery tasks. GOBHI conducted a test scenario in August 2015; the plan was not updated after that test.

It was unclear how data flows through GOBHI's information systems and in what order information systems need to be restored in the event of a disaster to facilitate recovery of business operations.

GOBHI has many outsourced or cloud-based solutions. GOBHI's recovery strategy may need to document contact information and items needed to use those services.

Finding #2: Monitoring

GOBHI and Moda Health are developing a process for monitoring contracted and partner organizations' policies, procedures and practices related to information systems. GOBHI expected to implement monitoring by summer 2016. At the time of the review, GOBHI was hiring a person to work with contracted or partner organizations on compliance with contract requirements and security best practices.

Finding #3: Provider payment and updates process

GOBHI staff perform credentialing decisions for new provider contracts, and inform PH Tech of necessary updates and contracting rates. GOBHI has instructed PH Tech to track payment based on the facility's contracted rates. It was unclear if PH Tech could pay for an encounter conducted by a practitioner who has not completed GOBHI's credentialing process.

FamilyCare CCO

FamilyCare, Inc., a 501(c)(4) public benefit corporation, contracts with OHA to provide physical, behavioral and dental health services to OHP members in Multnomah, Clackamas, Washington and Marion counties. FamilyCare contracts with eight dental plans. FamilyCare contracts with CVS Caremark as its pharmacy benefit manager and with Access2Care for NEMT.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with FamilyCare regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 5 of the 12 findings from 2014.
- Of 11 recommendations in 2014, 5 were resolved, 5 were partially resolved and 1 was not resolved.
- The CCO resolved all 3 findings from 2015.
- Of 11 recommendations in 2015, 1 was resolved and 10 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Provider outreach: Initiated educational program with dental prescribers.
- Comprehensive/alternative pain services
- Provider education
- Conducted on-site visits to top prescribing clinics by medical directors
- Existing interventions: Continued to implement prior authorization and quantity limits policies and procedures
- Internal data development

Barriers:

- Mailing had been planned to begin earlier but was delayed by timing of internal staff education. Training has now been completed.
- Data needed to facilitate pilot programs were incomplete. FamilyCare is building dashboards to support data requests.
- On-site visits are time-consuming to plan, implement and follow up.
- Staffing changes in provider services create a barrier to on-site visits.
- Difficult to achieve clinic-oriented outreach when many providers are non-contracted and there is no clinic affiliation information.

Next steps:

- Begin mailing notifications to top prescribers. Continue providing reports to clinics, adapting elements of the reports to meet individual clinic needs. Increase the number of clinics to receive reports.
- Try to recruit a community provider to participate in a Project ECHO-like program.
- Analyze acute prescribing of high-dose opioids, focusing on urgent care, emergency department and post-surgical prescribing. Initial data suggest that acute prescribing might be more problematic for the CCO.
- Opioid workgroup will develop a program for alternative treatments for chronic pain management.
- Conduct data analyses of metric and interventions to determine effectiveness.
- Implement MED-based coding by 4th quarter 2016.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increasing colorectal cancer screening
- Increasing adolescent well-child visits

CCO Focus Area:

- Improving chronic conditions in the serious and persistent mentally ill population

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.8)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (2.8)
Security	Partially met (2.3)	Provider Data	Fully met (2.7)
Administrative Data	Partially met (2.4)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: CCO monitoring of delegated IT activities

FamilyCare reported that it does not conduct monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. FamilyCare has developed a Provider Office Site Review Checklist that includes reviewing the IT systems and policies and procedures used by a provider or other type of partner organization. The CCO submitted the new checklist for review after the ISCA interview.

FamilyCare plans to phase the new checklist into operations during regularly scheduled site visits to provider offices in late 2016 and 2017.

Finding #2 : Encounter data certification

PH Tech handles data submission for FamilyCare. PH Tech submits a copy of the CIM database, provider master database and various tables once a month. It was unclear if FamilyCare receives copies of the 837 files that PH Tech submits to OHA. FamilyCare is developing additional reports and processes to augment the current certification process used by the Claims Department assistant manager to sign the encounter data certification for the CCO.

Greater Oregon Behavioral Health, Inc. (GOBHI)

GOBHI, a managed mental health organization (MHO), manages the OHP mental health benefit in 22 rural Oregon counties and provides services through local community mental health programs. GOBHI's governing board includes county commissioners of Columbia, Umatilla and Union counties, provider network representatives and consumers. Most MHO activities are delegated to the county mental health authorities, which receive a capitation payment to deliver services for enrollees.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with GOBHI regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews. GOBHI had made progress in addressing many findings that were carried over from 2012, though several findings remained unresolved or only partially resolved. More work is needed to bring GOBHI into full compliance with its MHO contract and federal Medicaid regulations in the following areas:

- Delivery network
- Policies and procedures
- Tracking of second opinions, seclusion and restraint and access to interpretation and materials in alternative formats and languages
- Oversight of delegated activities
- Oversight of quality management program
- Practice guidelines
- Management data specific to MHO enrollees

Performance Improvement Projects (PIPs)

As of the 2016 review, GOBHI had not developed either PIP beyond identifying and justifying the study topic (Standard 1 of the review protocol). By the time of the 2017 review, GOBHI is expected to have completed Standards 2–5 (study design) and 8 (improvement strategies) and to have supplied partial information for Standards 6 (study results) and 7 (interpretation of results).

Older Adult PIP (score = 14 out of 85, Not met)

GOBHI's data review indicated underutilization of mental health services by adults over age 60. The MHO decided to focus this PIP on improving the service penetration rate for older adults. GOBHI stated that its first step would be to identify the causes of low referrals and utilization. This topic clearly relates to quality of care for MHO enrollees since the target population does not appear to be receiving needed services. HealthInsight Oregon reviewed GOBHI's documentation and assigned a score of 85 (Substantially met) for Standard 1.

Children 0–6 Years Old Primary Care PIP (score = 17 out of 85, Not met)

GOBHI's data review indicated underutilization of services by young Hispanic children (0–6 years of age). This PIP will focus on improving the service penetration rate for young Hispanic children in Umatilla and Malheur counties, the counties with the highest percentage of GOBHI's target population. GOBHI documented the importance of the topic, its relevance to the local population and the topic prioritization process. The MHO identified a possible root cause for lower access by this population and briefly described its selected intervention. HealthInsight Oregon assigned a score of 100 (Fully met) for Standard 1.

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.2)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (2.6)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.7)
Security	Not met (1.9)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.1)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

PH Tech handles data submission for GOBHI, sending reports to GOBHI of what the providers submit. GOBHI is using these reports in a specialized cleanup process and is trying to determine how to use these data and reports on an ongoing basis. GOBHI is working to evolve its processes to ensure data completeness and accuracy.

GOBHI signs the attestation that data are accurate based on PH Tech's data submission to OHA. GOBHI is working with PH Tech and providers on processes to ensure the completeness and timeliness of the data.

Finding #2: Monitoring

GOBHI is developing a process for monitoring contracted and partner organizations' policies, procedures and practices related to information systems. GOBHI expected to implement monitoring by summer 2016. At the time of the review, GOBHI was hiring a person to work with contracted or partner organizations on compliance with contract requirements and security best practices.

Finding #3: Provider payment and updates process

GOBHI staff perform credentialing decisions for new provider contracts that are added. Staff members inform PH Tech of necessary updates and contracting rates. GOBHI has instructed PH Tech to track payment based on the facility's contracted rates.

It was unclear if PH Tech could pay for an encounter with a practitioner who has not completed the GOBHI credentialing process. It was unclear if this process would need to change in March 2016 when NPI numbers for the rendering practitioner must be used. It was unclear how additional practitioners would be added to the provider directory.

Health Share of Oregon

Health Share contracts with OHA to provide physical, behavioral and dental health services to OHP members in Multnomah, Washington and Clackamas counties. The CCO contracts with 16 risk-accepting entities (RAEs). Activities delegated to RAEs include network planning, monitoring and maintaining access, credentialing, care coordination/case management, pharmacy benefit management, claims payment, customer service and utilization management. The CCO has workgroups and committees charged with fully integrating behavioral and physical health and dental services. The CCO retains adjudication of final appeals and oversight of QI activities.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with Health Share regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved all 4 findings from 2014.
- The CCO resolved all 20 recommendations from 2014.
- No findings arose from Health Share's 2015 compliance review.
- Of 12 recommendations in 2015, 10 were resolved and 2 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Patient education and engagement—distribute materials to members about the new opioid prescribing policy and need for tapering plans
- Provider education and engagement (e.g., learning collaborative, pain conference, continuing medical education)
- Expand access to effective alternatives (e.g., acupuncture, physical therapy, aqua therapy)
- Implement new opioid prescribing limits
- Increase actionable data
- Increase leadership priority and buy-in

Barriers:

- Kaiser Permanente (KP) nurses lacked tools or knowledge to hold difficult conversations with members. The nurses are receiving appropriate training.
- KP members have filed complaints about changes to the opioid prescribing guidelines.
- Challenging to develop a process of working with high opioid-prescribing providers and clinics that is sustainable and not punitive.
- Tuality Health Alliance (THA) is not receiving accurate pharmacy data.

Next steps:

- Health plan partners will continue existing interventions.
- One of Kaiser's clinics will test a review board model for new opioid starts.
- Providence Health Plan will reevaluate its Pathways to Treat provider tool, develop a regional case review process and reschedule the pain symposium.
- THA will meet face to face with providers about back pain coverage and opioid prescribing practices.
- Health Share will develop a dashboard to provide to each of its RAEs on a monthly basis.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving maternal and infant outcomes using a new model of care (Project Nurture)
- Designing and implementing foster care medical home models of care

CCO Focus Area:

- Improving rate of effective contraception use

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (3.0)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (2.8)	Vendor Data Integration	Partially met with a finding (2.6)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Fully met (3.0)
Security	Not met (1.8)	Provider Data	Partially met with a finding (2.8)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Business continuity/disaster recovery (BC/DR) plan

Health Share is developing a CCO-level BC/DR plan; CCO management was reviewing a draft plan at the time of the ISCA interview. CCO management expects to continue to define critical functions, systems and resources that need to be maintained in the event of a disaster.

Health Share reported that it has developed a plan for supporting the phone systems and network infrastructure during a disaster. The CCO is evaluating how the use of virtual workstations could facilitate disaster recovery and business continuity plans.

Finding #2: Monitoring of business partners and PH Tech

Health Share did not provide evidence of monitoring and oversight of PH Tech for processing of claims and encounter data.

Several of Health Share's business partners contract with PH Tech to process claims and encounter data. PH Tech submits claims and encounter data to Health Share on behalf of those business partners. It was unclear if Health Share would be able to ensure the completeness and accuracy of business partners' data submitted to the CCO by PH Tech based on the current level of monitoring.

InterCommunity Health Network (IHN)

IHN, a wholly owned subsidiary of Samaritan Health Services, contracts with OHA to provide physical, behavioral and dental health services for OHP members in Benton, Lincoln and Linn counties. IHN is managed by Samaritan Health Plan Operations (SHPO), and all CCO staff members are SHPO employees. IHN contracts with the three counties for behavioral health services, and with Advantage Dental, Capitol Dental Care, ODS Community Health and Willamette Dental Group to provide dental care for members.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with IHN regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 3 and partially resolved 4 of the 7 findings from 2014.
- Of 29 recommendations in 2014, 11 were resolved, 10 were partially resolved and 8 were not resolved.
- The CCO resolved 2 and partially resolved 2 of the 4 findings from 2015.
- Of 29 recommendations in 2015, 13 were resolved, 15 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Conduct general public and provider education
  - 16 urgent care providers received education from IHN's chief medical officer (CMO)
  - 57 providers were educated through the regional task force
  - 8 providers on Pharmacy and Therapeutics Committee received education
  - 151 providers attended the continuing medical education offering
  - 20 leaders attended training in managing chronic conditions
  - 70 members received direct education through a class led by the CMO
- Implement prescription opioid limits
  - 87 providers and 964 members were sent letters about the new policy

Barriers:

- None

Next steps:

- Continue current interventions.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospitalizations
- Deploying care teams to reduce emergency department utilization

CCO Focus Area:

- Improving the oral health of pregnant women

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.8)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met (2.4)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.0)
Security	Not met (1.8)	Provider Data	Partially met (2.4)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Lack of business continuity/disaster recovery (BC/DR) plan

IHN did not maintain a CCO-level BC/DR plan, though IHN's parent organization has a draft plan. IHN has a pilot project underway to develop a CCO-level plan based on the parent organization's plan. IHN planned to continue working on this plan and developing a testing strategy during 2016.

Finding #2: Historical gaps in mental health data

In September 2013, IHN began receiving mental health encounters directly from providers and county mental health facilities. The CCO no longer contracts with PH Tech to administer mental health data. Mental health claims and encounters from the first three to four months of CCO operations were not migrated into IHN's Facets system due to data integrity issues. At the time of the ISCA review, these data were not in a database and not available for reporting.

Jackson Care Connect (JCC)

JCC, a wholly owned subsidiary of CareOregon, contracts with OHA to provide physical, behavioral and dental health services for OHP members in Jackson County. JCC has an agreement with Jackson County Health and Human Services (JCHHS) to provide mental health services, and CareOregon provides physical health services. CareOregon performs many administrative and operational activities on the CCO's behalf. JCC delegates dental service delivery to Willamette Dental Group, Capitol Dental Care, Moda Health and Advantage Dental; and NEMT services to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with JCC regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 5, partially resolved 5 and did not resolve 5 of the 15 findings from 2014.
- Of 45 recommendations in 2014, 12 were resolved, 16 were partially resolved and 17 were not resolved.
- The CCO resolved 1, partially resolved 2 and did not resolve 1 of the 4 findings from 2015.
- Of 25 recommendations in 2015, 11 were resolved, 12 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- JCC-specific interventions
  - Use claims data to identify subgroups of opiate users and refine outreach to providers based on users' primary characteristics
  - Communicate to providers about lowering the medication limit; offer technical assistance by behavioral health and CCO medical director
- Joint interventions with regional collaborative: With other southern Oregon CCOs, develop joint strategies around community education, provider education, pain management modalities and medication-assisted treatment

Barriers:

- Inconsistencies between internal and OHA study metric data make it difficult to identify and understand the study population.
- Large number of pain specialists in the area is a disincentive for primary care providers to manage their own patients. Treatment of chronic pain by a specialist increases the fragmentation of patient care.
- Collaboration among CCOs has been difficult due to lack of time, physical distance between organizations, different operating structures.

Next steps:

- Continue to distribute quarterly reports on high opioid users to providers.
- JCC's behavioral health team, pharmacist and medical director will continue to reach out to providers and clinics with the most patients on a quarterly basis.
- JCC's pharmacist will begin to incorporate additional actionable data (patient lists) as they are received. Pharmacist will begin retrospective review of members previously identified as achieving MED goal, and will begin to provide tapering technical assistance to providers.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving prenatal and perinatal care
- Adolescent well care and behavioral health integration

CCO Focus Area:

- Focus on high utilizers

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.1)	Enrollment Systems	Partially met (2.4)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Partially met (2.4)
Security	Not met (1.6)	Provider Data	Partially met (2.4)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

CareOregon handles data submission for JCC. It was unclear how JCC would monitor data received from partner organizations to ensure completeness and accuracy. CareOregon has some processes to check for expected/ estimated volume and trends, but it was unclear if those processes are used in certification. Currently, CareOregon staff sign the certification for the CCO. The CCO is transitioning this function to CCO staff.

Finding #2: Monitoring

JCC did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. The 2015 Jackson County Utilization Management Team (JC-UMT) delegation oversight review included a health information system corrective action plan that has been completed. During the ISCA interview, it was unclear who held the contracts and how many contracts were in place. It was unclear how monitoring would be divided between CCO staff and the CareOregon team. CareOregon's delegation oversight unit conducted a review of JC-UMT but was in the process of adding organizations and IT monitoring.

Finding #3: Lack of business continuity/disaster recovery (BC/DR) plan

JCC did not maintain a CCO-level BC/DR plan. CareOregon hired a disaster recovery expert to work on its disaster recovery plan. CareOregon planned to continue working on this plan and developing a testing strategy in 2016.

Finding #4: JC-UMT enrollment checks

JC-UMT relies on providers to check eligibility before delivering services. JC-UMT checks eligibility at the time of authorization but not at the time of the claims payment. The JC-UMT profiler system does not have access to 834 enrollment data. There may be post-payment mechanisms that could reconcile some of these payments.

Finding #5: Provider directory

JCC has updated its provider directory since the previous review. JCC has a directory of physical health providers, but not of mental health or dental practitioners in Jackson County. It was unclear how a member might find mental health provider-level detail. Also, some views of the physical provider directory do not display gender or specialty, but those items are searchable.

JCC's provider directory shows dental agencies without practitioner-level information or DCO assignment information. The portal may confuse members because they can obtain practitioner-level information from the website, but then they must follow a link located in a separate area of the website for each contracted DCO.

PacificSource Central Oregon (PSCS-CO)

PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CO and PSCS-Columbia Gorge. PSCS-CO serves OHP members in Deschutes, Jefferson and Crook counties. Each CCO has its own governing council with oversight from a subsidiary board of directors. PacificSource contracts with Deschutes County Health Services for mental health services and substance use disorders; with Caremark for pharmacy benefit management; and with Advantage Dental, Capitol Dental Care, Willamette Dental Group and Moda Health for dental services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with PSCS-CO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO partially resolved both of the 2 findings from 2014.
- Of 20 recommendations in 2014, 14 were resolved, 5 were partially resolved and 1 was not resolved.
- The CCO partially resolved all 4 findings from 2015.
- Of 22 recommendations in 2015, 9 were resolved, 11 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Promote safer prescribing practices
  - Limit opioid dosing threshold to <120 mg MED
  - Reduce co-prescribing of opioids and benzodiazepines
- Increase prescription drug monitoring program (PDMP) enrollment and usage
  - Continue to implement pharmacy prior authorization process that requires attestation of PDMP enrollment

Barriers:

- Definition of target population is delayed as the issue of whether or not to include members on buprenorphine has not been decided.
- Creation of mailing processes has taken longer than expected due to multiple pre-approval processes and the need to create processes to accommodate new technology.
- Need to coordinate efforts of multiple entities around the PDMP to avoid burdening providers with multiple requests for their time.

