FamilyCare Transformation Plan
Narrative

As a Managed Care Organization that has been serving Oregon Health Plan (OHP) Members for more than 27 years, FamilyCare already provides the coverage, services and networks essential to being a Coordinated Care Organization (CCO). FamilyCare has provided quality coordinated care in communities across the state, bringing the benefits of preventive medicine to the Medicaid population. We currently serve approximately 55,000 OHP Members and people with Medicare. FamilyCare's mission to create healthy individuals through innovative systems has brought about the development of many programs and strategies that provide the type of coordinated care that the Oregon Health Authority (OHA) seeks to achieve through health transformation.

FamilyCare is the only Managed Care Plan in the tri-county area that currently integrates physical and mental health care. FamilyCare has offered mental health care as part of its coverage since 1997. Early integration of physical and mental health has allowed our providers and staff to better coordinate patients' care in one setting. It has also enabled us to make the connections our Members need to access the right kind of care at the right time and develop operational efficiencies that maximize their benefits. Additionally, our primary care and mental health providers collaborate with our Service Coordinators (navigators) throughout our service area to help often disparate centers of care work together.

FamilyCare was one of the first organizations in the country to create and implement a Service Coordination Department. Our Service Coordination program was created to help our primary care providers manage the often complex needs of the Medicaid population. Our team of nearly 20 Service Coordinators supports providers in navigating the system so they can make patients' care their primary focus. Many of our Service Coordinators are based in clinics so they have close contact with providers, making it possible for them to reinforce care plans by promptly performing active interventions and addressing compliance issues. This results in greater satisfaction and positive outcomes for the provider and their patients, as well as higher quality health care for Members. Service Coordinators work with our Members to navigate the health care and social service system, acting as a hub of information for state agencies, family, and specialty care providers.

FamilyCare has a strong network of contracted providers throughout Oregon, many of whom are already reimbursed using alternative payment methodologies. FamilyCare works with an array of providers and private practices across the continuum of care. Our goal is to make it as easy as possible for our providers to care for our Members. By building strong relationships and establishing consistent communication, we are able to help remove access barriers and empower those we serve to make educated health care decisions. In addition, we are acutely aware of the growing population that will require long-term care and it is our desire to develop a care management structure that coordinates and supports all levels of our Members' care.

Our executive team brings over 100 combined years of experience in many levels of health care delivery, including hospital administration, compliance, clinic management, finance, information technology (IT), dental plan administration and, of course, physical and mental health plan administration. Our IT systems have been enhanced by strategic vendor relationships and new software interfacing. We have re-configured our staffing and management models to accommodate our growth in staff and to better

facilitate operations as a larger company. We continue to develop our infrastructure to provide better service to our Members and providers.

FamilyCare has been fully committed to serving the Medicaid population consistently for 27 years. This commitment continues as FamilyCare seeks to capitalize on our experience as an integrated health plan to achieve health system transformation.

Areas of Transformation

1. **Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This plan must specifically address the needs of individuals with severe and persistent mental illness**

FamilyCare enjoys the benefit of having operated as an integrated physical and mental health plan since 1997. Mental health and addiction services for adults, children and families are provided through an extensive system of care that includes outpatient, intensive outpatient, intensive home-based services, intensive case management, community-based crisis stabilization, respite, supported housing, transitional housing, psychiatric day treatment, psychiatric residential treatment, sub-acute and inpatient psychiatric care. Medical detoxification and medication-assisted treatment for Members struggling with addiction are also available. The vast array of services available for our Members allows them to receive services in a setting that is most conducive to meeting their needs.

Since FamilyCare has been an integrated health plan with both physical and mental health providers, we have years of experience providing a range of coordination intervention. Service Coordinators attempt contact with all Members transitioning care within 1-3 days. The Service Coordinator works with the Member to identify any barriers to successfully carrying out the discharge instructions. The Service Coordinator ensures the Member has the ability to follow-up as prescribed, including understanding when and with whom to follow-up and transportation needs. Partnering with hospital discharge coordinators is key for identifying Members at high-risk for readmission or poor outcomes post discharge. Service Coordinators ensure that appropriate services are in place to assist the Member in making a successful transition.

