

**Section 1: Transformation and Quality Program Details**

**(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)**

**A. Project short title:** Project 72: Baseline Assessment (Anonymous Consumer)

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

If continued, insert unique project ID from OHA: 72

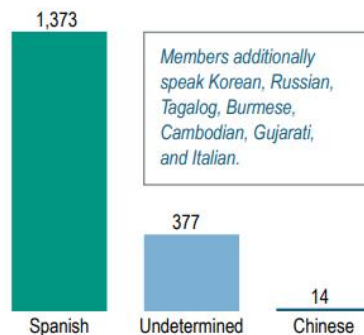
**B. Components addressed**

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

**C. Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Columbia Pacific CCO serves just under 30,000 members, of those 94% identify English as their primary language in enrollment. The next most common languages are Spanish (1373 members) and Chinese (14), in addition we have a few (<5) members that speak Korean, Russian, Tagalog, Burmese, Cambodian, Gujarati, and Italian.

**Language: 94% of members speak English as their primary language. Within each county, the next most common languages are Spanish and Chinese dialects.**



English speakers have been omitted from the graph above to allow for a more nuanced look into the breadth of racial/ethnic and language diversity across our membership. Language groups appear at the highest level of aggregation. While useful for presentation, this consolidation can misrepresent these groups as homogeneous and obscure variations within the group. In the context of this language data, “Chinese” is an umbrella term that encompasses multiple dialects or languages. However, we know from reviewing 2019/2020 interpreter vendor data that “Chinese” does not accurately reflect the language spoken by these members which might include Mandarin, Cantonese, Hakka, or other dialects.

One barrier to understanding the complete picture of language access in our region is that many organizations do not use CPCCO’s language access vendors for interpretation services. To capture how organizations in our network offer and

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support patient’s language assistance needs, CPCCO created an anonymous consumer process where an interpreter poses as a Spanish speaking patient and completes a standard evaluation. Spanish was decided as the language of focus due to our demographic make-up of Columbia Pacific CCO members. We determined to focus in on 12 clinic organizations that are assigned the majority (over 90%) of our patients for primary care and behavioral health. The 12 organizations are Adventist Tillamook, Tillamook County Community Health Centers, Rinehart Clinic, Providence Seaside, Tillamook Family Counseling Center, Clatsop Behavioral Health, Columbia Memorial Hospital, Coastal Community Health Center, Columbia Health Services, OHSU Scappoose, Columbia Community Mental Health, and Legacy St. Helens. None of the above clinics currently are sharing interpretation data for CPCCO members.

**D. Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

In early 2020 we began finalizing logistics for our first ever anonymous consumer project. In Q1 we finalized the logistics (scripting, fake patient details, reason for visit, etc.), which came to a complete halt with COVID-19. In Q2 we paused activities as we wrapped COVID-related supports around our network and our members. We determined that putting additional in person strain on our clinics and communities would not be appropriate at this time. However, we decided we could continue with a portion of the project which was attempted phone scheduling.

In Q3 we worked with our language access vendor, Linguava, to find an interpreter who could perform this task. Essentially, we needed an individual that was a certified interpreter with some acting skills to call as a Spanish speaking patient and not break the role. This is important, since the anonymous consumer would need to act as if they did not understand, if the clinic interpreter/scheduler interpreted or said something incorrectly, even if they understood it in English. For example: asking “sexual orientation” instead of asking “gender”. (this did happen). Luckily, we were able to find a great fit for the project.

In Q4 we began the anonymous consumer calls to our network clinics, and they will be completed at the end of Q1 2021. In total this will take 16 hours of direct interpretation time scheduled over 2-hour sessions. In addition, for each 2-hour session of interpreter the anonymous consumer also takes an hour to document findings. This process is proving to elicit valuable information on the barriers that our LEP patients are encountering just to get in the door with scheduling. See below for the assessment the interpreter completes.

<b>On phone appointment</b>		<Insert Clinic Name here> - Write or Circle Responses below									
What day and exact time (start and end) did you call the clinic?											
Was there a phone tree? (Press 1 for...)	Yes	No	Other								
If yes to above did the phone state the message in Spanish?	Yes	No	Other								
Please list names of staff you spoke with.											
Was interpretation provided by staff or vendor for telephone appointment?	Staff	Vendor	Other:								
Was interpreter introduced to you?	Yes	No	Other								
How would you rate the interpretation provided?	10	9	8	7	6	5	4	3	2	1	
	Very Good									Very Bad	
Why did you provide that rating?	<Insert detailed explanation>										
How accurate was the interpretation?	10	9	8	7	6	5	4	3	2	1	
	Very Accurate									Not Accurate	
Why did you provide that rating?	<Insert detailed explanation>										

How accurate was the interpretation?	10	9	8	7	6	5	4	3	2	1	
	Very Accurate									Not Accurate	
Why did you provide that rating?	<Insert detailed explanation>										
Were you able to schedule an appointment?	Yes	No	Other:								
When was your scheduled appointment made?	<Insert Date and provider schedule with>										
Did they offer you an interpreter for the visit scheduled?	Yes	No	Other								
If they do not offer, ask to have an interpreter for the visit. What was the response?											
Did staff seem knowledgeable about how to obtain interpretation services?											
Were you satisfied with the services? Would you want to come back to this clinic?	Yes	No	Other								
	Please provide as detailed information you can as to why you selected the above answer.										
Did you feel respected?	Yes	No	Other								
	Please provide as detailed information you can as to why you selected the above answer.										
	Please provide any additional details you feel would be relevant										

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### E. Brief narrative description:

In 2021 we will complete the 1<sup>st</sup> round of anonymous consumer experience calls in Q1. In Q2 we will begin to take this information to April/May Clinical Advisory Panel and Community Advisory Committees for review, questions, and strategic advisement. To ground meeting participants in this topic we will do the twenty minutes in Spanish with an interpreter interpreting into English. We are hoping this will help participants understand the discomfort felt when you can't understand directly what is being said, and the process of working with an interpreter. From these meetings we hope to get feedback on how we improve, what are the opportunities to improve on existing work strategies, and what do the clinics need to make this happen.