Next steps:

- Finalize data analysis process and begin distributing accurate lists of members on ≥120 mg MED, regenerating old reports if revisions are necessary.
- Develop process to identify members who are co-prescribed opiates and benzodiazepines; provide lists of these members to providers on a monthly basis.
- Conduct PDMP training in May 2016.
- If Deschutes County receives grant to improve PDMP usage, work collaboratively with grant project staff.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving post-partum care
- Integrating chronic pain management into primary care

CCO Focus Area:

- Increasing preventive care to members with serious and persistent mental illness

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.4)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.4)
Security	Partially met (2.0)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

PH Tech is submitting final data directly to OHA, and PSCS-CO is not receiving a copy of the submitted data. The CCO stated it continues to monitor trends related to the encounter and claims data and is developing additional reports to more completely reflect all CCO services. After the PH Tech transition, PSCS-CO worked to determine what additional reports were needed to monitor the data submission process. These new and existing reports are being used to support the CCO's attestation process.

PacificSource Columbia Gorge (PSCS-CG)

PacificSource Community Solutions, based in Bend, is the Medicaid line of business for PacificSource Health Plans, serving CCO members through PSCS-CG and PSCS-Central Oregon. PSCS-CG serves OHP members in Hood River and Wasco counties. Each CCO has its own governing council with oversight from a subsidiary board of directors. PacificSource contracts with contracts with Mid-Columbia Center for Living for mental health services and substance use disorders; with Caremark for pharmacy benefit management; and with Advantage Dental, Capitol Dental Care, and Moda Health for dental services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with PSCS-CG regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO partially resolved both of the 2 findings from 2014.
- Of 21 recommendations in 2014, 14 were resolved, 6 were partially resolved and 1 was not resolved.
- The CCO resolved all 4 findings from 2015.
- Of 18 recommendations in 2015, 8 were resolved, 9 were partially resolved and 1 was not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Charter a Pain and Opioid Treatment Work Group to advise the CCO's Clinical Advisory Panel and disseminate recommendations to providers and members
- Promote safer prescribing practices
  - Adherence to a ≥ 120mg MED opiate limit
  - Avoidance of polypharmacy
- Increase prescription drug monitoring program (PDMP) enrollment and usage
  - CCO is developing a PDMP training

Barriers:

- Barriers to a successful community strategy:
  - Limited access to Suboxone prescribers
  - Limited treatment options for chronic pain members with "below the line" diagnoses
  - Competing demands and priorities for PCPs affects participation in workgroup
  - Strong member resistance to decreasing opioid limits
  - Providers lack experience with difficult patient conversations

Next steps:

- Pain and Opioid Treatment Work Group will meet monthly and develop interventions in accordance with their charter, including PDMP education and assistance to providers.
- Develop process to identify members who are co-prescribed opiates and benzodiazepines; provide lists of these members to providers on a monthly basis.
- Conduct PDMP training in May 2016.
- Continue to refine data analysis process.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Improving postpartum care
- Integrating chronic pain management into primary care

CCO Focus Area:

- Increasing preventive care to members with serious and persistent mental illness

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially Met (2.4)	Enrollment Systems	Partially met (2.5)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.4)
Security	Partially met (2.0)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Partially met (2.4)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

PH Tech is submitting final data directly to OHA, and PSCS-CG is not receiving a copy of the data. The CCO stated that it continues to monitor trends related to encounter and claims data and is developing additional reports to more completely reflect all CCO services. After the PH Tech transition, PSCS-CG worked to determine which additional reports were needed to monitor the data submission process. These new and existing reports are being used to support the CCO's attestation process.

PrimaryHealth of Josephine County (PHJC)

PHJC, owned by Oregon Health Management Services (OHMS), provides physical, behavioral and dental health services for OHP members in Josephine County. OHMS sub-delegates mental health service delivery to Options for Southern Oregon; dental services to Capitol Dental Care, Advantage Dental, Willamette Dental Group, and Moda Health; and NEMT to TransLink.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with PHJC regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 5, partially resolved 4 and did not resolve 1 of the 10 findings from 2014.
- Of 18 recommendations in 2014, 7 were resolved, 10 were partially resolved and 1 was not resolved.
- The CCO resolved 5 and partially resolved 2 of the 7 findings from 2015.
- Of 22 recommendations in 2015, 18 were resolved, 4 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Community education
- Support and assist providers in reducing prescription opioids
- Pain management modalities
  - CCO helped sponsor chronic pain group classes in Josephine County.
- Medication-Assisted Treatment (MAT)
  - CCO is working with Choices Counseling Center to open a MAT clinic.

Barriers:

- New limits might be a challenge and burden to PCPs that serve chronic pain patients
- Lack of alignment among CCOs regarding chronic pain management
- Previous pain resiliency pilot program lost funding due to low patient participation, low provider engagement and poor coordination with other resources
- Very few providers of buprenorphine in Josephine County

Next steps:

- Develop an educational video, culturally and linguistically appropriate member education materials and other messaging (social media, public service announcements, etc.).
- Develop small toolkit (including tapering agreement, schedule, letters and materials) primarily focused on benefit changes. Collaborate with drug detail representative to spread the policy message.
- Develop community-based meetings to discuss benefit changes and distribute toolkits.
- After review and analyses, recommend a model of care to inform Center of Excellence development.
- Collect data and information on the Josephine County pain classes and share with the larger group.
- Open MAT clinic in Grants Pass.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Design and implement a local medical maternal health home
- Reduce emergency department utilization by moderate utilizers

CCO Focus Area:

- Implement Mental Health First Aid in the community

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.9)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (3.0)	Vendor Data Integration	Partially met with a finding (2.6)
Hardware Systems	Fully met (2.6)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met with a finding (2.6)	Provider Data	Fully met (2.9)
Administrative Data	Partially met (2.4)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Lack of integrated business continuity/disaster recovery (BC/DR) plan

PHJC developed a draft BC/DR plan and continues to refine it. PHJC is updating the plan to support virtualization of production servers. It was unclear whether this plan covers all CCO functions and services. PHJC has scheduled plan testing for 2017.

Finding #2: Informal process for monitoring data flow to ensure submission of all data

PHJC uses an informal process to monitor encounter trends for CCO services. The CCO should devote attention to capitated services due to the lack of incentive for an agency or partner organization to supply encounter data for these services. Monitoring for over- or underutilization of anticipated services will allow the CCO to address any issues early and minimize potential negative impacts on actuarial rates and performance measure calculations.

Finding #3: Monitoring IT policies and procedures of providers and other partner organizations

Intelligenz, on behalf of PHJC, has contracted with Amazon Web Services and PeHS for key production IT services and functions. Intelligenz submitted some IT policies and procedures, but it was unclear whether Intelligenz has developed or expanded its current policies, procedures and practices sufficiently to cover these new IT services and functions.

PHJC has developed a process for monitoring contracted and partner organizations' policies and procedures related to information systems. The CCO expected this monitoring process to be in full use sometime in 2017.

Finding #4: NEMT data not being submitted to OHA

As of the interview date, PHJC had not successfully submitted NEMT claims and encounter data to the state. PHJC is working with TransLink, its NEMT service provider, to resolve issues with submission of the 837 data.

Trillium Community Health Plan (TCHP)

TCHP, a wholly owned subsidiary of Centene Corp., contracts with OHA to provide physical, behavioral and dental health services for OHP members in Lane County and portions of other counties. Trillium Behavioral Health (TBH) provides behavioral health services for TCHP members. TCHP delegates to TBH the responsibility to establish and maintain the provider network needed to support behavioral services, utilization management, credentialing for behavioral health services and care coordination. TCHP provides dental services through contracts with Willamette Dental Group, Advantage Dental, Capitol Dental Care and Moda Health. NEMT services are delegated to RideSource.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with TCHP regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 3, partially resolved 1 and did not resolve 1 of the 5 findings from 2014.
- Of 25 recommendations in 2014, 10 were resolved, 10 were partially resolved and 5 were not resolved.
- The CCO partially resolved 1 and did not resolve 2 of the 3 findings from 2015.
- Of 18 recommendations in 2015, 5 were resolved, 7 were partially resolved and 6 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Clinical Advisory Panel adopted the Centers for Disease Control and Prevention (CDC) guidelines on opioid prescribing.
- Disseminate CDC guidelines to providers on laminated reference sheets.
- Conduct Living Well with Chronic Pain classes.

Barriers:

- Lack of staff delayed implementation of interventions.

Next steps:

- Once staff is hired and trained, implement interventions to offer and increase access to physical therapy or acupuncture and to behavioral health for managing chronic pain.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospital readmissions
- Improving depression screening

CCO Focus Area:

- Decreasing tobacco use during pregnancy

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (3.0)	Enrollment Systems	Fully met (3.0)
Staffing	Fully met (2.8)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (2.8)	Report Production/PM Reports	Fully met (2.9)
Security	Not met (1.9)	Provider Data	Fully met (2.8)
Administrative Data	Not met (1.6)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Business continuity/disaster recovery (BC/DR) plan

TCHP's BC/DR plan was being updated at the time of the ISCA review. Centene, the parent organization, has a BC/DR plan for its enterprise data center. TCHP plans to continue working on this plan and developing a testing strategy during 2016. TCHP submitted additional documentation detailing plans for updating the BC/DR plan and the expectation of testing the updated plan in the second quarter of 2017.

Finding #2: Monitoring

Centene is developing a new vendor oversight program that TCHP expects to use for monitoring and oversight of contracted and partner organizations' IT and security practices, procedures and policies. Centene is evaluating who will be the business owner for this process. It was unclear how TCHP will implement this program and communicate it to providers and other partner organizations.

Finding #3: Attestation process

It was unclear how TCHP monitors the submission of claims and encounter data by provider agencies. TCHP was not sure how the CCO and/or Centene would know if the volume of claims being submitted by providers was within expected norms. The onsite interview revealed that the TCHP staff member tasked with monitoring of data submission trends was unaware that NEMT claims and encounters had not been successfully submitted to OHA in several months.

Finding #4: NEMT data not monitored or submitted to OHA

TCHP contracts with RideSource (Lane Transit District) to provide NEMT services. TCHP reported that as of mid-September 2016, NEMT claims and encounter data had not been successfully submitted to OHA since the CCO's IT operations were migrated to Centene's corporate data center in June. Centene and TCHP were attempting to resolve these issues, resume regular submission of NEMT claims and encounter data to OHA and ensure that the backlogged claims are processed and submitted.

TCHP has not yet determined a strategy to monitor NEMT data for completeness. The ride vendor is responsible for ensuring that the transportation request has an associated appointment. The CCO needs to determine appropriate monitoring activities to ensure that transportation services have a corresponding encounter (e.g., a physician office visit).

Umpqua Health Alliance (UHA)

Douglas County Independent Practice Association *dba* UHA is the CCO for Douglas County. UHA contracts with Community Health Alliance (CHA) to provide mental health outpatient services; with ADAPT to provide substance use disorder treatment; with GOBHI to manage access to inpatient psychiatric services; with MedInsight for pharmacy benefits management; and with Advantage Dental and Willamette Dental Group for dental services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with UHA regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 5, partially resolved 5 and did not resolve 3 of the 13 findings from 2014.
- Of 35 recommendations in 2014, 9 were resolved, 6 were partially resolved and 20 were not resolved.
- The CCO partially resolved 3 and did not resolve 2 of the 5 findings from 2015.
- Of 26 recommendations in 2015, 2 were resolved, 11 were partially resolved and 13 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Monitoring of opioid policy, guidelines and adherence by CCO's Pain Committee
- Ongoing implementation of the prior authorization process
- Ongoing implementation of new opioid medication guidelines
- Ongoing provision of education and CME
- Ongoing case reviews conducted as needed
- Ongoing support for providers and clinics that have large drug-seeking patient populations

Barriers:

- Provider compliance with opioid policy guidelines: The Pain Committee chair and CCO pharmacist meet with individual providers who are "reticent to change."

Next steps:

- Continue existing interventions

CCO-Specific Project Topics

CCO-Specific PIPs:

- Identification of addiction issues in pregnancy
- Decreasing utilization of the emergency department

CCO Focus Area:

- Increasing PCPCH enrollment

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met with a finding (2.7)	Enrollment Systems	Partially met (2.4)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met with a finding (2.6)
Security	Partially met (2.1)	Provider Data	Fully met (2.9)
Administrative Data	Partially met (2.5)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Attestation sign-off

UHA receives reports of the claims and encounter data that ABCT submits to OHA. UHA performs attestation based on those reports. It was unclear who would monitor data received from partner organizations to ensure data completeness and accuracy.

Finding #2: Disaster recovery planning

UHA has developed a business continuity/disaster recovery plan and continues to refine it. It was unclear whether this plan covers all CCO functions and services. UHA reported that it had not yet developed a testing plan.

Finding #3: Provider monitoring

No documentation was submitted showing that the delegate was monitoring providers. The CCO performs only limited monitoring of GOBHI's IT functions. The CCO lacked a formal process to monitor IT activities of its delegates or partners. Relationships between the IT and business sides of the CCO were unclear; roles and responsibilities were not clearly defined for different monitoring activities.

Finding #4: Provider is not verifying enrollment at time of service

One provider agency stated that it checks eligibility only when billing for the claim/encounter.

Finding #5: Enrollment data components received from OHA "unloadable" in Plexis CM

The daily 834 file received from OHA contained components that were unloadable into the Plexis CM system. It was unclear what UHA and ABCT were doing to resolve this situation.

Finding #6: Reconciliation issues due to full capitation payment not being received by CHA

CHA reported problems reconciling capitation payment for UHA members assigned to CHA. CHA reported that it receives a capitation payment without information on which member services the payment covers. UHA reduces CHA's capitation payment when a CHA-assigned member receives care from a non-CHA provider.

Western Oregon Advanced Health (WOAH)

Based in Coos Bay, WOAH provides physical, behavioral and dental health services to OHP members in Coos and Curry counties. Behavioral health services are delegated to Coos Health and Wellness, Curry Community Health and ADAPT. Advantage Dental is delegated to provide dental services, manage the dental network, conduct utilization review and provide training, credentialing and oversight of dental care providers. WOAH contracts with TransLink to provide NEMT services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with WOAH regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 2 of the 9 findings from 2014.
- Of 34 recommendations in 2014, 26 were resolved, 5 were partially resolved and 3 were not resolved.
- The CCO resolved 3 and partially resolved 1 of the 4 findings from 2015.
- Of 18 recommendations in 2015, 9 were resolved and 9 were partially resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Participated in a Heroin Town Hall organized by law enforcement in May 2016.
- Supporting the opening of an Opioid Treatment Program (OTP) in 2017; supporting the local Federally Qualified Health Center in developing its own office-based OTP.
- Working with Lines for Life to present an Opioid Summit in fall 2016.
- Facilitated regular meetings of a Community Opioid Guidance Group to promote communication and coordination among community partners and providers.
- Supported North Bend Medical Center (NBMC) to conduct quarterly education programs for providers in Coos and Curry counties.

Barriers:

- Provider resistance: Some providers feel the CDC opioid guidelines are not appropriate; others do not want to change treatment that appears to be “working” for their patients.
- Lack of prescribing providers: Patients report difficulty in finding providers willing to treat people on chronic opioids.
- Delay in receiving member-specific data has delayed member and provider outreach.
- Medication-Assisted Treatment access: The OTP will not be functional until early 2017.

Next steps:

- Continue to support NBMC quarterly education events.
- Begin planned regional collaborative interventions in October 2016.
- Conduct an Opioid Summit in fall 2016.
- Conduct a care manager conference to train care managers in motivational interviewing techniques and difficult conversation skills.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Reducing preventable hospital readmissions
- Reducing co-prescribing of benzodiazepines and opioids

CCO Focus Area:

- One Key Question implementation

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.7)	Enrollment Systems	Fully met (2.8)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Partially met (2.4)	Report Production/PM Reports	Fully met (2.7)
Security	Partially met (2.1)	Provider Data	Partially met with a finding (2.8)
Administrative Data	Not met (1.9)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Remote access

DOCS employees have remote user access when sharing hardware, saving data to local storage devices and remote printing. WOAH employees do not often handle protected health information (PHI) and other confidential data while working. Remote access that allows local printing and/or saving data to local storage increases the potential and associated risk of a breach of either PHI or confidential company data by allowing these data to be printed on devices that are not properly secured.

Finding #2: Lack of current policies and procedures

WOAH is developing a strategy to work with delegates and partners to create, maintain and update policies. The CCO will determine if some policies can be CCO-level and may not need to be duplicated by partners. WOAH has some policies in draft format, and delegates have some draft policies and policies in need of updates. WOAH plans to purchase, install and implement policy tracking software to better enable the CCO to maintain policies.

Finding #3: CCO monitoring of delegated IT activities

WOAH did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. Also, WOAH provided no evidence of processes to monitor provider agencies' activities related to information systems.

Finding #4: NEMT monitoring and data submission to OHA

As of the ISCA interview, NEMT encounter data had not yet been submitted to state. WOAH later reported that all backlogged NEMT encounter data were submitted to the state as required.

WOAH has not yet determined policies and procedures for monitoring NEMT data. The ride vendor is responsible for monitoring that the transportation request has an associated appointment. The CCO needs to determine monitoring practices and/or reports to ensure that transportation services have a corresponding service that has been delivered (e.g., a physician office visit).

Finding #5: Provider directory

WOAH has contracted with a new vendor to redesign and support its website. Members can now search on multiple provider attributes, but cannot search for specific types of behavioral health providers. Members are redirected to the dental provider network (DPN) websites for dental provider information, but members cannot search for specific types of dental health providers on the DPN websites. WOAH uses informal processes for adding providers to or removing providers from the provider directory.