The Service Coordinator will serve as the communication hub for Members, Member's family, PCP and other specialty and service providers regarding changes in health status, transitions and care plans. FamilyCare will use available data, such as admission reports, claims data, emergency room reports, and communication with AAA/APD offices, specialty providers, hospitals and PCPs to assist Members and coordinate care to improve transitions and maintain the Member in the least restrictive setting. These efforts include, but are not limited to, the identification of planned transitions, unplanned transitions and Members at risk for transition.

FamilyCare currently holds an AMHI contract with OHA to coordinate and manage the care of Members who are transitioning from various stages of the long-term psychiatric care system. We have established an array of community based supports and services to provide for the mental and physical health needs of our Members. A mental health Service Coordinator works with our Members receiving services from extended or long-term psychiatric care programs and is responsible for ensuring that the physical and mental health needs of the Member are attended to. The Service coordinator is actively involved in developing and facilitating a timely discharge plan for each of the Members that ensures that the appropriate services are established for a successful transition to community-based care.

FamilyCare currently contracts with community agencies to divert, triage and manage Members who are experiencing a crisis. These agencies provide 24-hour coverage and emergent crisis services for Members at risk of inpatient care due to a mental health crisis. FamilyCare will continue our collaborative efforts with county and state agencies to engage, assess and effectively treat our Members with mental health needs.

FamilyCare has been building relationships with social and support service agencies for our entire 27-year history. FamilyCare sponsors and supports many community-based social service organizations, such as: Cascade AIDS Project (CAP), National Alliance on Mental Illness (NAMI), Children's Relief Nursery (CRN), Skanner Foundation, Asian Health Foundation, and Central City Concern and various other Federally Qualified Health Centers (FQHCs).

We have established key relationships with all the school districts and the education service districts in the metropolitan area, DHS child welfare, the court system, developmental disabilities, juvenile justice and the Oregon Youth Authority. In coordinating the care for children and their families through the intensive service array, we routinely partner with all the systems, social support networks and peer support organizations providing services to our Members.

FamilyCare ensures comprehensive transitional care by partnering with AAA and APD to promote and monitor improved transitions for Members receiving DHS Medicaid-Funded LTC services and supports. FamilyCare, AAA and APD are integral parts of the Members' care team and will routinely meet to identify ways to improve transitional care and supports for Members by proactively addressing barriers or gaps in services.

Coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation. Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting. We will provide a support structure that holds hospitals and specialty services accountable for achieving successful transitions of care and establish service agreements that include the role of patient-centered primary care homes.

Timely communication between FamilyCare and AAA/APD is critical to the successful coordination of care for Members receiving DHS Medicaid-funded LTC services. FamilyCare will develop strategic agreements and execute MOUs with AAA/APD offices in order to most effectively coordinate care and manage transitions of these Members.

In order to meet the state's expectations and goals for coordination of care for these Members, FamilyCare will deliver Member-centered care in the most appropriate setting that supports the highest level of functioning and independence. Doing so will support our goal of improving the Member's quality of life and reducing avoidable ER use or inpatient hospitalizations.

CCO Plan and Strategies:

Ensuring our primary care providers have the tools to engage Members in achieving a healthy lifestyle is essential to the goals of transformation. The SBIRT program, which is Screening, Brief Intervention and Referral to Treatment, is shown to be an effective tool to address substance abuse in the primary care setting. As part of our transformation plan, FamilyCare will seek to make this training available to all contracted primary care providers.

In addition, as dental care and services are included under the CCO model, FamilyCare will work to collaborate with Dental Care Organizations to develop strategies to integrate dental into Members' care regimen.

Milestones and Benchmarks:

By July 2015, FamilyCare will collect information on 80% of qualifying member's dental care needs. FamilyCare will collaborate with dental provider partners to determine appropriate risk analysis protocols and establish data collection process, by July 2014.

By July 2015, FamilyCare will offer Service Coordination for dental care needs to 80% of qualifying members. FamilyCare will collaborate with dental provider partners to establish appropriate care management process, by July 2014.