We will have meetings with our 12-core physical and behavioral health network organizations focused meeting in Q2-Q3 with leadership from each organization and their staff responsible for language access. In these meetings we will review their organization specific assessment report with specific recommendations for improvement in their organizations based on the interactions. Our hope is that we can partner directly with organizations on improvements that are noted from their reports work.

After said improvement work is implemented, we will go back and re-do the anonymous consumer assessment with the same organization in Q4 or Q1 2022, to see how improvements have taken effect.

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

**Activity 1 description** (continue repeating until all activities included): Clinics with completed baseline assessment

Short term or  Long term

**Monitoring activity 1 for improvement:** Complete baseline assessment with 12 core organizations who see majority of membership

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
10	12	03/31/2021	12	03/31/21

**Activity 2 description:** Clinics with completed baseline assessment and partnered improvement plan

Short term or  Long term

**Monitoring activity 2 for improvement:** Each clinic has improvements that need to make to ensure meaningful language access, to track we would like to partner together to create an improvement plan.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	6	09/30/2021	12	06/30/2022

A. **Project short title:** Project 77: [Oral Health Integration: Connecting Members with Diabetes to Oral Health Care](#)

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

If continued, insert unique project ID from OHA: 77

### B. Components addressed

- i. Component 1: Oral health integration
- ii. Component 2 (if applicable): Access: Timely
- iii. Component 3 (if applicable): Choose an item.
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?  
 Economic stability  Education  
 Neighborhood and build environment  Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

### C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Many new challenges to the oral health integration landscape were identified in 2020. Despite general healthcare access and bandwidth issues during the pandemic, much work has continued to support oral health awareness and navigation to dental services within physical health and community settings. Our focus shifted to stabilization of existing oral health integration programs during the pandemic rather than implementation of new processes. Below is a description of work related to oral health integration for diabetes priority population.

- Members with Diabetes: Throughout the year, we continued to share monthly diabetes dashboards with medical claims denominator and dental claims numerator along with actionable lists of patients with diabetes with dental plan partners. CPCCO's messaging emphasized patients with diabetes as a priority population for access and utilization even during COVID. Additionally, CPCCO's embedded TCCHC panel coordinator successfully integrated outreach for patients with diabetes to include key messaging on the importance of oral health and navigation to dental.
- During 2020, CPCCO onboarded a new primary care innovations specialist who received upskilling in key oral health initiatives and messaging. This role is integral in CPCCO's approach in providing integrated support to partners, with both dental and primary care innovations specialists working together as a team.
- Preparing for the year ahead, CPCCO began oral health strategic planning in Q4, including driver diagram development for a member-centric approach focusing on priority populations.

### D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception

- Development of informational tools for diabetes oral health portfolio that has clinical and navigation materials for providers, CCO staff and members by August 2020. This activity had a delayed launch and began during summer of 2020. Development is in progress, not completed by date intended.
- Distribution of the above informational tools to 10 sites by October 2020. As the development of tools has been delayed, this activity was not able to be met by the intended timeline.
- For our goal of 10 adult practice sites using the Dental Care Request form by December 2020. We have 6 total sites utilizing the Dental Care Request form, only 4 sites identify as adult practices.
- 28 Dental Care Request forms (8 with a request linked to diabetes) were submitted for members by December 2020. The total number of 2020 Dental Care Request forms submitted for individual adults was 18. We believe this decrease is due to COVID-19 impacting providers with limited staffing, reprioritizing of efforts, and shifting to accommodate pandemic priorities. Most of the members that come through portal are a product of First Tooth training, it is our hope that creating specific diabetes training we can get a similar effect.
- We did not complete dashboards to visualize dental care requests by June 2020. This activity was shelved in 2020 due to COVID-19 impacts and will begin development in 2021. The number and percentage of Dental Care requests for members with diabetes that result in a completed dental visit within 30, 60, and 90 days of the request will be measured for baseline and a target set by June 2021. Due to COVID-19, the resources to build the analytics for this report was reprioritized and the activity was shelved during 2020 operations; development of the buildout will be launched in 2021.

**E. Brief narrative description:**

We understand that primary care teams have multiple demanding priorities for provision of care during a short visit time. Provider buy-in is essential for the successful implementation of integration practices. We strive to make oral health integration an easy lift and as seamless as possible for partners. By creating integration tools, and providing targeted trainings, we aim to advance the knowledge and awareness of primary care teams on the importance of oral health for their patients with chronic conditions and to improve navigation pathways, ultimately increasing dental utilization and lowering the incidence of dental disease.

The diabetes oral health portfolio of provider and patient materials provides key messages to aid PCP and patient conversations on the bidirectional relationship between diabetes and periodontal disease. Provider materials also support the use of oral health screening tools and referrals to dental as part of routine diabetes care. The PCP diabetes dental dashboard is a health information technology tool to further strengthen these conversations and allows PCPs to discuss dental visit adherence and identify gaps in care. Continued PCP training, utilization, and spread of the dental care request form, specifically for patients with diabetes, builds communication pathways for care coordination with dental plans.