Willamette Valley Community Health (WVCH)

WVCH contracts with OHA to provide physical, behavioral and dental health services for OHP members in Marion and Polk counties. WVCH delegates many day-to-day operational activities to Willamette Valley Provider Health Authority, such as utilization and medical management, care management, disease management and credentialing. WVCH delegates behavioral health service delivery to Mid-Valley Behavioral Care Network; customer service, claims processing and information systems to PH Tech; dental services to Moda Health, Capitol Dental Care, Advantage Dental and Willamette Dental Group; pharmacy services to MedImpact; and NEMT services to the Salem-Keizer Transit District.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with WVCH regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 7 and partially resolved 2 of the 9 findings from 2014.
- Of 32 recommendations in 2014, 19 were resolved, 11 were partially resolved and 2 were not resolved.
- The CCO resolved 2, partially resolved 2 and did not resolve 1 of the 5 findings from 2015.
- Of 27 recommendations in 2015, 15 were resolved, 10 were partially resolved and 2 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Revise the CCO's preauthorization process with new criteria for prescribing opioids at >120 mg MED/day for new non-cancer pain
- Quantity and duration limits/tapering program: members on >120 mg; six-month taper for long-acting opioids, two-month taper for short-acting opioids
- Remove preauthorization criteria for physical and occupational therapy for members tapering off opioids and receiving an evaluation from pain management specialists

Barriers:

- Resistance by some physicians to using a pain contract. WVCH's Pharmacy and Therapeutics Committee will develop strategies to address this barrier.

Next steps:

- Continue the current interventions without changes.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Tobacco cessation and prevention
- Deploying care teams to improve care and reduce preventable or unnecessary utilization by "super users"

CCO Focus Area:

- Increasing the percentage of members assigned to a PCPCH

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Partially met (2.1)	Enrollment Systems	Fully met (2.6)
Staffing	Fully met (3.0)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.2)
Security	Not met (1.4)	Provider Data	Partially met (2.5)
Administrative Data	Partially met (2.2)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Encounter data certification

PH Tech is contracted to submit encounter data on behalf of WVCH. WVCH has increased the contractual expectations of PH Tech's role in this process. WVCH does not appear to be receiving copies of the 837 data submitted on its behalf. It was unclear how WVCH would monitor data received from partner organizations to ensure completeness and accuracy of the data. PH Tech has some processes to check for expected/estimated volume and trends. WVCH staff sign the certification documentation.

Finding #2: Business continuity/disaster recovery plan

WVCH has added to PH Tech's contract that it will participate in a recovery exercise later in 2016 to train all delegates regarding CIM and what to do if CIM is unavailable.

Many of the delegates have plans in draft form. WVCH is working to develop a strategy for the different plans and how they would interact or work together.

Finding #3: CCO monitoring of delegated IT activities

WVCH has begun the delegate monitoring process by understanding and augmenting contracted relationships. As part of this process, WVCH has started holding additional meetings to help communicate issues and work through roles and responsibilities. WVCH is planning to conduct additional oversight and monitoring in the future. WVCH has hired additional staff and is determining strategy and processes.

Finding #4: Provider directory

WVCH has updated its provider directory since the previous review. The CCO's website contains agency-level information for many types of services such as dental or mental health. WVCH has included updated information on how to access transportation services.

Yamhill Community Care Organization (YCCO)

YCCO, located in McMinnville, is a private not-for-profit organization, formerly a subsidiary of CareOregon. The CCO provides physical, dental and behavioral health services for OHP members in Yamhill County and parts of Polk, Marion and Washington counties. YCCO subcontracts with Yamhill County Health and Human Services to manage behavioral health services; with CareOregon to administer physical health services and provide administrative and management support; with Advantage Dental, Capitol Dental Care, and ODS Community Health for dental services; and with First Transit for NEMT services.

Compliance with Regulatory and Contractual Standards

During 2016, HealthInsight Oregon followed up with YCCO regarding steps it had taken to address findings and recommendations of the 2014 and 2015 compliance reviews.

- The CCO resolved 6, partially resolved 4 and did not resolve 2 of the 12 findings from 2014.
- Of 45 recommendations in 2014, 31 were resolved, 9 were partially resolved and 5 were not resolved.
- The CCO resolved 4, partially resolved 5 and did not resolve 2 of the 11 findings from 2015.
- Of 38 recommendations in 2015, 14 were resolved, 14 were partially resolved and 10 were not resolved.

Performance Improvement Projects (PIPs)

Statewide PIP on Opioid Safety

Interventions:

- Share CCO and provider-level trending data on opioid prescribing and ED utilization
- Implement community prescribing guidelines/ provider education on system resources, including prescription drug monitoring program (PDMP) registration, work flow, etc.
- Implement alternative payment model (APM), with add-on payments for practices with no members on >120 mg MED
- Community coordination/education
  - Created a Controlled Substance Quality Oversight Committee to assist providers
  - Community health workers conduct Living Well with Chronic Disease classes

Barriers:

- Little ability to access the PDMP program data. The CCO reached out to providers and asked them to report on their enrollment and use in day-to-day practice.

Next steps:

- Continue site visits and sharing data on chronic users and breakdown of various MED levels.
- Disseminate updated guidelines to providers; analyze data on the adoption of the guidelines.
- Explore how to promote the PDMP among providers not using the tool.
- Continue to evaluate APM strategies on a quarterly basis.

CCO-Specific Project Topics

CCO-Specific PIPs:

- Increase PCPCH enrollment
- Increase/improve adolescent well-care visits

CCO Focus Area:

- Reduce emergency department utilization

Information Systems Capabilities Assessment (ISCA)			
Section	**Score (out of 3.0)**	**Section**	**Score (out of 3.0)**
Information Systems	Fully met (2.8)	Enrollment Systems	Fully met (2.9)
Staffing	Partially met (2.4)	Vendor Data Integration	Fully met (3.0)
Hardware Systems	Fully met (3.0)	Report Production/PM Reports	Partially met (2.5)
Security	Not met (1.7)	Provider Data	Fully met (2.8)
Administrative Data	Partially met (2.0)	Meaningful Use of EHRs	Fully met (3.0)

Key Findings and Areas for Improvement

Finding #1: Backup media improperly handled

YCCO is not encrypting backup media. The backup media are connected to a server in a small closet during the week. YCCO uses two USB external drives as backup media. Each Friday, a staff member brings the USB external drive back into YCCO's office and exchanges it with the external drive currently connected to the server. This staff member then takes the USB external drive removed from the server to staff member's personal residence.

Finding #2: Monitoring

YCCO did not provide evidence of monitoring and oversight of contracted or partner organizations' IT systems, policies and procedures. YCCO provided no evidence of a process to monitor provider agencies' activities related to information systems. It was unclear how this function would be split between CCO staff and the CareOregon delegation team.

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Opioid Metrics for Statewide PIP – Primary Considerations

In June 2015, Acumentra Health conducted a literature review and identified a list of potential metrics for the second Statewide PIP on opioid misuse and abuse. The list was reviewed by the Oregon Health Authority (OHA) Office of Health Analytics department and several members of the Acumentra Health Prescription Drug Monitoring Program (PDMP) research team. In its review, the OHA Analytics Department conducted an initial scan for feasibility based on the following criteria: availability of metric specifications, amount of development work required to operationalize the metrics, and data availability. These metrics were also reviewed and recommended by the Healthy Columbia Willamette Collaborative opioid monitoring workgroup.

Note: The OHA Office of Analytics department recommends a secondary review to identify (and draft if needed) numerator and denominator statements and confirm data sources for the potential metrics identified as most feasible prior to final adoption.

Metric	Metric Source	Health Analytics comments	Acumentra Health comments
Percentage of patients on opioid doses >120 mg Morphine Equivalent Dosage (MED) per day	PQA[1], Washington State [2]	Feasible with existing data • Analytics would recommend adopting specifications based on the Pharmacy Quality Alliance (PQA) measures and the work already done in Oregon, rather than the Washington State guidelines. • PQA specifications are available online, and include denominator statements and MED calculations and measurement year. • PQA specifications will need some development work before operationalizing in claims data, e.g., opioid medications are listed by drug name rather than NDC. • Note this measure, as written here, would include all patients, regardless of cancer or other underlying chronic conditions.	• There is some question regarding the best cut off of MED to define highest risk (120 vs 100 or less). That discussion shouldn't distract from the fact that using MED/day is an effective way to evaluate opioid use and risk. • Consider population definition (chronic user vs acute, non-cancer). The PQA measure defines population as "The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120 morphine equivalent dosage (MED) for 90 consecutive days or longer" • CDC has tool kit for calculating MED that includes NDC for most opioids and Acumentra team has extensive experience as needed in this area.

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			• Be aware that the timeframe definition for MED (per day vs per 180days) will have impact on absolute value. (e.g. using the "days supply" field from dispensing pharmacist in claims data will give max dose per day that could be used, rather than how person is using it especially true for directions "as needed". For this reason, the measure is more meaningful for chronic users of opioids.
The proportion (XX out of 1000) individuals without cancer receiving a opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies	PQA[1], Veterans Administration /Dept Of Defense [3]	Feasible with existing data • PQA includes a third measure, which are both of the measures combined (individuals with both >120MED *and* 4x4)	• This commonly used measure targets areas of potential diversion. Unlike MED, there isn't evidence that this "4x4" measure correlates to risk of overdose or death.
ED visits with ICD-9-CM codes indicative of opioid adverse drug events (ADEs)	AHRQ, VA, DOD, CDC, SAMHSA [3]	Feasible with existing data • Measure could be connected to the existing emergency department utilization measure denominator. • Codes for ADE available from an AHRQ project.	• Considerations: Will claims be connected to prescription? How will the time period be defined? Is there a large enough individual yearly CCO study population that can demonstrate improvement?
Inpatient stays with ICD-9-CM codes indicative of opioid ADEs	AHRQ, DOD [3]	Feasible with existing data • Measure could be based on existing HEDIS measures to identify inpatient stays. • Codes for ADE available from an AHRQ project."	• Considerations: Will claims be connected to prescription? How will the time period be defined? Is there a large enough individual yearly CCO study population that can demonstrate improvement?
Proportion of patients with evidence of a serious adverse effect that might be related to opioid therapy in	VA [3]	Feasible with existing data. • Analytics would recommend adopting the adverse event code list from the AHRQ measure listed below."	• Other considerations: "What datasets would be used to capture adverse events? Claims? Verify

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the 6 months following an opioid prescription.			reliability of data to connect event with opioid."
Proportion of patients with overlapping prescriptions for an outpatient opioid and a benzodiazepine	VA [3,], Group Health Federal Interagency Workgroup for Opioid ADEs[4-6]	Feasible with existing data. • May be able to use other measure options as starting place for defining the medication lists."	• Evaluating overlap can be difficult and definitions of overlap vary. • Important to define benzodiazepine correctly so as not to exclude those used to treat seizure. Acumentra team could support as needed.

References:

1. Pharmacy Quality Alliance Performance Measures
Available at: http://www.pqaalliance.org/measures/default.asp

2. The Development of the Washington State Emergency Department Opioid Prescribing Guidelines; Darin E. Neven, Jennifer C. Sabel, Donelle N. Howell, and Russell J. Carlisle; J Med Toxicol. 2012 Dec; 8(4): 353–359. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3550252/

3. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (2014). National Action Plan for Adverse Drug Event Prevention. Washington, D.C. Available at: http://www.health.gov/hcq/pdfs/ADE-Action-Plan-508c.pdf

4. Measurement of adherence to clinical practice guidelines for opioid therapy for chronic pain; Amanda M Midboe, PhD, Eleanor T Lewis, PhD, Meenah C Paik, MPH, Rollin M Gallagher, MD, MPH, Jack M Rosenberg, MD, Francine Goodman, PharmD, Robert D Kerns, PhD, William C Becker, MD, and Jodie A Trafton, PhD. Transl Behav Med. 2012 Mar; 2(1): 57–64. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3717811/

5. Group Health's Initiative To Avert Opioid Misuse And Overdose Among Patients With Chronic Noncancer Pain; Claire E. Trescott, Randi M. Beck, Michelle D. Seelig, and Michael R. Von Korff; Health Aff (Millwood). 2011 Aug; 30(8): 1420–1424. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3286629/

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Opioid Metrics for Statewide PIP – Secondary Considerations

In June 2015, Acumentra Health conducted a literature review and identified a list of potential metrics for the second Statewide PIP on opioid misuse and abuse. The list was reviewed by the Oregon Health Authority (OHA) Office of Health Analytics department and several members of the Acumentra Health Prescription Drug Monitoring Program (PDMP) research team. In its review, the Analytics Department stated that it "conducted an initial scan for feasibility based on the following criteria: availability of metric specifications, amount of development work required to operationalize the metrics, and data availability."

Below are three tables: the first table lists metrics that Health Analytics determined may be feasible, but only with considerable developmental work; the second is a list of metrics that were not recommended by Health Analytics, and the third is a list of metrics that could be adopted as process measures by the individual CCOs.

Table 1: Measure is feasible, with reservations:

Metric	Metric Source	Health Analytics comments	Acumentra Health comments
Enrollment of 90 % of Emergency Department (ED) providers with the Prescription Drug Monitoring Program (PDMP)	Washington State[1]	"May be feasible with existing data, but development work required and the resulting metric will be messy. • Note this was not a metric as much as a goal Washington State set for themselves as one of seven "best practices" in 2012. Hospitals self-attested that they were implementing these best practices and there was no standardized reporting. • Enrollment = registered / account holder with PDMP. • Conversation with Oregon's Prescription Drug Monitoring Program indicated that registration does not *require* providers to list their NPI – it is an optional field. We may be able to match provider data from CCOs' provider network adequacy reports to those providers registered with PDMP to identify the % of ED providers within CCOs networks that are	• Registration does not equal use of the PDMP. • Challenging to access user registration or utilization data

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		"enrolled" with the PDMP, but more discussion is needed with analysts to determine full feasibility."	
Percentage of patients receiving long-term opioid therapy who had a care plan documented in the electronic health record	Group Health Federal Interagency Workgroup for Opioid ADEs (FIW)[2,3]	"Feasible only if EHR-based reporting is developed. Metric could theoretically be adopted with annual "paper" chart review, but would result in limited ability for CCOs to monitor progress with more frequent data and is not a recommended approach. • Note all providers in this study appear to have been on the same EHR. Operationalizing this metric will require a build that works for multiple EHR platforms and vendors. • Also note that in the study, the care plan was dependent on prescribing clinician tools in the EHR that supported a guideline. Does Oregon already have an adopted guideline, or would one need to be adopted before we could proceed? • Long-term therapy definitions exist in other publications from Group Health. E.g., >90 days with 120+ days supply or 10+ opioid prescriptions in a given year. [1] • Would align the timeframe with the PIP measurement year, although there are challenges in quarterly versus full year reporting in EHR-based measurement."	There are conflicting definitions of 'long term' in the literature.
Proportion of patients receiving an opioid prescription that received the following (1) drug screen for non-opioid abusable substances; (2) drug screen	VA [4]	May be feasible, but not recommended without further testing and development work. • Need to determine whether the qualifying opioid prescription is a new prescription in a certain period of time (e.g., following a clean	

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for heroin/morphine; and (3) drug screen for non-morphine opioid compounds		medication history period) or any opioid prescription regardless of history. • May be timeframe issues – does the drug screen need to happen before the prescription or any time in the measurement year? • We may not be able to different between drug screenings to ensure that all three occurred (as opposed to general drug screening that we are tracking through SBIRT).	
Number of new opioid prescriptions that are for a high-dose opioid formulation	VA [4]	Feasible, but not recommended without additional modification, and the development work needed. • Note this measure as written would include all patients, regardless of cancer or other underlying chronic conditions that other measure options exclude. • Also need to identify timeframe and whether the measure is focused on the total number of prescriptions, or a rate per 1,000 member months (for example).	Agree

Table 2: Measure is not recommended for statewide PIP

Metric	Metric Source	Health Analytics comments	Acumentra Health comments
Proportion of opioid therapy patients who receive any of the following treatments within the year: (1) coping skills/stress management training; (2) psychotherapy procedures	VA [4]	"Feasible with existing data, but not recommended. • More testing needed to determine the coding or potential lack of coding for skills / stress training available in claims data, as well as to define the broad bucket of "psychotherapy procedures. • Note this measure as written would assume that any skills / stress training and/or psychotherapy procedures are directly linked to the cause or condition.	

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Proportion of opioid therapy patients who receive treatments to increase activity including: (1) PT; (2) OT; (3) special populations therapy; (4) recreational therapy; (5) pain clinic; and (6) others	VA [4]	Feasible, but not recommended given the development work needed to define all codes for all activities. • Note the underlying assumption that any of these treatments are directly linked to the cause or condition that the patient is taking opioids for."	
Number of patients on long-term opioid therapy who have evidence of mental health assessment	FIW [2,3]	Feasible, but not recommended given the development work and modifications needed. • This metric would likely be developed as a hybrid from several of the other measures listed here. • Could use definitions from long-term opioid therapy from Group Health work referenced above. • Could base mental health assessments off our DHS Custody or Follow-up after Hospitalization for Mental Illness measure specifications. Agree timeframe will need discussion – is the assessment supposed to happen within the same timeframe as the long-term use, or prior, or within a certain time of a new prescription?	
Deaths due to opioid overdose	CDC [4]	Feasible with death certificate data, but not recommended. • Vital statistics has a code list that they use for reporting "drug induced deaths" which could be disaggregated. • Vital statistics already reports on opioid use as its own specific category. See 2013 data book. • Note the number of deaths due to opioids in the 2013 data book is VERY small (n<10) and that is already for the general population, prior	Very small numbers statewide, and broken down by CCO wouldn't be very helpful, difficult to show improvement, etc. Also, there is no standard definition for morbidity or mortality codes related to opioid ADEs.

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		to any stratification by Medicaid or other demographics.	

Table 3: Other Potential Process Measures

Metric	Metric Source	Health Analytics comments	Acumentra Health comments
Patients on long-term opioid therapy given a toxicology screen prior to initiating therapy and at least once a year while on long-term opioid therapy	FIW [2,3]	"Feasible with some development work. • Note this measure is a process measure rather than more outcomes focused; thus may be more appropriate for a CCO or practice or hospital to adopt in support of the PIP rather than statewide PIP metric. • Could use definitions for long-term opioid therapy from the Group Health work referenced above. • Timeframe is clearer than other metric options. • Defining toxicology screen codes would take some development work, but should be fairly straightforward."	
Proportion of opioid therapy patients with evidence of medication management or pharmacy reconciliation	VA [4]	• Not recommended as a statewide PIP metric, but could be a good process measure for a CCO, practice, or hospital to adopt in support of the PIP.	