FamilyCare will offer SBIRT training to all contracted primary care providers, by December 2013. By July 2015, 50% of contracted primary care providers will be trained in SBIRT.

2. Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).

FamilyCare and our providers are true partners in providing quality health care services to our Members and we are committed to a collaborative relationship that benefits our Members. We are dedicated to supporting the provider community with the information, tools, and resources needed to focus on our Members' care. FamilyCare provides a high-touch, high-tech approach that incorporates face-to-face meetings with Members and providers along with innovative programs and data management to improve the quality of care and achieve the Triple Aim objectives.

Our goal is to create an integrated strategy to support PCPCHs in achieving a patient-centered medical home, improve health outcomes and position PCPCHs for ongoing participation in primary care delivery under health reform. We will achieve this goal through these four approaches:

1. Engaging Members in accessing a patient-centered medical home.
2. Developing state and national level partnerships that provide coordinated training, technical assistance and support for clinic transformation to PCPCHs.
3. Continuing the strategic relationship with the State regarding reimbursement reform that supports the PCPCH model.
4. Exploring opportunities for measuring statewide health outcome improvements and cost effectiveness of the PCPCH model.

The Service Coordinator will serve as the communication hub for the PCPCH and other health and services providers to ensure timely communication for comprehensive care management. FamilyCare has always valued the relationship between the Member and PCP. FamilyCare is experienced in actively collaborating, exchanging information and facilitating and participating in care reviews with PCPs and specialists including mental, behavioral, and dental providers. FamilyCare will use the Interdisciplinary Care Team (ICT) to enable communication from all disciplines and service providers to develop and review plans of care and recommend interventions and strategies to ensure the care the Member receives is comprehensive.

Our Service Coordinators are well versed in the benefits of having primary care clinics that are certified as PCPCHs and will assist providers with certification, if needed. We have created a PCPCH policy and have included information in our provider manual and on our website. Specifically, we plan to provide:

- Monthly meetings for quality and utilization,
- Payment incentives,
- Data profiles,
- Identification of gaps,
- Service coordinators embedded within clinics, and,
- Registry information from our Care Management system on chronic conditions of our Members.

We anticipate the demand for Member enrollment into PCPCHs to be high and therefore plan to assist clinics to become PCPCHs. FamilyCare provides technical and operational support for PCPCHs by conducting baseline assessments for Members with chronic conditions assigned to PCPCHs, and identifies chronic condition prevalence by clinic.

FamilyCare is currently offering differential payments to PCPCH clinic providers for Members with chronic conditions. We are developing payment models that incentivize PCPCHs to provide a higher level of care and to help defray the cost of additional staff necessary to help coordinate that care. We use health information technology to monitor our Members' health as well as our providers' total population health.

CCO Plan and Strategies:

Currently we are contracted with 11 PCPCHs, which represents about 20% of our Membership currently assigned to a PCPCH. We believe this is high given our largely private provider panel and a good indicator of support for this program considering that the state just began to certify clinics last year. We will continue to build on this momentum by supporting workflow processes and providing technical assistance to participating practices to achieve higher tiered status. We will compensate high-performing primary care providers for providing excellent, patient- centered care based on national and statewide standard quality measures. We will continue to educate our providers on the immediate need to maximize their participation in the PCPCH program.

Milestones and Benchmarks:

By July 2015, 50% of FamilyCare members are assigned to a Tier 2 or Tier 3 PCPCH.

FamilyCare will identify barriers to clinics achieving Tier 3 status, by October 2013.

FamilyCare will implement payment models to contracted primary care providers to encourage PCPCH status, by July 2014.

3. Implementing consistent alternative payment methodologies that align payment with health outcomes

FamilyCare has developed payment methodologies and approaches that promote the Triple Aim by allowing providers the time to effectively manage their patients. The foundation of our reimbursement strategy is to provide the best compensation possible for our providers and facilities where care to our Members is delivered. Given our strong belief that Primary Care plays the most important role in our Members' care, we offer PCPs enhanced base rates and bonuses for providing services in a cost-effective manner. We also provide opportunities for providers to participate in a full range of applicable and innovative quality incentives. Examples of these incentives include setting targets for immunization rates, primary care access and health screening such as mammograms and A1c testing for diabetics.