Additionally, CPCCO’s embedded panel coordinators in primary care clinics have a unique position in supporting oral health messaging and dental care coordination for an integrated outreach approach, working with both the PCP and the dental plans. These health plan supports address a gap identified in navigation to dental services where the burden often falls on the PCP and patient to understand and navigate the complexities of the benefit structure. Data analytics and dashboard buildout on the percentage of members with diabetes who had a dental care request form submitted by the physical health provider and who completed a dental visit may provide insight on gaps within the navigation system, health disparities and/or access concerns. This will allow data-driven conversations with PCP and dental plan partners on timely access to care.

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

**Activity 1 description** (continue repeating until all activities included): Develop and share educational materials for members on the importance of oral health care for members with diabetes.

Short term or  Long term

**Monitoring activity 1.a for improvement:** Development of member informational tools

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No member-facing diabetes materials	Create member-facing diabetes materials	6/2021	Materials developed	6/2021

**Monitoring activity 1.b for improvement:** Distribution of member informational and navigation tool – focus on 12 clinics (9 primary care 3 Behavioral Health clinics that are assigned 90% of our members)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No member-facing diabetes materials distributed to provider sites	Tools distributed to 6 # provider sites	10/2021	Tools distributed to 9 # provider sites	06/2022

**Activity 2 description:** Develop and share a set of clinical educational and navigational tools for CCO staff and network providers on the dental care request form and the importance of oral health care for members with diabetes.

Short term or  Long term

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**Monitoring activity 2.a for improvement:** Development of CCO staff and provider clinical and informational tools

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Tools not available	Tools developed	06/2021	Tools developed	06/2021

**Monitoring activity 2.b for improvement:** Distribution CCO staff and provider clinical informational tools

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No tools distributed	Tools distributed to 6 provider sites and at CCO staff meeting	10/2021	Tools distributed to 9 provider sites and at CCO staff meeting	06/2022

**Monitoring activity 2.c for improvement:** Embedded panel coordinator outreach for patients with diabetes includes shared oral health messaging and dental care coordination

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
1 embedded panel coordinator provides shared messaging and dental care coordination	2 embedded panel coordinators provide shared messaging and dental care coordination	12/2021	3 embedded panel coordinators provide shared messaging and dental care coordination	06/2022

**Monitoring activity 2.d for improvement:** Monitor the number of individual adults referred through the dental portal.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
18 Dental Care Requests were for adults age 18+ years in 2020.	76 requests for adults	12/2021	100 requests for adults	12/2022

**Activity 3 description:** Add dental engagement data to CareOregon PCP dashboards. Data to include dental visit info, oral exam for adult members with diabetes metric data and dental plan assignment

**Monitoring activity for improvement:** Addition of dental data on CareOregon PCP dashboards.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Dental information not on PCP dashboard	Dental info on PCP dashboard	12/2021	Dental info on PCP dashboard	12/2021

**Activity 4 description:** Work with the analytics team to determine the number and percentage of members with diabetes who had a dental care request form submitted by the physical health provider and who completed a dental visit, and to develop a data dashboard visualization.

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**Monitoring activity 4 for improvement:** Completion of a dashboard to visualize dental care requests

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Dashboard not available	Dashboard created	06/2021	Dashboard created	06/2021

### A. Project short title: [Project 67: Interpreter Training](#)

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

If continued, insert unique project ID from OHA: 67

### B. Components addressed

- i. Component 1: CLAS standards
- ii. Component 2 (if applicable): Health equity: Cultural responsiveness
- iii. Component 3 (if applicable): Choose an item.
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?
 

<input type="checkbox"/> Economic stability	<input type="checkbox"/> Education
<input type="checkbox"/> Neighborhood and build environment	<input type="checkbox"/> Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

### C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Columbia Pacific CCO serves just under 30,000 members, of those 94% identify English as their primary language in enrollment. The next most common languages are Spanish (1373 members) and Chinese (14), in addition we have a few (<5) members that speak Korean, Russian, Tagalog, Burmese, Cambodian, Gujarati, and Italian. At CPCCO, we recognize that language access goes far beyond simply providing interpretation services. Meaningful and equitable language access depends on many variables and extensive coordination across numerous stakeholders and systems. For this quality improvement project however we will focus on increasing Spanish interpreters that are accessible (local) and qualified (OHA Certified). We determined this was a necessary project by administering a Community Advisory Council and Provider Network survey that noted:

- Clinics reported severe difficulty with accessing in-person interpreters on the coast and frequent rescheduling when in-person interpreters are accessed.
- Providers/Members had poor experiences with phone interpretation, reporting a negative impact on visit quality, leading many to prefer using their own video interpreter.

An internal audit of our language access vendor in 2019 showed that only 28% of the encounters were done by a certified/qualified interpreter and of those none were in person in encounters but rather were phone based. We repeated the audit for 2020 and have results below for % change.

Line of Business	2019 % of Interpreter Certified or Qualified	2020 % of Interpreters Certified or Qualified	Change
Columbia Pacific CCO	28%	33%	5%

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D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

In 2020 we had monthly meetings with our vendors to review reports and discuss strategies to increase % of encounters with certified and qualified interpreters and to increase use of service in the region. In 2020 we took a close look at OHA Interpreter Registry and can only see two interpreters who exclusively service our region (Tillamook). In reviewing vendor reports in 2020 we can see that the interpreters that serve our region are coming from Washington and Multnomah county. Often the interpreters willing to travel are booked and don't have travel time of 3-4 hours round trip needed for the encounter.