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		• Not feasible in claims data. We cannot currently monitor any medication management or medication reconciliation without chart review or EHR-based reporting."	

References:

1. The Development of the Washington State Emergency Department Opioid Prescribing Guidelines; Darin E. Neven, Jennifer C. Sabel, Donelle N. Howell, and Russell J. Carlisle; J Med Toxicol. 2012 Dec; 8(4): 353–359. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3550252/

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HEALTHINSIGHT

FINANCIAL STATEMENTS

June 30, 2016 and 2015

Table of Contents

Independent Auditors' Report 1 – 2

Basic Financial Statements

Consolidated Statements of Net Position 3

Consolidated Statements of Activities and Changes in Net Position 4

Consolidated Statements of Cash Flows 5

Notes to Financial Statements 6 – 11

Supplemental Information

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards* 12 – 13

Independent Auditors' Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by OMB Compliance Requirements 14 – 15

Schedule of Expenditures of Federal Awards 16

Status of Findings and Questioned Costs 17

Schedule of Findings and Questioned Costs 18

Schedule of Findings and Questioned Costs – Prior Year 19

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INDEPENDENT AUDITORS' REPORT

To the Board of Trustees of
HealthInsight

Report on the Financial Statements

We have audited the accompanying financial statements of HealthInsight (a nonprofit organization), which comprise the Statements of Financial Position as of June 30, 2016 and 2015, and the related Statements of Activities and Cash Flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HealthInsight as of June 30, 2016 and 2015, and the changes in its net position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by the Uniform Guidance, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 21, 2016, on our consideration of HealthInsight's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with Government Auditing Standards in considering HealthInsight's internal control over financial reporting and compliance.

B2a CPAs

B2a, CPAs
November 21, 2016

HealthInsight
Consolidated Statements of Net Position
For the Years Ending June 30, 2016 and 2015

	2016	2015
Assets		
Current Assets		
Cash and Cash Equivalents (Note 2)	$ 2,412,324	$ 2,808,599
Investments (Note 3)	3,170,863	3,314,018
Accounts Receivable - Federal Direct Contracts	3,710,227	2,306,648
Accounts Receivable - Federal Pass-Through, Other Contracts, and Grants	1,879,576	1,214,770
Accounts Receivable - Employee and Other	20,810	33,819
Prepaid Expenses	421,410	649,991
Total Current Assets	11,615,210	10,327,845
Capital Assets (Note 6)		
Furniture and Equipment	2,146,285	3,216,136
Leasehold Improvements	169,639	273,052
Total Capital Assets	2,315,924	3,489,188
Accumulated Depreciation	(1,733,489)	(2,851,840)
Net Capital Assets	582,435	637,348
Other Assets		
Intangible Assets, Net	-	2,148
Deposits	126,972	122,078
Other Investments (Note 3)	74,640	74,640
Total Other Assets	201,612	198,866
Total Assets	$ 12,399,257	$ 11,164,059
Liabilities and Net Position		
Current Liabilities		
Accounts Payable	$ 692,468	$ 643,427
Unearned Revenue	-	735,149
Other Current Liabilities	14,670	1,956
Accrued Vacation Expense	732,795	651,680
Accrued Payroll Expenses	903,689	604,910
Total Current Liabilities	2,343,622	2,637,122
Total Liabilities	2,343,622	2,637,122
Net Position		
Unrestricted Net Position	10,055,635	8,526,937
Total Net Position	10,055,635	8,526,937
Total Liabilities and Net Position	$ 12,399,257	$ 11,164,059

See accompanying notes to financial statements

HealthInsight
Consolidated Statements of Cash Flows
For the Years Ending June 30, 2016 and 2015

	2016	2015
Unrestricted Net Position		
Revenue and Support		
Federal Direct Contracts	$ 14,876,066	$ 10,487,027
Federal Pass-Through Contracts	10,087,578	10,340,405
Other Contracts, Grants and Revenue	308,830	697,611
Net Investment	(120,330)	49,797
on Sale of Assets	(1,541)	(43,940)
Total Unrestricted Revenue and Support	25,150,603	21,530,900
Expenses		
Accounting and Auditing	37,170	44,600
Board of Trustee Fees	3,591	10,435
Data Processing and Line Charges	195	1,538
Depreciation and Amortization	264,242	252,458
Dues, Registrations and Subscriptions	300,523	233,582
Employee Education and Relations	32,137	49,977
Insurance - Employee Benefits	1,292,032	1,135,479
Insurance - Corporate	61,928	60,700
Legal	24,341	40,224
Maintenance	123,401	97,917
Meetings and Conferences	41,022	48,267
Miscellaneous	162,371	121,466
Office Supplies	89,782	76,018
Other Outside Professional Services	693,185	515,171
Payroll Taxes	958,339	973,475
Pension (Note 5)	908,620	955,569
Physician Consultants	-	30,535
Postage and printing	97,358	78,058
Recruiting	68,809	129,619
Rent - Occupancy (Note 8)	742,141	761,586
Rent - Equipment	28,984	12,574
Salaries	12,472,636	11,705,800
Services	363,480	230,828
Small Equipment Purchases (Note 1)	52,794	21,204
Subcontract	3,518,205	2,246,406
Taxes and Licenses	94,117	61,622
Telephone	251,990	269,821
Temporary Office Labor	270,894	99,551
Training	24,892	27,870
Travel	607,324	546,054
Utilities	35,402	37,154
Total Expenses	23,621,905	20,875,558
Change in Unrestricted Net Position	1,528,698	655,342
Net Position at Beginning of Year	8,526,937	7,871,595
Net Position at End of Year	**$ 10,055,635**	**$ 8,526,937**

See accompanying notes to financial statements

HealthInsight
Consolidated Statements of Cash Flows
For the Years Ending June 30, 2016 and 2015

	2016	2015
Cash Flows from Operating Activities		
Change in Net Position	$ 1,528,698	$ 655,342
Adjustments to Reconcile Change in Net Position to		
Net Cash Provided (Used) by Operating Activities		
Depreciation and Amortization	264,242	252,458
on Sale of Assets	1,541	43,940
Net Investment	120,330	(49,797)
Decrease (Increase) in Operating Assets		
Accounts Receivable	(2,055,376)	276,631
Prepaid Expenses	228,581	(529,576)
Deposits	(4,894)	(20,000)
Increase (Decrease) in Operating Liabilities		
Accounts Payable	49,041	210,433
Unearned Revenue	(735,149)	(1,084,910)
Other Current Liabilities	12,714	1,000
Accrued Vacation Expense	81,115	(51,789)
Accrued Payroll Expenses	298,779	(143,109)
Net Cash Provided (Used) by Operating Activities	$ (210,378)	$ (439,377)
Cash Flows from Investing Activities		
Acquisition of Capital Assets	(208,722)	(534,186)
Proceeds from Disposition of Assets	-	726
Proceeds from Sale of Investments	-	1,217,384
Purchase of Investments	22,825	(2,197,093)
Net Cash Provided (Used) by Investing Activities	(185,897)	(1,513,169)
Cash Flows from Financing Activities		
Net Cash Provided (Used) by Financing Activities	-	-
Net Increase (Decrease) in Cash and Cash Equivalents	(396,275)	(1,952,546)
Cash and Cash Equivalents at Beginning of Year	2,808,599	4,761,145
Cash and Cash Equivalents at End of Year	$ 2,412,324	$ 2,808,599

See accompanying notes to financial statements

HealthInsight
Notes to Financial Statements
June 30, 2016 and 2015

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES

A. Organization and Activities - HealthInsight is a nonprofit organization which is tax exempt under Section 501(c)(3) of the Internal Revenue Code. HealthInsight serves as a community resource for health care quality improvement and quality assurance activities. This work is being performed primarily in the states of Utah, Nevada and New Mexico. The major source of revenue is from contracts and grants for services. Contributions to the Organization qualify as charitable contributions to the extent provided by section 170 of the Internal Revenue Code.

B. Consolidation of Related Entity - The Organization has adopted the provisions of the American Institute of Certified Public Accountants Statement of Position No. 94-3 (SOP 94-3) entitled *Reporting of Related Entities by Not-for-Profit Organizations. SOP 94-3* states that a not-for-profit organization should consolidate another not-for-profit organization if the reporting not-for-profit organization has both control of the other not-for-profit organization, as evidenced by either a majority ownership or a majority voting interest in the board of trustees of the other not-for-profit organization, and an economic interest in the other not-for-profit organization.

HealthInsight is comprised of the following related entities:

HealthInsight Management Corporation. HealthInsight Management Corporation, formerly HealthInsight, was incorporated March 6, 1974 in the state of Utah.

HealthInsight of Nevada. HealthInsight of Nevada was incorporated July 21, 2001 in the state of Nevada.

HealthInsight Utah. HealthInsight Utah was incorporated on April 7, 2011 in the state of Utah.

HealthInsight New Mexico. Health Insight New Mexico, formerly New Mexico Medical Review Association, was incorporated January 20, 1984 in the state of New Mexico.

C. Basis of Accounting - Assets, liabilities, revenues and expenses are recognized on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Revenues are recognized as earned, in accordance with the terms of contract agreements. In some instances, recognition of revenue may differ from amounts that are billed to clients.

D. Unrestricted and Restricted Revenue and Support - Contributions and grants are recorded as increases in unrestricted, temporarily restricted, or permanently restricted net position, depending on the existence and/or nature of any donor restrictions. When a restriction is satisfied, temporarily restricted net position are reclassified to unrestricted net position and reported in the statement of activities as net position released from restrictions. As of June 30, 2016 and 2015 all financial activity of HealthInsight was considered unrestricted.

E. Grants and Contributions - Grants and contributions, including unconditional promises to give, are recorded as receivables and as revenue in the period in which the donor's commitment to give is established. All grants and contributions are available for unrestricted use unless specifically restricted by the donor. Unconditional promises to give (grants and contributions) are recorded at their net realizable value.

F. Cash and Cash Equivalents - For financial statement purposes, the Organization considers all highly liquid investments purchased with an original maturity of three months or less to be cash equivalents.

G. Investments - Investments include mutual funds, equipment leasing and finance funds, and real estate investment trusts (REITs). Mutual funds are valued at quoted market prices as of the financial statement date. The REITs are registered as nontraded REITs. The equipment leasing and finance funds are not publicly traded. Investment return consists of investment income, as well as realized and unrealized gains and losses.

H. Property, Equipment and Depreciation - Property and equipment consists of furniture and equipment and leasehold improvements. Assets are recorded at cost and are depreciated using the straight-line method over their estimated useful lives. Maintenance, repairs and minor replacements are charged to expense as incurred. Major repairs and replacements that prolong the life of an asset are capitalized. The organization's policy is to capitalize amounts greater than $1,000.

I. Use of Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

J. Fair Value of Financial Instruments - The Organization's financial instruments include cash, investments, accounts receivable and accounts payable. The Organization estimates that the fair value of all financial instruments at June 30, 2016 and 2015 does not differ materially from the aggregate carrying value of its financial instruments recorded in the statement of financial position. The estimated fair value amounts have been determined by the Organization using available market information. The market values are not necessarily indicative of the amounts that the Organization could realize in a current market exchange.

K. Accounts Receivable - Accounts and grants receivable are recorded at the amount management expects to collect from clients. Because the Organization deals with a limited number of clients, mostly governmental agencies, management expects all receivables to be fully collectible, and has therefore not established an allowance for doubtful accounts. When accounts are judged by management to be uncollectible, they are written off directly as bad debt expense.

L. Income Taxes – The Organizations are organized as nonprofit corporations in their respective states and have been recognized by the Internal Revenue Service (IRS) as exempt from federal income taxes under Section 501(a) of the Internal Revenue Code as organizations described in Section 501(c)(3), qualifying for charitable contribution deduction under Section 170(b)(1)(A)(vi), and have been determined not to be private foundations under Section 509(a)(1). The Organizations are required annually to file Return of Organization Exempt from Income Tax (Form 990) with the IRS. In addition, the Organizations are subject to income tax on net income that is derived from business activities that are unrelated to their exempt purposes. The Organizations have determined they are not subject to unrelated business income tax and have not filed Exempt Organization Business Income Tax Returns (Form 990-T) with the IRS.

Federal tax returns are open for examination by the IRS for a period of three years after the due date of the return. As of June 30, 2016 the tax returns for the years ending June 30, 2013 and forward are open for examination by the IRS.

M. Subsequent Events – On July 1, 2016, HealthInsight finalized the merge of Accumentra Health. The company did not exchange any consideration at the time of the merge, the merge was considered mutually beneficial. At current the full effect of the merge has not been determined.

Subsequent events were evaluated through November 21, 2016, which is the date the financial statements were available to be issued.

N. Contingencies – Revenue received by the Organization from Medicare is subject to a subsequent audit by the DCAA. Adjustments in the closing out of a contract often arise when costs are disputed by the DCAA audit and when approved indirect costs are different from the actual indirect costs. Because of the unpredictable results of historic audits Management does not feel they can accurately estimate the results of uncompleted audits and books revenue as billed. As of November 21, 2016 the last year to be closed out with the DCAA and the final settlement is determined is the year ending June 30, 2002.

NOTE 2 - CONCENTRATIONS OF RISK

Business Risk
Direct federal and federal pass-through funds accounted for approximately 90 percent of the Organization's unrestricted revenues for the years ended June 30, 2016 and 2015. A significant reduction or elimination of federal or pass-through support would pose an economic risk to HealthInsight.

Cash and Cash Equivalents
Cash and cash equivalents that potentially subject the Organization to credit risk include deposits in financial institutions that exceeded the U.S. Federal Deposit Insurance Corporation insurance limit by $1,907,427 and $2,180,022 at June 30, 2016 and 2015, respectively.

NOTE 3 - INVESTMENTS

Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, Fair Value Measurements and Disclosures, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 - Inputs to the valuation methodology based on unadjusted quoted prices for identical assets or liabilities in active markets that are accessible.

Level 2 - Inputs to the valuation methodology based on quoted prices for similar instruments and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data.

Level 3 - Inputs to the valuation methodology that are generally unobservable and typically reflect management's estimates of assumptions that market participants would use in pricing the asset or liability.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets at Fair Value as of June 30, 2016

	Level 1	Level 2	Level 3	Total
Mutual Funds	$ 3,170,863	$ -	$ -	$ 3,170,863
REITs	-	75,672	-	75,672
Equity Interest in Partnerships	-	-	(1,032)	(1,032)
Ending Balances	$ 3,170,863	$ 75,672	$ (1,032)	$ 3,245,503

Assets at Fair Value as of June 30, 2015

	Level 1	Level 2	Level 3	Total
Mutual Funds	$ 3,314,018	$ -	$ -	$ 3,314,018
REITs	-	75,672	-	75,672
Equity Interest in Partnerships	-	-	(1,032)	(1,032)
Ending Balances	$ 3,314,018	$ 75,672	$ (1,032)	$ 3,388,658

All investment income is reported in the operating section of the statement of activities. Investment fees of $22,407 and $19,721for the years ended June 30, 2016 and 2015 are netted with investment income respectively. The following schedule summarizes investment return in the statement of activities for the years ended June 30, 2016 and 2015:

	2016	2015
Investment Income	$ 121,822	$ 73,014
Realized Gain	82,070	5,791
Unrealized Loss	(324,222)	(29,008)
Net Investment Gain (Loss)	$ (120,330)	$ 49,797

NOTE 4 - GOVERNMENT OWNED PROPERTY

Certain contracts require HealthInsight to purchase equipment. The contract revenue includes reimbursement to HealthInsight for the equipment purchases. Equipment purchased in these circumstances remains property of the contracting agency. These purchases are not capitalized and depreciated, but are considered an expense, even though expenditures may exceed the organization's $1,000 capitalization policy. This equipment is reported annually to Medicare through the Standard Data Processing System (SDPS).

NOTE 5 - EMPLOYEE RETIREMENT PLANS

The Organization has a retirement plan that covers all employees who have completed a minimum service requirement. Benefits under the plan are limited to the balance in participants' accounts. The plan combines a defined contribution feature and a 401(k) elective salary deferral feature. All employer contributions are subject to a four-year vesting schedule. Under the 401(k) provision, employees can contribute up to 100% of their compensation subject to the maximum amounts allowed under federal tax law. The Organization will match 50% of the first 4% of pay that employees contribute to the plan. The

Organization will make an additional contribution for each employee who is an active participant on the last day of that period in an amount equal to 7% of the participant's monthly compensation not in excess of 50% of the employee's "Integration Level," plus 10% of such compensation in excess of 50% of the employee's "Integration Level." Integration Level is the Social Security Taxable Wage Base of $118,500 for 2016 and 50% of this number is $59,250. The Organization's contributions to the plan included in expenses were $908,620 and $955,569 for the years ended June 30, 2016 and 2015 respectively. These expenses include $162,347 and $162,347 in employer matching contributions for the years ended June 30, 2016 and 2015 respectively. The Organization may make additional optional matching and discretionary contributions, not to exceed federal tax law limitations. For the years ended June 30, 2016 and 2015 the Organization did not make additional optional matching or discretionary contributions.

NOTE 6 – CAPITAL ASSETS

The following table summarizes the changes in Capital Assets for years ended June 30, 2016 and 2015:

	6/30/2015	Additions	Disposals and Adjustments	6/30/2016
Furniture and Equipment	$ 3,216,136	$ 199,063	$ (1,268,914)	$ 2,146,285
Leasehold Improvements	273,052	9,659	(113,072)	169,639
Total Capital Assets	3,489,188	208,722	(1,381,986)	2,315,924
Accumulated Depreciation	(2,851,840)	(262,094)	1,380,445	(1,733,489)
Net Capital Assets	$ 637,348			$ 582,435

	6/30/2014	Additions	Disposals and Adjustments	6/30/2015
Furniture and Equipment	$ 2,973,714	$ 509,855	$ (267,433)	$ 3,216,136
Leasehold Improvements	248,893	24,331	(172)	273,052
Total Capital Assets	3,222,607	534,186	(267,605)	3,489,188
Accumulated Depreciation	(2,828,764)	(246,015)	222,939	(2,851,840)
Net Capital Assets	$ 393,843			$ 637,348

NOTE 7 - DESCRIPTION OF OPERATING LEASE ARRANGEMENTS

The organization leases office space in Murray, Utah, Las Vegas, Nevada and Albuquerque, New Mexico under operating lease agreements.