CCO Plan and Strategies:

Future payment strategies may include allowing payment for patient management in a non-traditional setting, such as by e-mail or telephone.

We are also exploring ways to incentivize providers to work together and manage their shared patients. For instance, connecting dentists and hospitals in a program that works with Members who misuse the Emergency Room for non-emergent dental conditions. By ensuring access to primary dental services and redirecting appropriately, better outcomes for the Member are achieved, as well as significant savings.

Payments for PCPCH clinics are differential based on tier achieved, which incentivizes clinics to be certified at the highest level. Using outcome based measurements to determine provider payments will also allow providers to benefit from a healthier patient population, which is the essence of transformation.

Milestones and Benchmarks:

By July 2015, FamilyCare will offer alternative payment methods to contracted providers other than primary care providers, which include financial incentives for meeting certain outcome measures.

FamilyCare will review and assess provider contracts to determine if alternative payment methods are appropriate for that provider type, by October 2013.

FamilyCare will survey providers to determine the level of interest from providers in accepting alternative payment methods, by December 2013.

FamilyCare will develop a policy to consistently apply alternative payment methods to various contracted providers, by July 2014.

4. Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with 2012 Oregon Laws, Chapter 8 (Enrolled SB 1580), Section 13.

FamilyCare was founded with the purpose of promoting and encouraging the improvement of health care and personal health education in the community. We have offered and will continue to offer opportunities for providers, our Members and the public to learn about health care transformation, the Triple Aim and CCOs. In January 2012, we hosted an education session in Portland that explained how health care transformation would impact providers in the community. Attendees included primary and specialty care providers, county commissioners, local elected officials and state legislators. Dr. Bruce Goldberg spoke at the event and provided a vision of how CCOs will transform health care. Since then, we have hosted meetings with multiple provider and community partners. We intend to continue meeting with them as we work to develop and implement the transformational changes we anticipate as a CCO.

FamilyCare posts information relevant to our Members on our website, including links to OHA's website where they can find official information on CCOs. We will post links to articles and videos related to health transformation and CCOs, including recent televised appearances by FamilyCare leaders. We are also working with the Oregon Division of Medical Assistance Programs (DMAP) to develop materials for our Members to help them during the transition to CCOs.

CCO Plan and Strategies:

FamilyCare anticipates developing a baseline community health assessment by utilizing existing community health assessments published by local hospitals, counties and other service agencies, and partnering with other CCOs.

In addition, FamilyCare anticipates conducting a series of subjective data collection efforts aimed at targeting the Medicaid and low-income population. This effort will be overseen by the Community Advisory Council in order to incorporate consumer input.

Milestones and Benchmarks:

By July 2015, FamilyCare will develop a Community Health Assessment that informs the Community Advisory Council (CAC) in their work to adopt a Community Health Improvement Plan (CHIP).

Work with community partners to gather data, by September 2013.

Review and assess data to develop a Community Health Assessment (CHA), by October 2013.

Present CHA to Community Advisory Council (CAC), by October 2013.

Draft CHIP for CAC review, by October 2013.

CAC adopt CHIP by December 2013.

5. Developing electronic health records; health information exchange; and meaningful use.

Our goal is to act as liaison for our provider network and to provide leadership and coordination in creating a culture for adoption of the vision of sharing health information among providers to improve care and outcomes. To achieve this goal, a strong emphasis on change management and provider network engagement will be essential to ensure that providers support the effort and understand the benefits of using the advanced electronic health record (EHR) components.

FamilyCare assists with the flow of relevant information between all members of the care team to support coordinated care integration. Our Service Coordinators are co-located with some of our primary care providers and are able to convey timely dental, mental and physical health information necessary to coordinate care. We use a variety of health information technology (HIT) resources, from direct access to providers' EMRs to claims management, to link services and care providers across the entire continuum of care. Supporting the free exchange of information between providers will avoid duplication of services, medication errors, and missed opportunities to provide effective preventive and primary care.