In early 2020 we began a contracting process with Linguistics Global Associates to bring an in-person training to the coast and offer scholarships for those seeking training/certification. However due to COVID-19 we had to cancel the in-person training and opted to investigate virtual offerings. We were able to offer scholarships to two trainings in 2020, one with Linguistics Global Associates (July to September on Sundays) and one with the Oregon Health Care Interpreters Associations (OHCIA – June to August on Saturdays).

We shared a flyer (see screenshot below) with our network contacts, external meetings, staff at Consejo Hispano and asked everyone to share widely. We received a total of 8 applications, however 4 were out of region applicants. We provided 4 scholarships to applicants and told them we would follow up post course to help with certification/qualification. We followed up in beginning of Q4 2020 with applicants for certification. To assist with certification, we screenshared with applicants and completed and paid for registration for National Board of Certification for Medical Interpreters and exam scheduling together. Applicants shared they would struggle to complete this process alone because it was complicated and not linear. Those two applicants have completed and passed the necessary testing and have sent a completed application to the Health Care Interpreter Program to get on OHA registry as certified. One applicant had to drop out of course due to illness in the family and going on FMLA and the other feels they need a little more time interpreting before they are ready to take the test; we will follow up in 2021. We believe that community members will have improved access to health care services and social support services if they have qualified/certified interpreters available to support.



### Give others a voice with your gift of language

Columbia Pacific CCO is sponsoring scholarships for interpreters in the region! If you are interested in this opportunity, please review requirements below and complete the application on the next page, after you have completed the application please send it to Maranda Varsik ([varsikm@careoregon.org](mailto:varsikm@careoregon.org)) by June 15<sup>th</sup>.

#### Oregon Health Care Interpreters Association (OHCIA)

- The course is being offered online by OHCIA. [Click here to learn more.](#)
  - You must complete the OHCIA Questionnaire by **May 29<sup>th</sup> (see details on timeline below)**
- The course at reduced cost is \$480, this can be covered by Columbia Pacific CCO by reading below and completing the application for sponsorship.

#### Sponsorship Requirements:

- Be accepted into course by OHCIA
- Are not on the Medicaid exclusion list (OIG) <https://exclusions.oig.hhs.gov/>
- Must live and/or work in Clatsop, Tillamook, or Columbia county.

In 2020 we also worked to ensure our contracted provider network for primary care and behavioral health to ensure they are aware of interpreter requirements and resources. We presented at our CCO Quality Improvement Workgroup and Clinical Advisory Panel in April and May when we shared the interpreter scholarship application. We reviewed civil rights act and ACA 1557 and provided our interpreter flyer on how to access services for our members (see screenshot



below). The flyer also includes a line to cut off details on how to schedule; our staff often like to tape these by their computer. The staff that attend these meetings represent 12 clinics that are assigned the majority (over 90%) of our patients for primary care and behavioral health. To note: some primary care clinics are connected to our 3 area hospitals as well. We shared which of their organizations are currently accessing our vendors for services and the desired increase in number of organizations accessing services. We also had leadership meetings with each of these 12 organizations and shared interpreter resources, requirements, and desire for increase in utilization of services for a more personal touch.

## Schedule no-cost interpreters

Whether in person or via telehealth, interpretation is vital for members.

**Columbia Pacific CCO can help, at no cost to you.**

**Professionally trained interpreters are ready to meet clinic needs:**

- In person or by phone/video for telehealth and immediate care
- Work with certified/qualified interpreters for all patient interactions: reminder calls, lab results, etc.
- More than 40 languages, seven days a week.



### **E. Brief narrative description:**

In 2021 we will continue to offer scholarships to interpreter training. We currently have one open for the OHCIA spring session and are actively sharing flyers through our contacts. In addition, we have included funding for other items needed to complete the training like compensation for time missed at work, childcare, etc. We hope this will help mitigate additional barriers to attendance. In the future we hope to hold a license and be able to provide the training directly to our network. In Q1 2021 we hired our 1<sup>st</sup> FTE dedicated to language access coordination and hope that they can help build a team to help us fulfill the goal of providing training directly.

We will go to Clinical Advisory Panel, Quality Improvement Workgroup, and Community Advisory Councils in Q2 to review work to date, including what we hope will be an impactful look at the Spanish Anonymous Consumer results. These results will share the experience of an interpreter, posing as a Spanish patient and calling our network clinics to schedule an appointment. The report out will have customized technical assistance plans for organizations.

Our internal audit team will annually complete an audit on vendor network interpretation. This report will be provided Q4 of 2021 for review by staff and senior leadership. Audit findings will help inform an RFP on language access that will roll out towards the end of 2021.

Beginning in 2021 CPMCO primary care alternative payment model will require a narrative report on interpreter service delivery and utilization. Our hope is that adding interpretation into the CPMCO quality-based payment model will

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increase meaningful language access. We will get our first reports in June 2021 that will review with internal quality team to create additional organization specific technical assistance.