Utah. The Salt Lake City office lease covers the period from February 2012 through July 2018 during which the base rent is $24,147 per month during the first year with the first six months free and escalates 3% each year. The free rental period has been amortized over the life of the contract for rental expense.

Nevada. The Las Vegas office lease amendment covers the period from March 1, 2015 through May 31, 2020 with an option to renew for an additional three years. The monthly base rent of $17,157 shall increase every thirteen months by a fixed amount of 2.5%.

New Mexico. The original lease was extended and amended to extend the contract from January 1, 2016 to January 31, 2020. The monthly base rent $21,569.75 escalates each calendar year according to schedule.

Minimum lease payments for operating leases are as follows:

Years ending June 30	
2017	$ 809,986
2018	833,245
2019	530,445
2020	37,718
Total	$ 2,211,394

Total rental expense for all operating leases was $742,141 and $761,586 for the years ended June 30, 2016 and 2015, respectively. Rental expense in the statement of activities is shown net of sublease income.

NOTE 8 - LINE OF CREDIT

The Organization has a line of credit. It is a $750,000 revolving line of credit with a bank. The amount that can be borrowed at any given time may be less than $750,000, depending on the accounts receivable balance at the time. The interest rate is equal to the bank's prime rate, with a floor of 5 percent. There was no balance on the line of credit as of June 30, 2016 and 2015.

Subsequent to year end the line of credit was renewed with a maturity date of September 2, 2016. The renewed line of credit carries a limit of $750,000 and an interest rate equal to the bank's prime rate, with a floor of 4 percent. As of November 21, 2016, the line of credit was unused.

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INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Trustees of
HealthInsight

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the financial statements of HealthInsight (a nonprofit organization), which comprise the Statements of Financial Position as of June 30, 2016 and 2015, and the related Statements of Activities, and Cash Flows for the years then ended, and the related notes to the financial statements, and have issued our report thereon dated November 21, 2016.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered HealthInsight's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HealthInsight's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether HealthInsight's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

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Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the organization's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the organization's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

B2a CPAs

B2a, CPAs
November 21, 2016

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY OMB COMPLIANCE SUPPLEMENT

To the Board of Trustees of
HealthInsight

Report on Compliance for Each Major Federal Program

We have audited HealthInsight's compliance with the types of compliance requirements described in the *OMB Compliance Supplement Compliance Supplement* that could have a direct and material effect on each of HealthInsight's major federal programs for the years ended June 30, 2016 and 2015. HealthInsight's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of HealthInsight's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Compliance Supplement, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Compliance Supplement require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about HealthInsight's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of HealthInsight's compliance.

Opinion on Each Major Federal Program

In our opinion, HealthInsight complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the years ended June 30, 2016 and 2015.

Report on Internal Control Over Compliance

Management of HealthInsight is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered HealthInsight's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on

compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Compliance Supplement, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of HealthInsight's internal control over compliance. A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Purpose of this Report

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of uniform guidance. Accordingly, this report is not suitable for any other purpose.

B2a CPAs

B2a, CPAs
November 21, 2016

Supplemental Information

HealthInsight
Schedule of Expenditures of Federal Awards
For the year ended June 30, 2016

CFDA #	Program Grant Title	Program Description	HealthInsight Management	Nevada	New Mexico	Utah	Total
93.074	Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	DOH-Infection Control Ebola	$ 15,126				$ 15,126
93.226	Research on Healthcare Costs, Quality and Outcomes	UNM EvidenceNOW			96,504		96,504
93.241	State Rural Hospital Flexibility Program	DOH Critical Access	147,201				147,201
93.511	Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review	Price Transparency				188,392	188,392
93.611	Strong Start for Mothers and Newborns	Strong Start Nevada		160,070			160,070
93.621	Affordable Care Act Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents	ATOP		3,509,244			3,509,244
93.622	Coordinating Center for Interprofessional Education and Collaborative Practice	ATOP2		142,266			142,266
93.624	State Innovation Models: Funding for Model Design and Model Testing Assistance	SIM EOL		402,575			402,575
93.715	Comparative Effective Research - AHRQ	Ryan White AIDS Project				10,860	10,860
93.718	Health Information Technology (HIT) Regional Extension Centers Program	ONC HIT REC	74,128				74,128
93.719		UHIN Interoperability				44,524	44,524
93.757	State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health financed in part by PPHF	DOH Hypertension			120,175		120,175
93.815	Domestic Ebola Supplement to the Epidemiology Laboratory Capacity for Infectious Diseases	UDOH CIC				65,419	65,419
93.945	Assistance Programs for Chronic Disease Prevention and Control	UDOH Blood Pressure				46,279	46,279
93.969	PPHF Geriatic Education Centers	GWEP			146,163		146,163
		Total	$ 236,455	$ 4,214,155	$ 362,842	$ 355,474	$ 5,168,926

* Denotes major program

Note 1. Basis of Presentation

The accompanying schedule of expenditures of federal awards includes the federal grant activity of HealthInsight and is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of OMB Compliance Supplement, Audits of States, Local Governments, and Non-Profit Organizations. Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the basic financial statements

HealthInsight
Status of Findings and Questioned Costs
For the year ended June 30, 2016

Financial Statements

Type of Auditors' report issued:	Unmodified	
Internal control over financial reporting:		
• Material weakness(es) identified?	_____ Yes	___X___ No
• Significant deficiency(ies) identified that are not considered to be material weaknesses?	_____ Yes	___X___ None reported
Non compliance material to financial statements noted?	_____ Yes	___X___ No

Federal Awards

Internal control over major programs:		
• Material weakness(es) identified?	_____ Yes	___X___ No
• Significant deficiency(ies) identified that are not considered to be material weaknesses?	_____ Yes	___X___ None reported

Type of Auditors' report issued on compliance for major programs: Unmodified

Any audit findings disclosed that are required to be reported in accordance with the Compliance Supplement?	_____ Yes	___X___No

Identification of major programs

CFDA Number(s)	Name of Federal Program or Cluster
93.621	ACA Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
93.779	Medicare Quality Improvement Organization

Dollar threshold used to distinguish between type A and type B programs:	$ 750,000	
Auditee qualified as low-risk auditee?	___X___ Yes	_____ No

HealthInsight
Status of Findings and Questioned Costs
For the year ended June 30, 2016

HealthInsight
Schedule of Findings and Questioned Costs
June 30, 2016

Internal Control Over Financial Reporting

There were no findings to report for the year ended June 30, 2016.

Compliance

There were no findings to report for the year ended June 30, 2016.

HealthInsight
Schedule of Findings and Questioned Costs - Prior Year
June 30, 2015

Internal Control Over Financial Reporting

There were no findings to report for the year ended June 30, 2015.

Compliance

There were no findings to report for the year ended June 30, 2015.

FINANCIAL STATEMENTS

June 30, 2017 and 2016

B2a CPAs

Table of Contents

Independent Auditors' Report 1 – 2

Basic Financial Statements

Consolidated Statements of Net Position 3

Consolidated Statements of Activities and Changes in Net Position 4

Consolidated Statements of Cash Flows 5

Notes to Financial Statements 6 – 11

Supplemental Information

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards* 13 – 14

Independent Auditors' Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by OMB Compliance Requirements 15 – 16

Schedule of Expenditures of Federal Awards 17

Status of Findings and Questioned Costs 18

Schedule of Findings and Questioned Costs 19

Schedule of Findings and Questioned Costs – Prior Year 20

Certified Public Accountants and Business Advisors
low income housing, pension plans, business services,
auditing, tax preparation and financial planning

INDEPENDENT AUDITORS' REPORT

To the Board of Trustees of
HealthInsight

Report on the Financial Statements

We have audited the accompanying financial statements of HealthInsight (a nonprofit organization), which comprise the Statements of Financial Position as of June 30, 2017 and 2016, and the related Statements of Activities and Cash Flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HealthInsight as of June 30, 2017 and 2016, and the changes in its net position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by the Uniform Guidance, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 21, 2016, on our consideration of HealthInsight's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with Government Auditing Standards in considering HealthInsight's internal control over financial reporting and compliance.

B2a, CPA

B2a, CPAs
December 18, 2017

HealthInsight
Consolidated Statements of Net Position
For the Years Ending June 30, 2017 and 2016

	2017	2016
Assets		
Current Assets		
Cash and Cash Equivalents (Note 2)	$ 5,472,194	$ 2,412,324
Investments (Note 3)	3,502,217	3,170,863
Accounts Receivable - Federal Direct Contracts	2,433,121	3,710,227
Accounts Receivable - Federal Pass-Through, Other Contracts, and Grants	3,393,414	1,879,576
Accounts Receivable - Employee and Other	8,967	20,810
Prepaid Expenses	356,906	421,410
Total Current Assets	15,166,819	11,615,210
Capital Assets (Note 6)		
Furniture and Equipment	2,510,842	2,146,285
Leasehold Improvements	206,872	169,639
Total Capital Assets	2,717,714	2,315,924
Accumulated Depreciation	(2,140,662)	(1,733,489)
Net Capital Assets	577,052	582,435
Other Assets		
Deposits	129,472	126,972
Other Investments (Note 3)	44,773	74,640
Total Other Assets	174,245	201,612
Total Assets	$ 15,918,116	$ 12,399,257
Liabilities and Net Position		
Current Liabilities		
Accounts Payable	$ 757,713	$ 692,468
Unearned Revenue	-	-
Other Current Liabilities	47,212	14,670
Accrued Vacation Expense	1,082,797	732,795
Accrued Payroll Expenses	1,309,258	903,689
Total Current Liabilities	3,196,980	2,343,622
Total Liabilities	3,196,980	2,343,622
Net Position		
Unrestricted Net Position	12,721,136	10,055,635
Total Net Position	12,721,136	10,055,635
Total Liabilities and Net Position	$ 15,918,116	$ 12,399,257

See accompanying notes to financial statements

HealthInsight
Consolidated Statements of Activities and Changes in Net Position
For the Years Ending June 30, 2017 and 2016

	2017	2016
Unrestricted Net Position		
Revenue and Support		
Federal Direct Contracts	$ 18,417,405	$ 14,876,066
Federal Pass-Through Contracts	14,198,315	10,087,578
Other Contracts, Grants and Revenue	620,602	308,830
Net Investment Gain (Loss)	321,330	(120,330)
Loss on Sale of Assets	(15,839)	(1,541)
Total Unrestricted Revenue and Support	33,541,813	25,150,603
Expenses		
Accounting and Auditing	59,007	37,170
Depreciation and Amortization	320,518	264,242
Dues, Registrations and Subscriptions	304,284	300,523
Employee Education and Relations	56,508	32,137
Insurance - Employee Benefits	2,202,108	1,292,032
Insurance - Corporate	60,555	61,928
Legal	23,681	24,341
Maintenance	146,501	123,401
Meetings and Conferences	25,531	41,022
Miscellaneous	171,239	162,371
Office Supplies	231,132	89,782
Other Outside Professional Services	790,529	693,185
Payroll Taxes	1,383,991	958,339
Pension (Note 5)	1,349,579	908,620
Physician Consultants	12,092	-
Postage and printing	151,934	97,358
Recruiting	247,627	68,809
Rent - Occupancy (Note 8)	1,139,641	742,141
Rent - Equipment	41,327	28,984
Salaries	16,961,223	12,472,636
Services	741,767	363,480
Small Equipment Purchases (Note 1)	71,967	52,794
Subcontract	3,951,630	3,518,205
Taxes and Licenses	248,055	94,117
Telephone	346,565	251,990
Temporary Office Labor	326,800	270,894
Training	30,917	24,892
Travel	831,680	607,324
Utilities	31,533	35,402
Total Expenses	32,259,921	23,621,905
Change in Unrestricted Net Position	1,281,892	1,528,698
Net Position at Beginning of Year	10,055,635	8,526,937
Equity Contribution-HealthInsight Oregon	1,383,609	-
Net Position at End of Year	**$ 12,721,136**	**$ 10,055,635**

See accompanying notes to financial statements

HealthInsight
Consolidated Statements of Cash Flows
For the Years Ending June 30, 2017 and 2016

	2017	2016
Cash Flows from Operating Activities		
Change in Net Position	$ 1,281,892	$ 1,528,698
Adjustments to Reconcile Change in Net Position to		
Net Cash Provided (Used) by Operating Activities		
Depreciation and Amortization	320,518	264,242
Loss on Sale of Assets	15,839	1,541
Net Investment Gain (Loss)	(321,330)	120,330
Decrease (Increase) in Operating Assets		
Accounts Receivable	(224,889)	(2,055,376)
Prepaid Expenses	64,504	228,581
Deposits	(2,500)	(4,894)
Increase (Decrease) in Operating Liabilities		
Accounts Payable	65,245	49,041
Unearned Revenue	-	(735,149)
Other Current Liabilities	32,542	12,714
Accrued Vacation Expense	350,002	81,115
Accrued Payroll Expenses	405,569	298,779
Net Cash Provided (Used) by Operating Activities	$ 1,987,392	$ (210,378)
Cash Flows from Investing Activities		
Acquisition of Capital Assets	(417,131)	(208,722)
Proceeds from Disposition of Assets	116,024	-
Sale/(Purchase) of Investments	(10,024)	22,825
Net Cash Provided (Used) by Investing Activities	(311,131)	(185,897)
Cash Flows from Financing Activities		
Equity Contribution-HealthInsight Oregon	1,383,609	
Net Cash Provided (Used) by Financing Activities	1,383,609	-
Net Increase (Decrease) in Cash and Cash Equivalents	3,059,870	(396,275)
Cash and Cash Equivalents at Beginning of Year	2,412,324	2,808,599
Cash and Cash Equivalents at End of Year	$ 5,472,194	$ 2,412,324

See accompanying notes to financial statements

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES

A. Organization and Activities - HealthInsight is a nonprofit organization which is tax exempt under Section 501(c)(3) of the Internal Revenue Code. HealthInsight serves as a community resource for health care quality improvement and quality assurance activities. This work is being performed primarily in the states of Utah, Nevada, New Mexico and Oregon. The major source of revenue is from contracts and grants for services. Contributions to the Organization qualify as charitable contributions to the extent provided by section 170 of the Internal Revenue Code.

B. Consolidation of Related Entity - The Organization has adopted the provisions of the American Institute of Certified Public Accountants Statement of Position No. 94-3 (SOP 94-3) entitled *Reporting of Related Entities by Not-for-Profit Organizations. SOP 94-3* states that a not-for-profit organization should consolidate another not-for-profit organization if the reporting not-for-profit organization has both control of the other not-for-profit organization, as evidenced by either a majority ownership or a majority voting interest in the board of trustees of the other not-for-profit organization, and an economic interest in the other not-for-profit organization.

HealthInsight is comprised of the following related entities:

HealthInsight Management Corporation. HealthInsight Management Corporation, formerly HealthInsight, was incorporated March 6, 1974 in the state of Utah.

HealthInsight of Nevada. HealthInsight of Nevada was incorporated July 21, 2001 in the state of Nevada.

HealthInsight Utah. HealthInsight Utah was incorporated on April 7, 2011 in the state of Utah.

HealthInsight New Mexico. HealthInsight New Mexico, formerly New Mexico Medical Review Association, was incorporated January 20, 1984 in the state of New Mexico.

HealthInsight Oregon, Inc. HealthInsight Oregon was formed June 3, 2003 in the state of Oregon to operate in the state of Oregon. Prior to July 1, 2016 HealthInsight Oregon operated as Acumentra Health.

HealthInsight Assure, LLC. HealthInsight Assure was formed February 28, 2017 in the state of Utah.

C. Basis of Accounting - Assets, liabilities, revenues and expenses are recognized on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Revenues are recognized as earned, in accordance with the terms of contract agreements. In some instances, recognition of revenue may differ from amounts that are billed to clients.

D. Unrestricted and Restricted Revenue and Support - Contributions and grants are recorded as increases in unrestricted, temporarily restricted, or permanently restricted net position, depending on the existence and/or nature of any donor restrictions. When a restriction is satisfied, temporarily restricted net position are reclassified to unrestricted net position and reported in the statement of activities as net position released from restrictions. As of June 30, 2017 and 2016 all financial activity of HealthInsight was considered unrestricted.

E. Grants and Contributions - Grants and contributions, including unconditional promises to give, are recorded as receivables and as revenue in the period in which the donor's commitment to give is established. All grants and contributions are available for unrestricted use unless specifically restricted by the donor. Unconditional promises to give (grants and contributions) are recorded at their net realizable value.

F. Cash and Cash Equivalents - For financial statement purposes, the Organization considers all highly liquid investments purchased with an original maturity of three months or less to be cash equivalents.

G. Investments - Investments include mutual funds, equipment leasing and finance funds, and real estate investment trusts (REITs). Mutual funds are valued at quoted market prices as of the financial statement date. The REITs are registered as nontraded REITs. The equipment leasing and finance funds are not publicly traded. Investment return consists of investment income, as well as realized and unrealized gains and losses.

H. Property, Equipment and Depreciation - Property and equipment consists of furniture and equipment and leasehold improvements. Assets are recorded at cost and are depreciated using the straight-line method over their estimated useful lives. Maintenance, repairs and minor replacements are charged to expense as incurred. Major repairs and replacements that prolong the life of an asset are capitalized. The organization's policy is to capitalize amounts greater than $1,000.

I. Use of Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

J. Fair Value of Financial Instruments - The Organization's financial instruments include cash, investments, accounts receivable and accounts payable. The Organization estimates that the fair value of all financial instruments at June 30, 2017 and 2016 does not differ materially from the aggregate carrying value of its financial instruments recorded in the statement of financial position. The estimated fair value amounts have been determined by the Organization using available market information. The market values are not necessarily indicative of the amounts that the Organization could realize in a current market exchange.

K. Accounts Receivable - Accounts and grants receivable are recorded at the amount management expects to collect from clients. Because the Organization deals with a limited number of clients, mostly governmental agencies, management expects all receivables to be fully collectible, and has therefore not established an allowance for doubtful accounts. When accounts are judged by management to be uncollectible, they are written off directly as bad debt expense.