FamilyCare is experienced in actively collaborating, exchanging information, and providing care reviews and planning with DHS LTC providers. Communication is coordinated and exchanged by Service Coordinators regular participation in care team meetings with LTC transitions teams. FamilyCare has long-standing collaborative relationships with DHS providers to assist and coordinate care for Members such as those in LTC, those with special needs receiving services for developmental disabilities and mental health concerns, and those in the custody of the Oregon Youth Authority or foster care.

Through implementation of McKesson's CareEnhance® Clinical Management Software (CCMS), FamilyCare will be able to identify high-risk Members through registries in order to collaborate with providers and ensure appropriate care planning and effective evidence-based interventions. Successful disease management relies on identifying the right Members at the right time for the right reasons. CCMS focuses on 22 common or high-cost diseases and conditions, and can be customized to include others. This relevant Member data assists providers in achieving the aims of the PCPCH.

Additional analysis provided by FamilyCare is supported by our MicroStrategies software that allows us to identify key activities designed to help the provider focus on their patients with chronic conditions. This key data, along with analysis and consultation with FamilyCare's Medical Director, allow providers to better manage their patients' care and promote provider and Member engagement.

CCO Plan and Strategies:

We are building on our existing relationships to standardize and more effectively manage the flow of information for all of our Members. We will also provide information to our providers to help encourage the use of electronic health records. We believe the best strategy is a statewide effort to allow all types of electronic formats to work together. We are working closely with the statewide vendor for health IT, OCHIN, to develop such a solution.

Milestones and Benchmarks:

By July 2015, FamilyCare is able to determine a majority of contracted providers use electronic health records and exchange health information electronically.

FamilyCare will assess current provider use of electronic health records and identify barriers to provider use of electronic health records and health information exchange, by December 2013.

FamilyCare will work with OHA to develop a statewide Health IT solution, by July 2014.

6. Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.

FamilyCare has a long history of partnering with families and teams to provide coordinated care for our Members. We are committed to the meaningful engagement of our Members, their families and caregivers and support networks with an emphasis on Member education regarding the importance of engagement and activation to ensure the most successful health outcomes. Members enrolled in FamilyCare will be actively engaged partners in the design and, where appropriate, implementation of their treatment and care plans through ongoing consultation regarding preferences and goals for health maintenance and improvement. Member choices will be reflected in the development of treatment plans and Member dignity will be respected.

FamilyCare strives to engage all Members in establishing health care. We include education in our Member handbook that encourages Member involvement. Members are encouraged to take a lead in and follow their treatment and/or recovery plans. FamilyCare also uses Member feedback from surveys, the grievance process and representation within the Quality Committee structure to plan, design and implement the Quality Improvement Program. Information gathered from these sources assists FamilyCare with identifying areas for improvement.

All FamilyCare Members are given the choice of selecting their Primary Care Provider (PCP). Members are encouraged to contact our multi-lingual and multi-cultural Customer Service Department if they need any assistance or have any questions in choosing a PCP. However, Members are not required to consult FamilyCare before choosing their PCP.

Members who are new to FamilyCare are contacted with a “Welcome to FamilyCare” call. These calls are made by our Customer Service Representatives who are trained in Culturally and Linguistically Appropriate Services (CLAS), as defined by The Office of Minority Health of The U.S. Department of Health & Human Services. This call includes a brief orientation to FamilyCare, which includes physical health, mental health and oral health information. We also offer assistance in choosing a PCP and ask screening questions to determine if the Member currently has any health care needs. Upon selection of a PCP, Members are informed of their dedicated FamilyCare Service Coordinator and are provided with the Service Coordinator’s contact information. Calls are documented in FamilyCare’s Care Management System, where specific health care information or appropriate registries for special needs can be utilized to better assist Members in the coordination of their care.

Our Service Coordinators are trained to work with the PCP to look beyond the illness being treated to include the Member’s family, home and community for factors that might be affecting the Member’s health. The CAC will conduct periodic community assessments to identify and address underlying social determinants impacting health outcomes of our Members, such as socio-economic status, housing, discrimination, physical environment, food security, child development, culture, social support, transportation, working conditions, etc.