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

**Activity 1 description** (continue repeating until all activities included): # of the 12 clinics that are assigned majority (over 90%) of patients that are utilizing interpreter services from vendor data

Short term or  Long term

**Monitoring activity 1 for improvement:** # of local organizations utilizing interpreter services or having their interpretation data on CPCCO patients (12 possible)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
6	9	06/30/21	12	12/31/21

**Activity 2 description:** Vendor data measurement of % of interpreted encounters that have a certified/qualified interpreter

Short term or  Long term

**Monitoring activity 2 for improvement:** % of Interpreter Certified or Qualified from language access vendors (Passport to Language and Linguava)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
33%	50%	06/2022	80%	12/2023

**Activity 3 description:** Measuring the number of certified/qualified (national + OHA) that live in region

Short term or  Long term

**Monitoring activity 2 for improvement:** # of qualified or certified interpreters in region

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
4	10	06/2022	15	12/2022

A. **Project short title:** Project 73: Improved access to grievances and appeals for members with Limited English Proficiency

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

If continued, insert unique project ID from OHA: 73

### B. Components addressed

- i. Component 1: Grievance and appeal system

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- ii. Component 2 (if applicable): Health equity: Data
- iii. Component 3 (if applicable): CLAS standards
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?
  - Economic stability  Education
  - Neighborhood and build environment  Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations

**C. Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Coordinated Care Organizations are contractually required to provide linguistically appropriate information to members about their rights to submitting grievances and appeals. These contractual requirements outline a range of criteria for translating materials, making information available in alternative formats, and providing free interpretation services through written policies and procedures.

Year over year, CareOregon has provided evidence of compliance upon annual submission of policies and procedures to OHA, and during the OHA audit cycle of appeals and grievances. During this process, CareOregon policies and procedures have consistently been found to be up-to-date and reflect OAR and CCO 2.0 contract requirements. CareOregon regular review data like below to monitor grievances and appeals and look for complaints related to potential bias and language barriers, however as evidence by data below there are few coming in.

CPCCO	Access	Billing	Consumer Rights	Interaction	Quality of Care	Quality of Service	Totals:
<b>2019</b>	21	25	10	62	35	3	156
<b>2020</b>	18	19	8	49	12	9	115

CPCCO	2019	2020
IPj-Mbr diff Understanding due to Lang/Cultural Barriers	0	0
CRf-Provider/Plan bias barrier	5	0

As it would appear, CareOregon has met all obligations to make grievance and appeals information available to our members. However, satisfying contractual requirements does not always translate to an optimal experience for people that access services. Toward this end, CareOregon conducted a study beginning in late 2019 to better understand how our members interface with our appeals and grievances process.

Led on behalf of CPCCO, the study analyzed two years of grievance data for dually eligible members, grouped by age, ethnicity, and (when possible), primary language. The data suggest that non-white, non-English speakers are far less likely to file a grievance than members who are white and speak English. By extension, CareOregon extrapolated that non-white, non-English speakers were also less likely to submit an appeal. After careful review of these findings, the

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CareOregon Member Engagement Coordination Committee suspected a disparity may exist for LEP members accessing translation and interpretation in grievance and appeal processes.

The disparate distribution of grievances filed by non-white, non-English speakers compared to their white, English-speaking counterparts—despite practices that meet all regulatory and contractual requirements—is a distinct illustration of structural and institutional systems that perpetuate inequities.

Accordingly, CPCCO set out to use data to inform processes, improve access to appeals and grievances for members with LEP, and create a dashboard to share progress with Community Advisory Councils, the CCO provider network, and the CareOregon Quality Committee.

**D. Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

CPCCO acknowledges that language access to grievance and appeal processes is a contractual requirement. We have also discovered that these contractual requirements are not doing enough to ensure truly equitable access to members with LEP. Providing meaningful language access requires that we have an honest look at the impact of institutional and structural systems that uphold inequities. We believe this work is transformational. Though CareOregon consistently meets regulatory requirements related to grievance and appeals, we feel that we can do better, and must, to help improve services, and provide equitable rights to all members. Our current structure may limit members in their ability to exercise their member rights due to language and cultural barriers.

In 2020 CPCCO adopted the Protocol for Culturally Responsive Organizations as the framework to guide, organize and assess our Justice, Equity, Diversity, and Inclusion (JEDI) work. This Protocol is organized into nine domains that address a broad spectrum of JEDI impact areas. CPCCO has split these domains into internal and external categories, each of which is overseen by a JEDI Committee. A workgroup has been convened for each domain to dive deeper into each impact area. Grievance and appeals initiatives will be supported and informed by two workgroups: the Member voice and Influence Workgroup—to ensure all our members can share their experiences to inform the work of the CCO; and the Data and Continuous Quality Improvement Workgroup—to ensure that the CCO is measuring the quality and impact of its work in a way that is meaningful to our members. In 2020, CPCCO’s Internal and External JEDI Committees were convened and chartered, with foundational premises and team agreements put in place to support an inclusive and anti-racist culture. As of February 2021, CPCCO has also convened all nine workgroups. These structures will advise and support improvement work with grievances and appeals in partnership with other CareOregon committees.

**E. Brief narrative description:**

We plan to continue activities related to LEP in 2021 but may adjust our approach as we analyze barriers, conduct deeper exploration of community and member needs, and take into consideration the CPCCO Health Equity Plan. Information will then drive our process improvement strategy and plans. We anticipate this will be a multi-year project as there will be a range of improvements that may include small relatively easy initiatives to larger, more complex organizational wide change. In 2021 we will work to ensure REAL-D data integrated into regular grievance and appeal reporting to the CPCCO Network & Quality Committee, Clinical Advisory Panel, Board of Directors, and Community Advisory Councils. Staff will be training in 2021 in best practices on centering equity in analyses and when making data-driven decisions. We are currently in the process of seeking feedback from key stakeholders, with a focus on partners of color and organizations that serve communities that have been marginalized. By improving both the quality of our data and shifting our culture around how we use data, we hope to build better strategies to support our members. Substantial gaps prohibit our ability to use the current demographic data provided by OHA to analyze health equity among historically disadvantaged groups. However, often in white dominant culture we place heightened emphasis on quantitative data and what we define to be objective information. Rich insight can also be gleaned by collecting information about the experiences of our communities in other ways. CPCCO JEDI committee will dive into other mechanicals for collecting information and work to inform and implement a focus group process.