L. Income Taxes – The Organizations are organized as nonprofit corporations in their respective states and have been recognized by the Internal Revenue Service (IRS) as exempt from federal income taxes under Section 501(a) of the Internal Revenue Code as organizations described in Section 501(c)(3), qualifying for charitable contribution deduction under Section 170(b)(1)(A)(vi), and have been determined not to be private foundations under Section 509(a)(1). The Organizations are required annually to file Return of Organization Exempt from Income Tax (Form 990) with the IRS. In addition, the Organizations are subject to income tax on net income that is derived from business activities that are unrelated to their exempt purposes. The Organizations have determined they are not subject to unrelated business income tax and have not filed Exempt Organization Business Income Tax Returns (Form 990-T) with the IRS.

Federal tax returns are open for examination by the IRS for a period of three years after the due date of the return. As of June 30, 2017 the tax returns for the years ending June 30, 2014 and forward are open for examination by the IRS.

M. Subsequent Events – Subsequent events were evaluated through December 18, 2017, which is the date the financial statements were available to be issued.

N. Contingencies – Revenue received by the Organization from Medicare is subject to a subsequent audit by the DCAA. Adjustments in the closing out of a contract often arise when costs are disputed by the DCAA audit and when approved indirect costs are different from the actual indirect costs. Because of the unpredictable results of historic audits Management does not feel they can accurately estimate the results of uncompleted audits and books revenue as billed. As of December 18, 2017 the last year to be closed out with the DCAA and the final settlement is determined is the year ending June 30, 2005.

NOTE 2 - CONCENTRATIONS OF RISK

Business Risk
Direct federal and federal pass-through funds accounted for approximately 90 percent of the Organization's unrestricted revenues for the years ended June 30, 2017 and 2016. A significant reduction or elimination of federal or pass-through support would pose an economic risk to HealthInsight.

Cash and Cash Equivalents
Cash and cash equivalents that potentially subject the Organization to credit risk include deposits in financial institutions that exceeded the U.S. Federal Deposit Insurance Corporation insurance limit by $4,972,194 and $1,907,427 at June 30, 2017 and 2016, respectively.

NOTE 3 - INVESTMENTS

Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, Fair Value Measurements and Disclosures, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 - Inputs to the valuation methodology based on unadjusted quoted prices for identical assets or liabilities in active markets that are accessible.

Level 2 - Inputs to the valuation methodology based on quoted prices for similar instruments and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data.

Level 3 - Inputs to the valuation methodology that are generally unobservable and typically reflect management's estimates of assumptions that market participants would use in pricing the asset or liability.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Assets at Fair Value as of June 30, 2017

	Level 1	Level 2	Level 3	Total
Mutual Funds	$ 3,502,217	$ -	$ -	$ 3,502,217
REITs	-	45,805	-	45,805
Equity Interest in Partnerships	-	-	(1,032)	(1,032)
Ending Balances	$ 3,502,217	$ 45,805	$ (1,032)	$ 3,546,990

Assets at Fair Value as of June 30, 2016

	Level 1	Level 2	Level 3	Total
Mutual Funds	$ 3,170,863	$ -	$ -	$ 3,170,863
REITs	-	75,672	-	75,672
Equity Interest in Partnerships	-	-	(1,032)	(1,032)
Ending Balances	$ 3,170,863	$ 75,672	$ (1,032)	$ 3,245,503

All investment income is reported in the operating section of the statement of activities. Investment fees of $19,693 and $22,407 for the years ended June 30, 2017 and 2016 are netted with investment income respectively. The following schedule summarizes investment return in the statement of activities for the years ended June 30, 2017 and 2016:

	2017	2016
Investment Income	$ 229,354	$ 121,822
Realized Gain (Loss)	(19,888)	82,070
Unrealized Gain (Loss)	111,864	(324,222)
Net Investment Gain (Loss)	$ 321,330	$ (120,330)

NOTE 4 - GOVERNMENT OWNED PROPERTY

Certain contracts require HealthInsight to purchase equipment. The contract revenue includes reimbursement to HealthInsight for the equipment purchases. Equipment purchased in these circumstances remains property of the contracting agency. These purchases are not capitalized and depreciated, but are considered an expense, even though expenditures may exceed the organization's $1,000 capitalization policy. This equipment is reported annually to Medicare through the Standard Data Processing System (SDPS).

NOTE 5 - EMPLOYEE RETIREMENT PLANS

The Organization has a retirement plan that covers all employees who have completed a minimum service requirement. Benefits under the plan are limited to the balance in participants' accounts. The plan combines a defined contribution feature and a 401(k) elective salary deferral feature. All employer contributions are subject to a four-year vesting schedule. Under the 401(k) provision, employees can

contribute up to 100% of their compensation subject to the maximum amounts allowed under federal tax law. The Organization will match 50% of the first 4% of pay that employees contribute to the plan. The Organization will make an additional contribution for each employee who is an active participant on the last day of that period in an amount equal to 7% of the participant's monthly compensation not in excess of 50% of the employee's "Integration Level," plus 10% of such compensation in excess of 50% of the employee's "Integration Level." Integration Level is the Social Security Taxable Wage Base of $118,500 for 2017 and 50% of this number is $59,250. The Organization's contributions to the plan included in expenses were $1,349,579 and $908,620 for the years ended June 30, 2017 and 2016, respectively. These expenses include $143,153 and $210,780 in employer matching contributions for the years ended June 30, 2017 and 2016 respectively. The Organization may make additional optional matching and discretionary contributions, not to exceed federal tax law limitations. For the years ended June 30, 2017 and 2016 the Organization did not make additional optional matching or discretionary contributions.

NOTE 6 – CAPITAL ASSETS

The following table summarizes the changes in Capital Assets for years ended June 30, 2017 and 2016:

	6/30/2016	Additions	Disposals and Adjustments	6/30/2017
Furniture and Equipment	$ 2,146,285	$ 404,265	$ (39,708)	$ 2,510,842
Leasehold Improvements	169,639	12,866	24,367	206,872
Total Capital Assets	2,315,924	417,131	(15,341)	2,717,714
Accumulated Depreciation	(1,733,489)	(436,926)	29,753	(2,140,662)
Net Capital Assets	$ 582,435			$ 577,052

	6/30/2015	Additions	Disposals and Adjustments	6/30/2016
Furniture and Equipment	$ 3,216,136	$ 199,063	$ (1,268,914)	$ 2,146,285
Leasehold Improvements	273,052	9,659	(113,072)	169,639
Total Capital Assets	3,489,188	208,722	(1,381,986)	2,315,924
Accumulated Depreciation	(2,851,840)	(262,094)	1,380,445	(1,733,489)
Net Capital Assets	$ 637,348			$ 582,435

NOTE 7 - DESCRIPTION OF OPERATING LEASE ARRANGEMENTS

The organization leases office space in Murray, Utah, Las Vegas, Nevada and Albuquerque, New Mexico under operating lease agreements.

Utah. The Salt Lake City office lease covers the period from February 2012 through July 2018 during which the base rent is $24,147 per month during the first year with the first six months free and escalates 3% each year. The free rental period has been amortized over the life of the contract for rental expense.

Nevada. The Las Vegas office lease amendment covers the period from March 1, 2015 through May 31, 2020 with an option to renew for an additional three years. The monthly base rent of $17,157 shall increase every thirteen months by a fixed amount of 2.5%.

New Mexico. The original lease was extended and amended to extend the contract from January 1, 2016 to January 31, 2020. The monthly base rent $21,569.75 escalates each calendar year according to schedule.

Oregon. The Portland office original lease was extended and amended to extend the contract from August 29, 2014 to May 31, 2019. The monthly base rent $24,084.75 escalates by 3% each September according to schedule.

Minimum lease payments for operating leases are as follows:

Years ending June 30	
2018	$ 1,147,529
2019	827,049
2020	374,718
Total	$ 2,349,296

Total rental expense for all operating leases was $1,139,641 and $742,141 for the years ended June 30, 2017 and 2016, respectively. Rental expense in the statement of activities is shown net of sublease income.

NOTE 8 - LINE OF CREDIT

The Organization has a line of credit. It is a $750,000 revolving line of credit with a bank. The amount that can be borrowed at any given time may be less than $750,000, depending on the accounts receivable balance at the time. The interest rate is equal to the bank's prime rate, with a floor of 5 percent. There was no balance on the line of credit as of June 30, 2017 and 2016.

Subsequent to year end the line of credit was renewed with a maturity date of September 2, 2018. The renewed line of credit carries a limit of $750,000 and an interest rate equal to the bank's prime rate, with a floor of 4 percent. As of December 18, 2017, the line of credit was unused.

SUPPLEMENTAL INFORMATION

Certified Public Accountants and Business Advisors
low income housing, pension plans, business services,
auditing, tax preparation and financial planning

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Trustees of
HealthInsight

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the financial statements of HealthInsight (a nonprofit organization), which comprise the Statements of Financial Position as of June 30, 2017 and 2016, and the related Statements of Activities, and Cash Flows for the years then ended, and the related notes to the financial statements, and have issued our report thereon dated December 18, 2017.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered HealthInsight's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HealthInsight's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether HealthInsight's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

office 801.872.9470 mail PO Box 1516 | Bountiful, Utah 84010
www.b2acpa.com

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the organization's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the organization's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

B2a, CPA

B2a, CPAs
December 18, 2017

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY OMB COMPLIANCE SUPPLEMENT

To the Board of Trustees of
HealthInsight

Report on Compliance for Each Major Federal Program

We have audited HealthInsight's compliance with the types of compliance requirements described in the *OMB Compliance Supplement Compliance Supplement* that could have a direct and material effect on each of HealthInsight's major federal programs for the years ended June 30, 2017 and 2016. HealthInsight's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of HealthInsight's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Compliance Supplement, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Compliance Supplement require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about HealthInsight's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of HealthInsight's compliance.

Opinion on Each Major Federal Program

In our opinion, HealthInsight complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the years ended June 30, 2017 and 2016.

Report on Internal Control Over Compliance

Management of HealthInsight is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered HealthInsight's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on

compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Compliance Supplement, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of HealthInsight's internal control over compliance. A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Purpose of this Report

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of uniform guidance. Accordingly, this report is not suitable for any other purpose.

B2a, CPA

B2a, CPAs
December 18, 2017

HealthInsight
Schedule of Expenditures of Federal Awards
For the Year Ended June 30, 2017

Agency/Program Grant Title	CFDA Number	Amount of Expenditures
U.S. Department of Health and Human Services (HHS)		
ATOP	93.621	$ 931,546
ATOP2	93.622	3,530,572
Strong Start	93.611	90,726
GWEP	93.969	407,648
UHIN Interoperability	93.719	192,582
AHRQ OR	93.226	198,955
PDMP	93.279	253,333
CDC Opioid Use Sep 16	93.136	60,752
DOH - Chronic Disease Prevention	93.241	124,375
UNM EvidenceNOW	93.226	209,376
Total Expenditures of Federal Awards		$ 5,999,865

Financial Statements

Type of Auditors' report issued:	Unmodified	
Internal control over financial reporting:		
• Material weakness(es) identified?	_____ Yes	___X___ No
• Significant deficiency(ies) identified that are not considered to be material weaknesses?	_____ Yes	___X___ None reported
Non compliance material to financial statements noted?	_____ Yes	___X___ No

Federal Awards

Internal control over major programs:		
• Material weakness(es) identified?	_____ Yes	___X___ No
• Significant deficiency(ies) identified that are not considered to be material weaknesses?	_____ Yes	___X___ None reported

Type of Auditors' report issued on compliance for major programs: Unmodified

Any audit findings disclosed that are required to be reported in accordance with the Compliance Supplement?	_____ Yes	___X___No

Identification of major programs

CFDA Number(s)	Name of Federal Program or Cluster
93.621	ACA Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
93.779	Medicare Quality Improvement Organization

Dollar threshold used to distinguish between type A and type B programs:	$ 750,000	
Auditee qualified as low-risk auditee?	___X___ Yes	_____ No

Internal Control Over Financial Reporting

There were no findings to report for the year ended June 30, 2017.

Compliance

There were no findings to report for the year ended June 30, 2017.

Internal Control Over Financial Reporting

There were no findings to report for the year ended **June 30, 2016**.

Compliance

There were no findings to report for the year ended June 30, 2016.

Statement of Financial Position
as of December 31, 2017

ASSETS		Actual Amt
Current Assets		
	Cash & Cash Equivalents	9,345,824
	Accounts Receivable	7,624,014
	Other Current Assets	480,744
		17,450,582
Long-Term Assets		
	Property & Equipment	656,865
	Other Long-Term Assets	125,941
		782,806
Total ASSETS		**18,233,387**

LIABILITIES & OPERATING FUND		
Liabilities		
	Current Liabilities	3,516,946
	Other Current Liabilities	10,173
	Long-Term Liabilities	0
		3,527,119
Net Assets		
	Operating Fund	14,706,268
		14,706,268
Total LIABILITIES & OPERATING FUND		**18,233,387**

Statement of Activities

Company: 1 HealthInsight
Organization: 1 - HealthInsight

For FY 2017 Period 6 Ending 2017-12-31

	YTD Amount
Revenue	
Utah Medicare Revenue	9,599,397
Nevada Medicare Revenue	2,944,429
Other Contract Revenue	7,865,928
Grant Revenue	432,994
Other Revenue	421
Interest & Investment Revenue	95,832
Total Revenue	**20,939,001**
Direct Expenses	
Labor	6,786,102
Fringe Benefits	3,367,064
Rent & Utilities	52,688
Equipment & Maintenance	39,122
Office Expenses	194,381
Consultants	203,611
Travel	309,520
Meetings	10,262
Temporary Help	49,580
Other Direct Costs	949,101
Subcontracts & Passthru	2,398,083
Total Direct Expenses	**14,359,514**
Indirect Expenses	
Indirect Costs	4,629,126
Total Indirect Expenses	**4,629,126**

Direct Expenses	
Unallowable	137,442
Total Direct Expenses	**137,442**

Non-Operating Items	
Gain (Loss) on Sale of Assets	600
Unreal. Gain (Loss) on Invest	153,571
Total Non-Operating Items	**154,171**
CHANGE IN NET ASSETS	**1,967,089**

Executive Summary

DataStat specializes in survey data collection services and advanced reporting, specifically in support of health services research and public policy research. No other survey organization in the country exceeds our combined level of quality and efficiency in this area.

DataStat Overview

- Founded by professional researchers from the Institute for Social Research and the School of Public Health at the University of Michigan
- Specialists in health services research and public policy research
- 29+ years' experience in complex and large scale survey research
- Managed by original founders who direct research projects on a day-to-day basis
- 100+ highly-qualified professional staff
- Extensive in-house automated mailing, CATI, web, and IVR facilities

CAHPS®[1]-specific Experience

- Primary contributor to CAHPS Consortium pilots and development
- Conducted more complex CAHPS projects than any other vendor, from stand alone to state-wide
- Certified by NCQA for 10+ years for health plan CAHPS (500 samples), and for PCMH CAHPS
- Certified by CMS for MA&PDP CAHPS, ACO CAHPS, QHP and MIPS CAHPS surveys
- Consistently achieve optimal response rates and superior levels of data quality
- 16+ years' experience in AHRQ CAHPS Benchmark Database and NCQA reporting requirements

Other Experience

- Routinely conduct projects from 900 to 200,000 respondents
- Production and project management systems in place to manage work of all magnitudes
- Clients include the original Picker Institute, Harvard Medical School, RAND, the Centers for Disease Control and Prevention, NIH, the Department of Defense, and NCQA/CMS
- Certified by NCQA for 200 HOS (Health Outcomes Survey) samples
- Only vendor certified by NCQA to conduct the HOS-M project on behalf of Medicare PACE organizations

Standards of Quality Assurance – The DataStat Advantage

- Full academic rigor applied to all sampling tasks, from intake through final sample selection
- All mail materials produced by our in-house commercial printing plant
- Laser printing systems able to produce 400 fully customized pages per minute
- Automated insertion process producing customized mail packets with 100% video scan matching
- Proprietary CATI software: developed in-house; most advanced system in use today
- 100-station CATI facility in-house; full-time Spanish-speaking interviewers on staff
- Full-time interviewers with thorough research training and native Spanish-speaking capabilities
- Extensive interviewer assessment based on professional conduct, never on raw productivity
- Full audio and video ongoing monitoring of all professional interviewing staff
- In-house CATI facility with supervisory ratios of 3:1; in-house web and IVR systems
- Proprietary response rate booster: designed and programmed in-house, using a neural network rulebase call patterning to reach hard-to-contact respondents

[1] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Overview

DataStat specializes in survey data collection services and advanced reporting in support of health services research and public policy research. We serve a wide range of clients, including state governments, federal agencies, foundations, academic institutions, health plans—large and small, and quality improvement organizations (QIOs), with whom we have partnered to provide both general and highly specialized survey research services. Some projects require the large volume efficiencies offered by our in-house systems and technologies. In other cases, our client is interested in a close working relationship for case-by-case management in project design and development. We serve all of these situations, and provide our clients excellence in value and dependability as we consistently meet the unique and changing needs of a single project, or flow of projects, throughout the term of our working relationship.

We began over 25 years ago as a computer assisted telephone interview (CATI) facility, and in that role developed highly sophisticated sample management and data collection processes. As other methods of data collection have emerged over the years, we have integrated them into new protocols, to become part of our survey management system. We recognize that the attainment of completed surveys, by mail and telephone, has become more challenging due to computer technology, cell phones and answering machine devices. We keep pace with these changes by continually adapting our protocols, to consistently obtain the highest response rates in the country. We offer data collection by mail only, mail with telephone follow-up, telephone only, mail plus web-based survey response option, web-based surveys only, and other combinations specific to project needs.

DataStat is composed of over 100 professional staff who are responsible for project management, technical implementation, quality assurance, data collection, and client liaison. In order to maintain complete quality control from start to finish, professional staff and all survey facilities are housed under one roof: full mailed-survey capabilities for printing, assembly, and automated insertion within our headquarters building; our 100-station CATI facility; and our web survey facility, which runs from secure servers within our building.