FamilyCare’s Interdisciplinary Care Team (ICT) also engages Members with specialized needs in their care and treatment planning. The ICT is a Member-centric integrated Systems of Care approach to treatment and care planning, which ensures a holistic approach to the Member’s care. The ICT develops and reviews plans of care and recommends interventions and strategies to determine best practices ensuring good health outcomes for the Member. Objectives of the ICT include use of a Member-centric approach that empowers and engages the Member in the participation of his or her care plan, ensures integrated care across the health care spectrum, and improves coordination of services especially for Members with special needs and complex health issues. The ICT creates an individualized Member-centric care plan based on the Member’s specific needs determined by the health risk assessment and is revised when there is a change in the Member’s health status. The plan can be reviewed and revised at any time by ICT members, preferably with input from the member.

FamilyCare has a long tradition of reaching out to our Members and the broader community in a culturally and linguistically appropriate way to encourage wellness and prevention. For instance, we organize an annual Health Fair focusing on community health needs, education and wellness with participation from a variety of local sponsors and presenters. We offer immunizations, dental treatments, bicycle safety practices, car seat safety and wellness information. We utilize and support several community-based programs, such as CRN, NAMI and CAP. These local programs offer services intended to address the specific needs of the community.

FamilyCare provides quarterly newsletters to our Members that focus on various topics related to health and wellness. We are aligning our efforts with national health and wellness awareness months to better target our Members. For example, in an effort to fight obesity and type II diabetes, we are using Diabetes Awareness Month to improve nutritional habits by incorporating newsletter topics for Members and providers, while partnering with farmers markets and education groups to promote healthy eating. We also offer an interactive health education library on our website for our Members and providers, which includes health self-assessments. We can customize these resources with local articles, links to other websites, and our own articles on relevant health and wellness topics. Tobacco cessation programs remain a high priority for the Medicaid population and we continue to develop communication strategies that reach all of our Members, especially adolescents and teens.

All written communication to the Member uses plain language, written at a sixth grade reading level and offered in the prevalent languages of the Member population. Our new Member orientation materials currently include a provider directory, general information about FamilyCare, and Member's rights and responsibilities. We include specific information on how to navigate the transformed health care system and encourage the Member to connect with their dedicated Service Coordinator at FamilyCare. The Service Coordinator can appropriately link the member to, and work as an extension of, the Primary Care Home and offer any clarification and assistance in navigating the new CCO landscape.

FamilyCare has developed a comprehensive, coordinated, community-based service delivery system that offers effective services that are matched to the individualized needs of the Member or family. The service array reflects the cultural, linguistic and social diversity of the Members we serve. The providers selected for our network must align with the values of FamilyCare that emphasize holistic person- centered, individualized, strengths-based recovery oriented, culturally competent care that is accessible, collaborative, cost efficient care and community-based. Many of our contracted providers offer culturally appropriate peer support in addition to relevant treatment modalities.

One of our network chemical dependency providers offers cultural and linguistically appropriate care to our Native American Membership. The Member can elect to receive treatment that is specific to their culture. For example, they offer recovery programs such as the Red Road to Recovery and the White Buffalo Society, which incorporate ancient spiritual traditions with modern medical approaches to substance abuse recovery. They offer to connect the Member with tribal elders for sweat lodges, beading, and other ceremonial practices as a part of their chemical dependency treatment.

Another provider offers treatment with a focus on Hispanic traditions, which offer greater family involvement. They also recognize that connection to specific religious institutions is important for some of our Hispanic Membership seeking chemical dependency treatment.

CCO Plan and Strategies:

FamilyCare will continue to develop and build upon our existing provider networks as we expand our Membership and better understand their cultural and linguistic needs. FamilyCare is committed to continuous learning, exploration, and education of the provider network and all care teams to ensure the diverse needs of our Membership are met.

Member engagement will continue to be a major focus of our attention. The Care Management Team is implementing a new care management system and is trained in Motivational Interviewing to improve Member commitment. For example, we will explore creative ways to reach our urban population, which tends to be more transient, by obtaining multiple contact information, texting, secure e-mail and other internet and social media outlets.