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

In 2021, each of Columbia Pacific’s JEDI nine workgroups will be tasked with two major deliverables: advance immediate and existing initiatives; and complete a current state assessment. To advance immediate and existing initiatives, the workgroups will define a vision statement, take an inventory of all identified work, complete an ease vs. Impact analysis to identify priorities and focus on advancing those bodies of work that will have the greatest impact towards the vision. For those bodies of work that include grievances and appeals, the workgroup will support and inform this work—ensuring that our members and communities can also contribute to initiatives by which they are impacted. Additionally, the External JEDI Committee will also support this work by coordinating cross collaboration across workgroups and external stakeholders and offering additional guidance and perspective. The current state assessment will be developed, administered, and analyzed in close collaboration with our members and the communities we serve—specifically with a lens toward our LEP members. This work will inform the development of a comprehensive improvement plan with more robust long-term strategies—which will include appeals and grievances.

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

**Activity 1 description** (continue repeating until all activities included): analysis of CPCCO grievance and appeals data and processes to understand if the lower rates of grievances and appeals among members with LEP.

Short term or  Long term

**Monitoring activity 1 for improvement:** Understand if the lower rates of grievances and appeals among members with LEP observed in the 2019 findings demonstrate a statistically valid trend among CPCCO members.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No regular reporting	REAL-D data will be integrated into regular grievance and appeal reporting to the CPCCO Network & Quality Committee, CAP, CAC, and Board.	12/2021	Regular cadence of reporting out with REAL-D data to the Network and Quality committee, CAC, CAP, and Board on appeals and grievances	12/2021

**Activity 2 description:** Explore alternative ways to allow for members to request an appeal or grievance in culturally appropriate manner.

Short term or  Long term

**Monitoring activity 2 for improvement:** Collect feedback from members and communities from historically marginalized groups to create more equitable processes.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
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## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

n/a	1 focus group completed	06/2022	Processes and structures established to regularly collect feedback from members and communities from historically marginalized groups.	12/2022
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### A. Project short title: [Project 74: Equity Data Guidelines](#)

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

If continued, insert unique project ID from OHA: Project 74

### B. Components addressed

- i. Component 1: Health equity: Data
- ii. Component 2 (if applicable): [CLAS standards](#)
- iii. Component 3 (if applicable): [Choose an item.](#)
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?
 

<input type="checkbox"/> Economic stability	<input type="checkbox"/> Education
<input type="checkbox"/> Neighborhood and build environment	<input type="checkbox"/> Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? [11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery](#)

### C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

It has been determined that substantial gaps prohibit our ability to use the current member demographic data provided by OHA to analyze health equity among historically disadvantaged groups. To assess barriers, a small, multidisciplinary workgroup was convened to focus specifically on the REAL D data that CCOs receive from OHA. This workgroup first spent time deepening an understanding of the REAL D questions, how they are asked on the OHP application, and the format in which CCOs receives this data. Next, the workgroup selected the set of REAL D/834 data fields and built a table in CareOregon's data warehouse to test them. Findings from a series of tests on the data revealed several barriers: most notably, a significant percentage of members have incomplete demographic data available. The structure of this data is also inconsistent and often misaligned with the REAL D standards.

To better understand these discrepancies, the CCO met with a member of the OHA's Office of Equity & Inclusion to review their guides for addressing concerns with the REAL D data provided by the state. In addition to previously discovered barriers, this process uncovered substantial data validity concerns. From this process, the workgroup recommended two action items:

1. Create a user guide for the 834 REAL D data fields to establish standards and advise CPCCO and CareOregon analysts on how to use this data with its current limitations.
2. Develop a plan for collecting REAL D data directly from members to improve the long-term quality of the data itself.

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

**D. Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

CareOregon has been challenged with access to accurate, complete, and high-quality demographic data for years. Over the last 12 months, CareOregon’s Quality Improvement Team was able to assess barriers, develop an action plan for improving our data, and recommend best practices for using the data with its current limitations.

During the summer of 2020, a CareOregon workgroup was convened to identify all the sources of member data for CPCCO. The group found that member data may come from OHA, the Centers for Medicare & Medicaid Services (CMS), from the CCO’s own data collection, or from other vendors.

With this information, the group will lead two initiatives to improve the member data set:

1. Identifying data types that come from multiple sources and creating a prioritization hierarchy of the sources based on reliability — prioritizing data that is collected directly from the member and/or data that is more recent and more frequently updated.
2. Building a demographic data table allows multiple sources to feed one demographic field, providing the most accurate and up-to-date member data.

We recognize that even with gaps in data it is important to work with what we have and continue the conversation with our network on equity and data disaggregation. Due to COVID-19, CCO quality metrics were put on hold in 2020 and we saw this as an ideal opportunity to use Quality Improvement Workgroup (QIW) to work on equity and data disaggregation. QIW in Columbia Pacific is comprised of practice administration, quality improvement staff, and clinic providers/navigators. We began this discussion in April and began implementation in June; below is a table showing each month June to December and the equity data topic.