A key element of many survey projects is optimal efficiency in connecting with sometimes hard-to-reach groups of people, such as Medicaid or transient populations, while producing a very high quality dataset that is representative of the population and their experiences in getting health care. Before the field period even begins, we give special attention to sample construction to ensure that respondent contact information is accurate and up to date. All materials in mail phases are customized to the respondent level and, for projects with a telephone component, we implement a refined CATI follow-up protocol to reach non-respondents. This is where our CATI experience is most valuable. Because of our data collection expertise and experience, the outcome is not only a high response rate, but results that can be used and presented with confidence.

DataStat: Experience and Performance

DataStat has a long history and solid record of results as a top-tier survey research organization, conducting health care, academic, pharmaceutical, and other types of survey research projects. Our clients include institutions such as Harvard Medical School, the Centers for Disease Control and Prevention, the RAND Corporation, the MacArthur Foundation, the National Institute of Mental Health, NCQA, the Centers for Medicaid and Medicare (CMS), and the Department of Defense, in addition to many state agencies and health plans. Our client list represents the leading organizations in health services research, and the projects we work on frequently receive national attention.

Projects we have conducted over the years vary widely in size and scope: from a single academic organization, for example, field testing a single instrument among several hundred selected respondents using a uni-modal protocol, to hundreds of health care organizations and hundreds of thousands of respondents, state- or nation-wide, using a multi-modal protocol and requiring a multitude of aggregate or individualized custom graphical reports. Typically, we work with the quality improvement or health care improvement staff within a health care organization, who then disseminate survey results to other key personnel, such as board members or directors, within their organization as well as to key stakeholders in their larger health care community.

DataStat plays a major role as well in CAHPS and HEDIS research projects, dating back to the beginning of CAHPS when we partnered with the Picker Institute in the early testing and development of these instruments. We continue to participate in CAHPS development efforts and annually conduct many CAHPS, HEDIS, as well as HOS and other studies and surveys on behalf of our health plan clients, CMS, and state Medicaid partners.

Our expertise with CAHPS surveys comes from years of partnering with designers of CAHPS tools and protocols, ranging from the development of tools for non-English languages, to field testing new materials and protocols, such as the health literacy module designed for use in health plan, hospital, and provider settings.

DataStat is authorized by NCQA to process 500 CAHPS samples and 200 HOS samples per year. We conduct CAHPS, HEDIS, and HOS survey projects for hundreds of clients each year. Over time, we have increasingly specialized in large-scale state-level projects, such as CAHPS surveys for Utah, New York, Ohio, Minnesota, Washington State, Hawaii, and California. Sample sizes for these projects range from 50,000 or so, to well over 100,000, which means that we handle sample frames that are several orders of magnitude larger. Most of these projects run concurrently, with all materials and data collection tools produced and managed in-house.

Summaries of key projects are described below.

- ***Tri-State Children's Health Improvement Collaborative (T-CHIC)*.** In 2012-13, DataStat was chosen to conduct the Clinician and Group with Patient-Centered Medical Home (PCMH) Items CAHPS Survey for this demonstration project, incorporating practice sites in Oregon, West Virginia, and Alaska. The Oregon Health Authority provided coordination for the project and T-CHIC practices, and structured the project such that practices in Oregon outside the scope of the grant were able to join the project, field their samples alongside T-CHIC sites, and have the opportunity to participate in NCQA's PCMH Recognition Program. Quality Corporation, a not-for-profit group working to improve health care quality in Oregon, worked with DataStat to coordinate efforts with non-T-CHIC sites. DataStat worked directly with all practice sites to obtain sample frame data files. A total of 21 T-CHIC and 23 non-T-CHIC practice sites (N=27,000, approximately) participated in

the survey, which used the adult and child versions of the PCMH CAHPS instrument, with some custom items. A two-wave mail only protocol was implemented in English and Spanish; a telephone follow-up was added for sites in Alaska, given the limits of mail delivery in remote areas there. About half of the sites elected to submit data to NCQA.

- ***The California Managed Risk Medical Insurance Board.*** **Children's Health Insurance CAHPS Member Satisfaction Survey.** From 2000 through 2013, when California reorganized its administration of public health care programs, DataStat conducted an evaluation of member services provided by 27 California health plans under the California Healthy Families program, which was federally funded under the SCHIP program. Approximately 25,000 respondents were involved. The project was conducted in five languages with complex ethnic oversampling. We did extensive consumer report design work for this project, including focus groups of likely consumers, and prepared final reports in the 11 official languages supported by MRMIB.

- ***State of Oregon – Oregon Medical Assistance Program.*** Since 2001, DataStat has been chosen to implement the CAHPS surveys for the State of Oregon Medicaid, Fee-for-Service, and low-income medical assistance programs. Using an enhanced approach to recommendations by NCQA and the CAHPS Consortium, we use a multi-wave mail plus telephone follow-up mixed methodology to collect the experiences of these beneficiaries.

- ***State of Utah – DHS Office of Healthcare Statistics.*** DataStat has worked with the State of Utah since the early 1990's surveying the adult and child Medicaid populations. Utah was one of the very early adopters of the CAHPS survey, and began using it in telephone surveys in 1995. DataStat has enjoyed a long and successful relationship with OHCS and the Medicaid plans in Utah.

- ***New York State Department of Health (NYSDOH) – CAHPS Adult Medicaid Survey Project.*** Since 2009, DataStat has been awarded the contract for conducting the CAHPS Adult Medicaid survey project for the NYSDOH. For each survey administration, about 35,000 enrollees are sampled across 15-20 managed care organizations. The project uses the current year CAHPS adult Medicaid survey instrument, with additional custom items, for approximately 64 total questions. We implement a mixed-mode protocol consisting of four mailing waves and a telephone follow-up; some years have included a $5 check incentive mailed to respondents who completed a survey. Project data are reported to the National CAHPS Benchmarking Database.

- ***New York State Department of Health – Adult and Child PCMH CAHPS Survey Project.*** DataStat was selected to conduct the Clinician and Group with PCMH CAHPS Survey for the NYSDOH. The 2013 project was a pilot consisted of adult and child samples (N=6,000) drawn from PCMH and non-PCMH practices, and used a mixed-mode (3 wave mail plus phone) data collection in English and Spanish. Analysis compared experience of care in PCMH and non-PCMH practices.

  In 2015, Data was selected to conduct 5 consecutive years of data collection in conjunction with Public Consulting Group and focused on the Delivery System Reform Incentive Payment Program (DSRIP). The DSRIP survey project surveys the adult populations enrolled in 25 NYSDOH Preferred Provider Systems (PPS); N=37,500. The DSRIP project uses the 2015 C&G CAHPS survey instrument, with some modifications, for approximately 47 total questions, and a mixed mode (mail and telephone) survey protocol in English and pre-identified Spanish. Custom state and PPS-level reports were developed and delivered along with the dataset.

HEALTHINSIGHT ASSURE
Experts in Quality Review

February 20, 2018

Ronda Miller, Purchasing Officer II
State of Nevada, Purchasing Division
515 E. Musser Street, Suite 300
Carson City, Nevada 89701

RE: HealthInsight Assure Request for 5% Preference
Request for Proposal 3491 External Quality Review Organization

Dear Ms. Miller:

HealthInsight Assure, LLC (Assure) a division of HealthInsight Management Corporation (HealthInsight), has submitted a response to the Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP) Request for Proposal (RFP) number 3491 to provide external quality review services for the State of Nevada.

HealthInsight's Nevada affiliate, HealthInsight Nevada, has provided services to DHCFP and other state divisions since 1988, beginning with 15 years of service as a Medicaid Utilization Review contractor. HealthInsight has had a very long and rich history working in and with the State of Nevada as the CMS Quality Innovation Network-Quality Improvement Organization (QIO).

Since we conduct EQRO work in multiple states, HealthInsight Assure was incorporated in Utah and registered with the State of Nevada as a foreign corporation. As a significant portion of the work for Nevada will be produced by staff living and working in Nevada and staff from our other nearby offices will often travel to Nevada to execute the onsite portions of their work, we are requesting the 5% preference referenced in the RFP in Section 9.2 on page 28, as follows:

> *Effective July 1, 2017, a five percent (5%) preference will be awarded to businesses based in Nevada. A Nevada business is defined as a business which certifies either that its 'principal place of business' is in Nevada, as identified in Section 3.1, Vendor Information or that a 'majority of goods provided for the contract are produced in Nevada.' The preference will be applied to the total score.*
>
> *9.2.1 Financial stability shall be scored on a pass/fail basis.*

Five individuals will be working out of HealthInsight Nevada's existing Las Vegas office or telecommuting from their homes in northern Nevada. We have listed those employees and their roles below. We estimate that their efforts, and the local support provided by our Nevada facilities (information technology, office space and supplies, etc.) and EQRO work performed in Nevada by other staff will encompass more than 50% of the work required for this contract.

- **Project Manager**- a Key Personnel who will be responsible for managing the timeline, tasks and deliverables for the contract
- **Nurse Reviewer**- a Key Personnel who will work on compliance review activities as well as other areas where an RN is preferred
- **Medical Director**- available when needed for consultation
- **Project Coordinator**- providing coordination and assistance to the team
- **Project Assistant**- providing support to the team

I, Sharon Donnelly, HealthInsight Assure Board Chair, certify that the DHCFP RFP 3491 for External Quality Review, if awarded to HealthInsight Assure, will result in a contract where the majority of goods for the contract are produced in Nevada.

We thank you for this opportunity and look forward to providing DHCFP with Nevada External Quality Review services. Please feel free to contact me if you have any questions. I am available at your convenience by email at SDonnelly@healthinsight.org or by phone at (801) 892-6668.

Sincerely,

Sharon Donnelly, MS
Senior Vice President, Development
HealthInsight Assure Board Chair

HealthInsight Assure • 6830 W. Oquendo Road, Suite 102 • Las Vegas, NV 89118
Phone: 702-385-9933 • Fax: 702-385-4586 • **www.healthinsight.org**

Corporate Summary

HealthInsight

HealthInsight is a private, nonprofit, community-based organization dedicated to improving health and health care, composed of locally governed organizations in four western states: Nevada, New Mexico, Oregon and Utah. HealthInsight also has operations in Seattle, Washington, and Glendale, California, supporting End-Stage Renal Disease Networks in the Western United States. As such, it is able to draw upon the unique social and cultural elements of each region, as well as quality improvement expertise that has been developed over four decades.

The HealthInsight enterprise holds contracts and grants in key areas of health care improvement:

Medicare/Medicaid

- Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) – Nevada, New Mexico, Oregon and Utah
- Partnership to Advance Tribal Health (PATH) – New Mexico, Arizona and nationally
- Hospital Improvement Innovation Network (HIIN) – Nevada, New Mexico, Oregon and Utah
- HealthInsight End Stage Renal Disease (ESRD) Alliance – Western United States
- Centers for Medicare & Medicaid Innovation (CMMI) Admissions and Transitions Optimization Program (post-acute payment redesign) – Nevada and Colorado
- Project ECHO Patient Flow – Nevada, New Mexico, Oregon and Utah
- Strong Start – Nevada
- Medicaid External Quality Review Organization (EQRO) – New Mexico and Oregon
- Qualified Entity (QE) – New Mexico and Utah

Health Information Technology/Health Information Exchange (HIT/HIE)

- Community Health Information Exchange (HealtHIE Nevada and cHIE) – Nevada and Utah

Learning Systems Support, Knowledge Management and Technical Assistance

- CMMI Heath Care Innovations Award Rounds One and Two – National
- CMMI Integrated Learning Systems – National
- Quality Innovation Network-Strategic Innovation Engine – National

Patient and Family Engagement

- End of Life/POLST – Utah
- UtahHealthScape – Utah

Patient Safety

- Prescription Drug Monitoring Programs Research – Oregon

Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO)

HealthInsight is leading health care quality improvement activities for the Medicare Program as the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for a four-state region serving Nevada, New Mexico, Oregon and Utah. The five-year contract awarded by the Centers for Medicare & Medicaid Services (CMS) runs from July 2014 to July 2019.

HealthInsight has held federal contracts to support Medicare quality improvement activities continuously in Utah since 1984 and in Nevada since 1988. The New Mexico Medical Review Association continuously held the Medicare Quality Improvement Organization (QIO) contract for its state since 1984 and affiliated with HealthInsight in 2012. Acumentra Health also conducted Oregon's Medicare QIO activity since 1984 and joined HealthInsight as a

subcontractor under the QIN-QIO structure in 2014. In March 2016, Acumentra Health entered into a formal affiliation with HealthInsight.

As the QIN-QIO, HealthInsight works with providers and the community on multiple, data-driven quality initiatives to improve patient safety, reduce harm, engage patients and families, and improve clinical care locally and across our region. The QIN-QIO work includes assisting outpatient clinicians to keep pace with the rapid changes of the health care system, employing lean methodology, assisting with quality reporting and incentive programs and developing innovative approaches to quality improvement.

Partnership to Advance Tribal Health (PATH)

CMS selected HealthInsight to become the QIN-QIO dedicated to understanding and supporting quality improvement efforts within the Indian Health Service (IHS) hospital system. IHS hospitals serve American Indian and Alaska Native people, and HealthInsight supports their leadership, providers and staff in providing high quality care for the people they serve. To best support the hospitals, HealthInsight partnered with organizations in Montana, Minnesota, North Dakota, South Dakota and Oklahoma. HealthInsight will serve hospitals in New Mexico and Arizona. Additionally, an American Indian owned small business will provide advice to strengthen patient, family and tribal government engagement. HealthInsight and its partners are working collaboratively with IHS to provide quality improvement training, spread best practices and ensure clinical, operational and safety standards are met or exceeded in order to improve health for American Indian and Alaska Native people.

Hospital Improvement Innovation Network (HIIN)

The Hospital Improvement Innovation Network (HIIN) contracts awarded by CMS will build on the momentum of the CMS-funded Hospital Engagement Networks and Quality Improvement Organizations to further reduce patient harm and readmissions. This initiative is part of a broader effort to transform our health care system into one that works better for the American people and for the Medicare program.

Through 2019, the Hospital Improvement Innovation Networks will work to achieve a 20 percent decrease in overall patient harm and a 12 percent reduction in 30-day hospital readmissions as a population-based measure (readmissions per 1,000 people) from the 2014 baseline. Addressing health equity for Medicare beneficiaries and incorporating person and family engagement in health care will be central to these efforts.

HealthInsight End Stage Renal Disease (ESRD) Alliance

The HealthInsight ESRD Alliance was formed in 2015 to bring together the strengths of all partners to further integrate quality efforts across the care continuum for patients at risk for kidney disease, those with chronic kidney disease, and those on dialysis or receiving kidney transplant care.

The HealthInsight ESRD Alliance is composed of HealthInsight, the Northwest Renal Network 16 (serving Alaska, Idaho, Montana, Oregon and Washington, Hawaii and Pacific Islands) and Network 18 (serving Southern California), along with stakeholders in both regions. The alliance brings together the strengths of all partners to ensure broader impact and the best quality health care for ESRD beneficiaries. The alliance serves more than 55,000 patients with ESRD in 569 dialysis facilities.

Admissions and Transitions Optimization Program (ATOP)

HealthInsight Nevada was one of seven organizations across the nation selected by the Centers for Medicare & Medicaid Innovation (CMMI) to lead the charge in reducing avoidable hospitalizations among nursing facility residents in 2012.

The statewide initiative, called the Admissions and Transitions Optimization Program (ATOP), aimed to preserve the quality of life for residents in their homes by supporting nursing facility staff members, who help identify, communicate and respond to subtle changes in residents' conditions, which ultimately reduce unnecessary hospital admissions.

In 2016, HealthInsight Nevada was selected to carry on stage 2 of this work with an added payment reform component. In this model, nursing facilities that provide a higher level of care for specific conditions will be paid at a higher level. Practitioners will also see a change in compensation. In a strategy to equalize pay between sites of care, physicians will receive the same amount for treating the patient within a skilled nursing facility as he or she would in a hospital. ATOP will continue implementing clinical interventions in Nevada facilities and add the payment reform piece to the work. To measure effectiveness, ATOP will also work with nursing facilities in Colorado to test the payment-only component of the intervention.

Strong Start

Strong Start is an initiative to support pregnant women within the Nevada Medicaid program with the goal of reducing pre-term births and low-birth-weight babies. The program focuses on women with high-risk behaviors, such as alcohol, tobacco and drug use, as well as those with high-risk health conditions.

Strong Start promotes its goals by teaching healthy behaviors, decisions and experiences using the Group Prenatal Care model. This model begins with routine health assessments, which include a prenatal check by a clinical professional and instruction for patient self-care.

Medicaid External Quality Review Organization (EQRO)

HealthInsight's New Mexico and Oregon affiliates have served as the Medicaid EQRO for their respective states since 2005, under contract with the state Medicaid agencies. In New Mexico, HealthInsight provides quality oversight for all Medicaid managed care physical health, behavioral health and long-term care contracts. This work includes assessing contract performance against applicable state and federal standards and policy, measuring actual performance using approved methodology and performing other audits as requested. The Oregon EQRO performs similar quality oversight of 16 coordinated care organizations formed as part of Oregon's Medicaid transformation model. Oregon work also includes conducting major annual surveys of mental health service consumers on behalf of the Medicaid agency, and performing on-site quality and utilization review of inpatient and residential mental health treatment for Medicaid recipients under 21 years of age or 65 and older.

In April 2017, HealthInsight formed a separate corporate entity, HealthInsight Assure, LLC, to provide independent direction and governance of the company's EQRO contracts and related quality assurance lines of business.

Qualified Entity (QE)

HealthInsight is certified as a Qualified Entity (QE) by CMS under its Qualified Entity Certification Program, developed to implement Section 10332 of the Affordable Care Act. This status, active for three years, certifies HealthInsight as qualified to access and handle certain Medicare claims data and protect patient privacy during the process. Qualified entities are able to combine Medicare and private insurance data to create comprehensive, useful reports on provider performance, intended to help consumers get more information regarding their local doctors, hospitals and other health care providers. HealthInsight is also currently preparing to publicly report Medicare and commercial data in Utah, in partnership with the Utah All-payer Claims Database.

Community Health Information Exchange (HealtHIE Nevada and cHIE)

In Nevada, HealthInsight has collaborated with statewide stakeholders to launch a private, nonprofit, community-based health information exchange, known as HealtHIE Nevada (HIE). Launched in 2011, HealtHIE Nevada lets doctors offices, hospitals, clinics, labs, pharmacies and other health care professionals access and share patient medical records quickly, securely and accurately at the point of care. This exchange improves timeliness, quality and coordination, and eliminates the need for costly and duplicative testing. By working together toward a more unified system for managing care, medical professionals can focus more time and energy on patients instead of paperwork. The management of HealtHIE Nevada and its services are performed by HealthInsight Nevada.