Milestones and Benchmarks:

By July 2015, Members will have access to a variety of culturally-specific materials, such as the handbook, welcome letter and wellness materials, electronically on FamilyCare's ADA compliant website.

FamilyCare will assess the Medicaid portion of its website to determine compliance with ADA requirements, by December 2013.

FamilyCare will conduct member survey and review CHA to identify potential gaps in language or culturally-specific delivery of materials, by July 2014.

7. Assuring provider network and staff ability to meet cultural diverse needs of community (cultural competence training, provider composition reflects Member diversity, nontraditional health care workers composition reflects Member diversity).

We understand that our current and new providers in our network will require additional attention to support them in understanding the new CCO process.

Through trainings, newsletters and our website, providers have access to the tools necessary to communicate with Members and their families in a linguistically and culturally appropriate fashion. We contract with interpreters, who are committed to providing high-quality on-site and telephonic interpretation in any language as a means of bridging the language barrier between our providers and all Members for whom English is not their primary language.

A PCP's culture and language skills are considered in Member assignment. The Member's PCP will conduct an initial health evaluation in a culturally and linguistically appropriate manner using interpreter services during the visit, if needed. The Service Coordination Team conducts a Health Risk Assessment (HRA) using interpreter services, TTY line or braille when needed to ensure the accurate exchange of Health Information. We provide a multi-lingual customer service line. Screening calls, Primary Care evaluations, and HRAs are used to assess appropriate levels of care and to determine if a higher level of care is needed.

FamilyCare will build upon our foundation of evidence-based practices by exploring innovative ways to move beyond the clinic setting in order to expand the use of non-traditional methods to engage Members to be active participants in their health care and health outcomes. FamilyCare has experience in exploring and implementing innovative ways to coordinate care. Our Service Coordination Program was implemented six years ago to coordinate care and services by co-locating Service Coordinators in providers' offices to assist Members with navigating through the health care system. Service Coordinators become part of the care team and encourage the primary relationship between Members and their primary care home. FamilyCare's Service Coordination program is a Member-centric approach for all mental, physical, social, environmental, and behavioral health care needs that are coordinated across the spectrum of care, including preventive, acute, chronic, and end-of-life care.

Service Coordinators facilitate communication across diverse providers and settings, assemble and manage meetings among interdisciplinary teams of practitioners and develop a comprehensive health management plan. Service Coordinators often are the bridge to multiple social service agencies to provide appropriate care for our Members. FamilyCare intends to expand on our Service Coordination Program by using non-traditional health care workers, such as Community Health Workers, Advocates, and Health Coaches. We are also interested in creating opportunities for utilizing peers for physical health support. We recognize that many Members are disenfranchised and do not have access to traditional modes of health care. Providing innovative care and services to Members in our community will help reduce health disparities and achieve healthier outcomes for our Members.

CCO Plan and Strategies:

FamilyCare will create culturally and linguistically appropriate materials to serve as tools to assist providers in educating Members about our Service Coordination program components and the role of our Service Coordinators. We will include contact information for the Member's designated FamilyCare Service Coordinator, philosophy of the Service Coordination program and Member's rights and responsibilities to assure effective communication in all language and formats necessary for our Members to understand. Designated Service Coordinators are an additional resource for educating Members and providers about Service Coordination.

Milestones and Benchmarks:

By July 2015, FamilyCare is able to identify the race and ethnicity of a majority of contracted providers and members, in order to better assist members in finding a provider.

FamilyCare will collect member data on preferred language via survey, by December 2013.

FamilyCare will collect contracted provider data on languages spoken, by December 2013.

FamilyCare will work with OHA to identify barriers to providing race and ethnicity data on member enrollment files, by December 2013.

8. Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

FamilyCare's Board of Directors authorizes FamilyCare's quality measurement and reporting systems. The Board of Directors delegates the oversight of the quality measurement and reporting to the Quality Management Committee (QMC). The QMC evaluates and makes necessary changes to the progress and development of quality program elements, overall quality program strategy, and quality program administration. QMC works with FamilyCare's management team to ensure that provider and consumer input is actively considered in the Compliance and Medical Management program assessment and revisions. The Board of Directors Compliance and Utilization Committee oversee the QMC.