Equity Data and Discussions/Trainings in QIW 2020:

Summary narrative in each month	Main points
<b>May:</b> Presented approved cultural responsiveness online training and funding for interpreter training available and requirement trainings for providers per CareOregon Provider Manual.	<ul style="list-style-type: none"> <li>• Cultural Responsiveness training</li> <li>• Interpreter training</li> </ul>
<b>June:</b> Introduced an opportunity to disaggregate data from the CPCCO dashboard by a comparison variable like language and race to QIW. We also discussed approved funding and requirement trainings for providers (reminder).	<ul style="list-style-type: none"> <li>• Metrics Equity Explorer</li> <li>• Cultural Responsiveness training</li> <li>• Interpreter training</li> </ul>
<b>July:</b> Discussion regarding equity in the practices and how they implement equitable work. This meeting we introduced the JEDI and what CPCCO is doing to educate and increase awareness when reviewing our own strategies to support the practices of equality and equity. This was done by specifically diving into intersectionality, dominant cultures, individual and systematic ideologies, and shared language.	<ul style="list-style-type: none"> <li>• Equity responses from survey in June discussion</li> <li>• Updated on CPCCO equity work</li> <li>• Shared language</li> <li>• CPCCO Justice, Equity, Diversity &amp; Inclusion overview (JEDI)</li> <li>• CCO Health Equity Plan                             <ul style="list-style-type: none"> <li>○ Cultural responsiveness</li> </ul> </li> <li>• Liberatory Consciousness Model</li> </ul>

**OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO**

	<ul style="list-style-type: none"> <li>• Rural disparities</li> <li>• Equality vs. Equity</li> </ul>
<p><b>August:</b> This month we presented and discussed how impactful it is for our work in the Health Equity plan to center the margins and include our marginalized populations instead of designing strategies to benefit the most people. We also discussed creating awareness through a structural, institutional, and internal lens broadening our knowledge and strategies of inclusion.</p>	<ul style="list-style-type: none"> <li>• JEDI overview - reminder</li> <li>• Equality vs. Equity</li> <li>• CCO Health Equity Plan             <ul style="list-style-type: none"> <li>○ Centering the margins</li> <li>○ Developing an Equity Lens</li> </ul> </li> <li>• Lens components to improve strategies:             <ul style="list-style-type: none"> <li>○ Member education and accountability</li> <li>○ Culturally and linguistically appropriate services</li> <li>○ Organizational training and education</li> <li>○ Workforce composition</li> <li>○ REAL-D data</li> </ul> </li> </ul>
<p><b>September:</b> This month we presented and discussed language access as a centering the margins lens for strategy. We dove into how language access is appropriate for one of the many components to achieve meaningful health equity.</p>	<ul style="list-style-type: none"> <li>• Reminders: Centering the margins</li> <li>• Health Equity: meaningful language access</li> <li>• Best practices: language access</li> <li>• Structural bias</li> <li>• Awareness</li> <li>• OHA metric: equity narrative</li> </ul>
<p><b>October:</b> This month we did a recap of what we have presented prior on centering the margins and discussed REAL-D from DHS and OHA policy. One of the practices presented an activity that we did with them on disaggregating data for this reason and to share best practice and discuss.</p>	<ul style="list-style-type: none"> <li>• REAL-D data opportunities and practice</li> </ul>
<p><b>November:</b> This month another practice presented their REAL-D data (disaggregated) as a best practice and discussion.</p>	<ul style="list-style-type: none"> <li>• REAL-D data opportunities and practice</li> </ul>
<p><b>December: Meeting cancelled this month</b></p>	

**E. Brief narrative description:**

CareOregon’s Quality Improvement Team is in the process of developing a training curriculum on how to use data to support equity work. This training covers best practices on centering equity in analyses and when making data-driven decisions. We are currently seeking feedback from key stakeholders, with a focus on BIPOC led organizations that serve communities that have been marginalized. By improving both the quality of our data and shifting our culture around how we use data, we hope to build better strategies to support our members. In 2021 all analysts that support Columbia Pacific will complete the training and then we will share it with all strategy leads so that they can use that to help guide their strategy development.



## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

The QIW will continue to be a forum for data disaggregation. In 2021 we are working to ensure that when we share data, we disaggregate it in every meeting. We will in addition use this as a venue to offer technical assistance to network providers on disaggregating data and data equity practices in the hopes that we can get more providers (currently 2) to share disaggregated data with us and their peers.

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

**Activity 1 description:** [Guide for the 834 REAL D data fields to establish standards and training](#)

Short term or  Long term

**Monitoring activity 1 for improvement:** Create a user guide for the 834 REAL D data fields to establish standards and advise CareOregon analysts on how to use data with its current limitations and train staff

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
None	All CCO/CareOregon analysts trained	06/2021	All strategy leads trained	12/31/2021

**Activity 2 description:** [Provide technical assistance to network providers on disaggregating data and data equity practices.](#)

Short term or  Long term

**Monitoring activity 2 for improvement:** Help core network of 12 primary care and behavioral health clinics that are assigned over 90% of membership.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2 clinics	4 clinics	12/31/2021	6 clinics	06/30/2022