In Utah, HealthInsight was a founding member of the Utah Health Information Network (UHIN) administrative data exchange, which has been active for more than a decade. UHIN's clinical HIE (cHIE) is online and clinical data currently is being exchanged. HealthInsight staff contributed in many areas of development, including vendor selection, governance design, communication strategy, provider engagement, evaluation design and the resolution of political issues. Marc Bennett, president and CEO of HealthInsight, is the present chairman of the UHIN board.

CMMI Health Care Innovation Award Round One & Two, Integrated Learning Systems, Quality Innovation Network-Strategic Innovation Engine

Since 2012, HealthInsight has provided learning system development, training and technical assistance support to national health care innovation programs. Support includes environmental scans, lessons learned synthesis, knowledge product development, collaborative learning facilitation and direct technical assistance to innovations projects. Support customers include the full health care-to-community continuum. Support targets range from strategic design, applications of emerging science, operations and challenges common to innovations initiatives, sustainability and payment model design.

Project ECHO Patient Flow

Catalyzing Complex Systems Change by Optimizing Patient Flow with the ECHO Model™ is a Centers for Medicare & Medicaid Services (CMS) funded special project. HealthInsight is supporting 50 primary care practices across Nevada, New Mexico, Oregon and Utah in building their capacity to improve their care processes by optimizing patient flows.

While the ECHO model has traditionally been used to increase rural clinicians' ability to care for patients with complex diseases, this initiative will use an ECHO virtual learning community to increase primary care practices' capacity to adapt their internal processes to improve quality and contain cost.

End of Life/POLST

HealthInsight Utah is funded via the Utah Department of Health under the State Innovation Model cooperative agreement from CMMI to focus on multiple aspects of advanced care planning. HealthInsight Utah created an Advanced Care Planning Advisory Group that focuses on empowering patients and their families to engage in meaningful end-of-life conversations with their physicians. The group provides training to providers in facilitating these critical discussions, and enhancing the portability and accessibility of documented preferences (Physician Order for Life Sustaining Treatment, or POLST, and other documents) at the time of need using a secure electronic process. This group has come together to plan Utah's first-ever conference specifically targeting advanced care planning challenges and successes, with hopes of improving awareness and education on end-of-life topics for providers, families and the community.

Prescription Drug Monitoring Programs Research

HealthInsight Oregon plans and manages research projects on behalf of, and in coordination with, research partners in academic, health care and government settings. Current projects include a five-year study, funded by the National Institute on Drug Abuse, to research the effectiveness of Oregon's Prescription Drug Monitoring Program (PDMP) as a clinical decision tool for providers; a collaboration with Oregon State University in a three-year research grant from the Agency for Healthcare Research and Quality to develop a PDMP toolkit for pharmacists; and research on prescription opioid topics funded by the Centers for Disease Control and Prevention, the U.S. Bureau of Justice Assistance and the Pew Charitable Trusts.

UtahHealthScape

After working with community stakeholders for more than three years, in 2011, HealthInsight launched www.utahhealthscape.org, a comprehensive health care quality data-reporting website for providers, health plans and the public, representing a significant step forward in health care transparency. The site provides consumers with a directory of Utah providers, listing their characteristics and service offerings, quality of care data and patient experience/satisfaction survey results for health plans, hospitals, nursing homes and home health agencies. The site is available in English and Spanish.

Key Partnerships

HealthInsight is a key partner in the following areas:

- New Mexico Coalition for Healthcare Value – *New Mexico*
- Network for Regional Healthcare Improvement Collaborative (NRHI) – *Nevada, New Mexico and Utah*
- The Nevada and Utah Partnerships for Value-Driven Health Care (NPV, UPV) – *Nevada and Utah*

New Mexico Coalition for Healthcare Value

HealthInsight New Mexico is a founding member and a strong supporter of the New Mexico Coalition for Healthcare Value, a not-for-profit organization that includes private and public employers, health care providers and insurers. The coalition was formed as a result of the momentum generated by the Robert Wood Johnson Foundation's *Aligning Force for Quality* (AF4Q) grant that had been operating in New Mexico under the auspices of HealthInsight. HealthInsight offices are home to the coalition, and operations are conducted through an administrative services arrangement. The coalition aims to improve health care value and cost transparency in the state.

Network for Regional Healthcare Improvement Collaborative (NRHI)

Through the work of the Nevada and Utah Partnerships for Value-Driven Health Care and the New Mexico Coalition for Healthcare Value, HealthInsight is designated in each state as a Regional Health Improvement Collaborative (RHIC) and is a member of NRHI. In this role, HealthInsight provides coordinated multistakeholder support in our communities in a neutral forum for health care transformation.

Oregon Health Care Quality Corporation (Q Corp), with whom HealthInsight has announced a formal merger agreement, is also a RHIC and a member of NRHI. For more information, visit www.nrhi.org.

The Nevada and Utah Partnerships for Value-Driven Health Care (NPV and UPV)

HealthInsight is the Agency for Healthcare Research and Quality Chartered Value Exchange (CVE) in Nevada and Utah. The CVE is a multistakeholder collaborative effort that includes health care purchasers, health plans, providers and consumers.

Corporate Summary

HealthInsight

The HealthInsight Value Program is working with a diverse set of community stakeholders to lead, develop and implement appropriate change around the value and transparency of health care. HealthInsight has identified the value proposition as a key strategy to improving the overall health of our communities. The program's key agenda strategies include:

- Aligning health care payment with quality
- Reporting provider performance
- Engaging consumers
- Promoting and advancing health information technology

Convening our Community

At HealthInsight, we understand the complexity of the health care system and the points of leverage for change:

- **Health care providers:** We work intensively with hospitals, physician offices, long-term care and home health providers. As a thought leader and trusted adviser to those actively delivering health care, we engage our community partners in "learning labs" for continuous improvement.
- **Payers, purchasers, policy makers:** We lead our communities in improving our health care system.
- **Public/consumers:** We translate health care data into actionable information that patients and their families can use to navigate the health care system and improve their health.
- **Patients and families:** We are working to bring clinicians and patients together to address the ever-increasing costs and complexities of our health care system. HealthInsight convenes Patient and Family Advisory Councils to bring understanding of the public perspective in order to help improve health outcomes.

Drivers of Change: Improved System Performance Relationships

While HealthInsight's efforts have produced measureable improvements in health care quality, we believe we need a multifaceted approach if we are to move beyond gradual, incremental improvements to produce the major changes needed to achieve better outcomes at reasonable costs.

This figure represents a model developed at HealthInsight to show the interrelated efforts we believe our communities must work on simultaneously in order to create sustainable gains. Our organizational strategy is to organize, expand upon existing efforts, support our partners and reinforce, encourage or otherwise foster initiatives that move these levers.

These levers for change include:

- Sharing clinic data across the continuum of care
- Making optimal use of health information technology to improve and coordinate care
- Promoting transparency of quality and cost data and continuously providing actionable data to front-line workers
- Redesigning work flow and care processes and supporting associated culture change

- Engaging consumers of health care in owning their own care and their own health, enabled with cost and quality data

All of this has to happen in an environment with payment aligned to reward quality and efficiency. No single entity can drive all that change. Effectively engaging as a community, including alignment of government efforts, has to be an overarching key strategy.

Currently many of these efforts are funded from different sources as independent projects. HealthInsight is working to coordinate across these efforts in our communities and obtain funding in the areas not covered. We are working toward building a sustainable, integrated community approach through the many initiatives we take on.

For more information about HealthInsight, visit www.healthinsight.org or follow us on Twitter at @HealthInsight_.

VIII- Glossary of Acronyms

PLACEHOLDER

Term	Definition
ADA	**American Disabilities Act:**
BH	**Behavioral Health:** The service by which behavioral healthcare services are provided and monitored by the State, EQR and the managed care organizations. While administered by the same Medicaid managed care organizations, behavioral health is considered distinct from physical health and long-term support services.
BHSD	**Behavioral Health Services Division:** The division within State government tasked with overseeing the provision of behavioral healthcare services for Medicaid members.
CAHPS	**Consumer Assessment of Healthcare Providers and Systems:**
CAP	**Corrective Action Plan:** A plan that is implemented to correct serious issues that were identified either internally by the managed care organization or by an external review. A managed care organization can implement a corrective action plan internally or may be placed on one by the State if the managed care organization's EQR score falls below a predefined threshold.
CCO	**Coordinated Care Organizations:**
CCP	**Comprehensive Care Plans:** Plans developed by the managed care organizations in collaboration with the member and the member's family to coordinate care for members who have complex medical cases or need additional help managing their healthcare.
Centennial Care	**Centennial Care:** The name given to the Medicaid Managed Care program administered by the State effective January 1, 2014. It replaced the previous system, which included Salud! State Coverage Insurance, coordination of long-term services, and behavioral health, all administered as separate programs.
CFR	**Code of Federal Regulations:** The codification of the general and permanent rules published in the Federal Register by the departments and agencies of the federal government. It is divided into 50 titles. Title 42 deals with Public Health.
CHIP	**Children's Health Insurance Program:**
Citation of Authority	**Citation of Authority:** The official source from which the EQRO developed a question for the MCOs. The citation of authority is generally one of three things: 1) the contract between the MCOs and HSD; 2) the HSD Managed Care Policy Manual; or 3) the federal language found in the CFR.
CLAS	**Culturally and Linguistically Appropriate Services:**
CMO	**Care Management Organization:**
CMS	**Centers for Medicare & Medicaid Services:** A department within the United States Department of Health and Human Services that oversees the implementation of the Medicare and Medicaid programs.

Term	Definition
CY	**Calendar Year:** The period of a year beginning with January 1 and ending with December 31. It is not to be confused with Fiscal Year or Measurement Year as defined elsewhere in this document.
DBA	**Doing Business As:**
DBHR	**Division of Behavior Health and Recovery:**
DHCFP	**Division of Health Care Financing and Policy:**
DHCS	**Department of Health Care Services:**
DHHS	**Nevada Department of Health and Human Services:**
DOH	**Department of Health:**
DSN	**Delivery System Network:**
EDV	**Encounter Data Validation:** This is a type of review where auditors look at medical records and billing to make sure that the billing is appropriate to the services rendered. The term "encounter" refers to an event such as an office visit or procedure that is the subject of the review.
EQR	**External Quality Review:** The analysis and evaluation by an External Quality Review Organization (EQRO) of information on quality, timeliness and access to the healthcare services that an MCO or its contractors furnish to Medicaid members.
EQRO	**External Quality Review Organization**: An organization contracted with the State to conduct reviews of the contracted Medicaid managed care organizations. The External Quality Review Organization also writes reports of findings and recommendations for improvement to the State. The contracted External Quality Review Organization that developed this report is HealthInsight New Mexico.
FH	**Fair Hearing:** The process by which the State hears an appeal by a member. Members submit appeals to the managed care organization.
FY	**Fiscal Year:** The year as defined for accounting purposes. It may or may not be concurrent with the calendar year. As of this writing, the State Fiscal Year is July 1 through June 30. This is not to be confused with Measurement Year or Contract Year, as defined elsewhere in this document.
FWA	**Fraud, Waste and Abuse**: The federal government monitors, investigates and prosecutes cases of fraud, waste, or abuse against the Medicaid program as a function of the Program Integrity program.
HA	**Health Authority:**
HEDIS®	**Healthcare Effectiveness Data and Information Set:** A set of quality metrics developed by the National Committee for Quality Assurance to measure and certify the quality achievements of health plans. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
HHS	**Health and Human Services:** This is the department within the federal government that is responsible for administering the Medicaid and Medicare programs.

Term	Definition
HSD	**State of New Mexico Human Services Department, Medical Assistance Division:** The agency of New Mexico State government responsible for administering a portfolio of programs, including Medicaid.
IDSS	**Interactive Data Submission System:** This is the workbook where MCOs submit their HEDIS rates and data to NCQA for validation and reporting.
IHCPs	**Indian Health Care Providers:**
IRR	**Inter-rater Reliability:** A metric used to determine the extent to which two or more reviewers agree on a scored item. It is an indicator of the consistency of the implementation of a rating system. It is also an indicator of the accuracy and quality of a review or review process.
ISCA	**Information Systems Capabilities Assessment:**
IT	**Information Technology:**
LEP	**Limited English Proficiency:** Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English These individuals may be entitled language assistance with respect to a type or service, benefit, or encounter.
LTSS	**Long-term Services and Supports:** Services provided by the contracted managed care organizations for members who need long-term care. What care is needed is determined through a series of assessments. This care may be provided in a variety of settings.
MCO	**Managed Care Organizations:** Organizations contracted with the State Human Services Department to provide Medicaid managed care services. As of this writing, the four contracted Medicaid managed care organizations are Blue Cross and Blue Shield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Health Plan, Inc. and United Healthcare of New Mexico, Inc.
MCP	**Managed Care Health Plan:**
MHP	**Molina Healthcare of New Mexico:** One of the four Medicaid managed care organizations in New Mexico. This organization was also contracted with the State under the Salud! and State Coverage Insurance programs prior to the implementation of Centennial Care.
MLTSS	**Managed Long-Term Services and Supports:**
MME	**Morphine Milligram Equivalent:**
MMIS	**Medicaid Management Information System:**
MY	**Measurement Yea**r: The year defined as criteria for measurement of a quality indicator or other metric. It may or may not be concurrent with the calendar year. It is not to be confused with Fiscal Year or Calendar Year as defined elsewhere in this document.

Term	Definition
NCQA	**National Committee for Quality Assurance:** An independent nonprofit organization that works to improve health care quality through evidence-based standards, measures, programs and accreditation.
NDPP	**National Diabetes Prevention Program:** The NDPP administered by the Centers for Disease Control and Prevention, is a structured change program for health behavior delivered in community and health care settings by trained community health workers or health professionals. A diabetes prevention program is an evidence-based intervention targeted to individuals with prediabetes, meaning those who have blood sugar that is higher than normal, but not yet in the diabetes range.
NEMT	**Non-Emergency Medical Transportation:**
NF LOC	**Nursing Facility Level of Care:** This refers to the amount of care that a member in a nursing facility requires. There are two care levels: Low and High.
NMAC	**New Mexico Administrative Code:** The official compilation of current rules filed by State agencies.
NOD	**Notice of Direction:** Notices issued by the State to HealthInsight New Mexico, outlining the areas to be reviewed and deliverables to be completed as part of EQR audits and reviews. A separate Notice of Direction is issued for each review or review conducted.
OHA	**Oregon Health Authority:**
PAHP	**Prepaid Ambulatory Health Plan:**
PCP	**Primary Care Physician:** A member's primary physician, who should serve as the member's primary point of contact with the healthcare system. Typically, a PCP is a general practice or family practice doctor or nurse practitioner.
PDF	**Portable Document Format File:** PDF is a file format used to present and exchange documents reliably, independent of software, hardware, or operating system.
PDMP	**Prescription Drug Monitoring Program:**
PDSA	**Plan, Do, Study, Act:**
PH	**Physical Health:** The process by which physical healthcare services are provided and monitored by the State, external quality review and the managed care organizations. While administered by the same Medicaid managed care organizations, physical health is considered distinct from behavioral health and long-term support services.
PHI	**Personal Health Information:**
PHP	**Presbyterian Health Plan, Inc.:** One of the four Medicaid Managed Care Organizations in New Mexico. This organization was also contracted with the State under the Salud! and State Coverage Insurance programs prior to the implementation of Centennial Care.
PII	**Personal Identifiable Information:**

Term	Definition
PIP	**Performance Improvement Project:** A PIP is an official plan that outlines an MCO's method of measuring and improving a quality indicator and tracking that indicator's movement over time. A quality indicator is usually the percent of qualified members who receive a given service, such as a cholesterol screening or dental exam.
PM	**Performance Measures:** The specific representation of a process or outcome that is relevant to the singular assessment of performance; it is quantifiable and can be documented.
PMP	**Performance Measurement Program:** The portfolio of programs and initiatives that an MCO undertakes to measure and improve performance indicators.
PMV	**Performance Measurement Validation:**
PQA	**Pharmacy Quality Alliance:**
QAPI/QAPIS	**Quality Assessment Performance Improvement/Quality Assessment Performance Improvement Strategy:**
QHOC	**Quality Health Oversight Committee:**
QHP	**Qualified Health Plans:**
QIN	**Quality Innovation Network:**
QIO/PRO	**Quality Improvement Organization/Peer Review Organization:**
QM/QI	**Quality Management and Quality Improvement:** The processes and interventions and MCO undertakes to improve processes related to PMs and PIPs.
QRS	**Quality Rating System:**
REDCap	**Research Electronic Data Capture:**
Review Subject / Review Area	**Review Subject/Review Area:** A review subject or review area is a particular area under review, such as program integrity or care coordination.
RESPOND	**Resources Encouraging Safe Prescription Opioid Medication Dispensing:**
RFP	**Request For Proposal:**
RHIT	**Registered Health Information Technology:**
RSN	**Regional Service/Support Network:**
Salud!	**Salud!:** A former Medicaid managed care program implemented by the State. The program ended and was replaced with Centennial Care, effective January 1, 2014.
SBIRT	Screening, Brief Intervention and Referral to Treatment:
SCI	State Coverage Insurance: is a former Medicaid managed care program implemented by the State. The program ended and was replaced with Centennial Care, effective January 1, 2014.

Term	Definition
SHP	**Strategic Healthcare Program:**
SPMI	**Serious and Persistent Mental Illness:**
SWBH	**Southwest Behavioral Health:**
UHC	**United Healthcare of New Mexico, Inc.:** One of the four Medicaid managed care organizations in New Mexico. This organization was also contracted with the State under the Coordination of Long Term Services program prior to the implementation of Centennial Care.
UM	**Utilization Management:** UM is the evaluation of the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the applicable health benefits plan, sometimes called utilization review.
Universe	A universe consists of all the records from an MCO that meet specified criteria. The universe is the dataset from which the analyst pulls the sample. The MCOs use the sample to pull the records for the file review.
Validation	The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.