FamilyCare's Quality Management Program (QM) maintains quality improvement projects. The QM goal and purpose is aligned to the FamilyCare mission to create healthy individuals through innovative systems through the ongoing monitoring of utilization management, financial management, quality assessment & improvement, compliance, and education activities that link together insuring efficient and effective utilization of resources and compliance with applicable Federal and State laws, regulations and contracts.

FamilyCare maintains multiple quality improvement projects. Recent and on-going projects include projects focused on diabetes mellitus (DM), breast cancer screening (BCS), congestive heart failure (CHF), and other projects aimed to improve the outcomes and satisfactions of our members. Each project is selected based on 1) identified need from internal data (utilization data, claims data, etc.); 2) identified need based on external data/reporting (HEDIS, CAHPS, or from enrollee grievances for example); 3) regulatory requirements (i.e. 2012 CCIP focus to be based on cardiovascular disease per CMS).

All performance measures are measured using national standards and methodologies, whenever possible. Improvement is determined based on the plan's baseline threshold, unless specified otherwise. QIPs are measured using consistent methodology to insure accurate results and trending.

In order to address health outcome inequities, care coordination and transitions between care settings, Care Coordination/Care Management activities are a collaborative process that promotes quality care and cost effective outcomes that enhance the physical, psychosocial and vocational health of individuals. The care management process uses a continuous cycle of identification, stratification, assessment, planning, implementation, monitoring and evaluation of options and services from multiple sources in accord with the interdisciplinary health care team.

FamilyCare aligns wellness and health improvement efforts with national health awareness activities throughout the year. FamilyCare reaches out to members, providers, and internal staff to improve the health quality of the community through activities including: mailings, telephone contact, community health fairs, FamilyCare's website, and newsletters.

The QMC is focused on individual quality improvement plans which help to eliminate racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes by identifying:

1. Members identified with a repetitious admission history.
2. Members who do not meet the utilization review criteria for continued stay, but require alternative placement for care in an effort to prevent further deterioration of their medical and/or psychological condition and/or readmission.
3. Members for whom alternative placement for care has become a deterrent for discharge.
4. Members who are at risk for extensive utilization of medical and/or behavioral care and services, as identified by diagnosis and/or condition.
5. Members who meet criteria for the disease management program.
6. Members with accumulated claims of a specified dollar amount or greater within a specific time period.
7. Members with inappropriate utilization of services as identified by deviation from expected treatment for the presenting diagnosis. (Example: Several emergency room visits for a non-

emergent diagnosis.)

8. Member referral by participating providers, Member and/or Member family.
9. Members with SPMI receiving home and community-based services covered under the State's 1915(i) SPA.

For those Members who meet these criteria, the Service Coordinator uses the HRA to develop an individualized plan of care with the Member to address the following:

- Knowledge and understanding of their disease(s)/condition(s),
- Intervention options and goals,
- Availability of community resources to support care plan, and,
- Target education to support care plan.

The Service Coordinator encourages the Member to actively participate in developing the plan of care by using outreach efforts aimed at providing health and wellness information, healthy behavior coaching, disease specific information/education and encouragement to actively participate in their health management and consistent follow-up with the Member. Evidence-based Care Guidelines are used to encourage and educate Members regarding the importance of active participation in their self-care.

CCO Plan and Strategies:

FamilyCare will ensure that Performance Improvement Projects (PIPs) and Quality Assessment and Performance Improvement projects (QAPIs) are conducted under the organization's Medical Management program to address and achieve improvement in major focus areas of clinical care and non-clinical services. FamilyCare's quality activities aim to improve member outcomes using evidenced-based best practices, emerging best practices, and innovative strategies.

Milestones and Benchmarks:

By July 2015, FamilyCare's Quality Improvement Plan will include metrics for identified disparities in access, quality, experience and outcomes.

FamilyCare will conduct a Member survey to identify potential areas of disparity, based on race/ethnicity and linguistic needs, by December 2013.

FamilyCare's CHA will identify potential areas of disparity, based on race/ethnicity and linguistic needs, by July 2014.