### A. Project short title: [Project 78: PCPCH Supports](#)

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

If continued, insert unique project ID from OHA: Add text here

### B. Components addressed

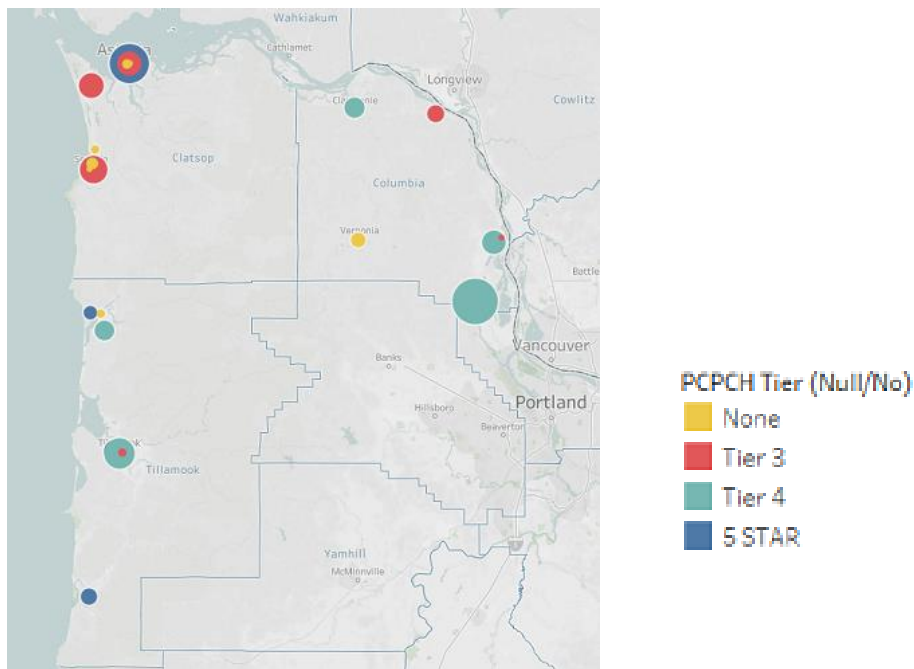
- i. Component 1: PCPCH: Tier advancement
- ii. Component 2 (if applicable): [PCPCH: Member enrollment](#)
- iii. Component 3 (if applicable): [Choose an item.](#)
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?
 

<input type="checkbox"/> Economic stability	<input type="checkbox"/> Education
<input type="checkbox"/> Neighborhood and build environment	<input type="checkbox"/> Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? [Choose an item](#)

**C. Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Patient Centered Primary Care Home (PCPCH) assessment is tracked by Oregon Health Authority's (OHA) PCPCH Recognition Information for Oregon Payers excel document which CPCCO has ingested to map across our counties.

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO



We use this data to do proactive outreach to clinics in proximity to yellow. We identified Seaside and Vernonia as areas to focus based on patient population density and assignment as well as PCPCH map. This map intentionally excluded Washington and Lincoln counties to focus on regional clinics as a priority. The map denotes potential areas of opportunity as it shows clinics that have lapsed in re-attestation in the PCPCH program.

We also incentive tier recognition by requiring PCPCH tier to participate in value-based payments and requiring PCPCH to get quality bonus payout for CCO metrics. To make this accessible we do not put a tier level needed to participate in basic value-based payments or quality bonus payout. However, we incentivize higher tier levels by having more complex value-based payments only available to tier 4 or higher. To support all of this we have created a PCPCH support procedure noted below.

We currently have 83% of CPCCO members assigned to PCPCH primary care clinics in our region (NOTE that 10% assigned to PCPCH outside of region). You can see in data table below the member assignment and tier level.

PCPName	County	PCPCH Tier	# of Members Assigned	% of CPCCO Membership
ADVENTIST HEALTH BAYSHORE MEDICAL PACIFIC CITY	Tillamook	5 STAR	649	2%
ADVENTIST HEALTH TILLAMOOK MED GRP WOMENS & FAMILY HEALTH	Tillamook	5 STAR	1271	4%
ADVENTIST HEALTH TILLAMOOK MEDICAL GROUP MANZANITA	Tillamook	5 STAR	474	2%
ADVENTIST HEALTH TILLAMOOK MEDICAL GROUP VERNONIA	Columbia		541	2%
ADVENTIST TILLAMOOK MEDICAL PLAZA	Tillamook	5 STAR	1241	4%
CMH ASTORIA PRIMARY CARE CLINIC	Clatsop		1037	3%
CMH MEDICAL GROUP & URGENT CARE - SEASIDE	Clatsop		429	1%

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

CMH PEDIATRIC CLINIC	Clatsop	Tier 3	1466	5%
CMH PRIMARY CARE CLINIC	Clatsop	Tier 3	1500	5%
COASTAL FAMILY HEALTH CENTER	Clatsop	5 STAR	3875	13%
COLUMBIA PACIFIC MEDICAL SERVICES	Clatsop		121	0%
COMMUNITY HEALTH CENTER OF CLATSKANIE	Columbia	Tier 4	1025	3%
LEGACY CLINIC ST HELENS INTERNAL MEDICINE	Columbia	Tier 4	1400	5%
LEGACY CLINIC ST HELENS PEDIATRICS	Columbia	Tier 4	1152	4%
LOWER COLUMBIA CLINIC	Clatsop		232	1%
NOURISH NATURAL FAMILY MEDICINE	Tillamook		150	0%
OHSU FAMILY HEALTH CENTER AT SCAPPOOSE	Columbia	Tier 4	5160	17%
PROVIDENCE SEASIDE CLINIC	Clatsop	Tier 3	1859	6%
RAINIER HEALTH CENTER	Columbia	Tier 3	725	2%
RINEHART CLINIC	Tillamook	Tier 4	977	3%
SACAGAWEA HEALTH CENTER	Columbia	Tier 3	84	0%
SAINT HELENS INTERNAL MEDICINE	Columbia		118	0%
THE MIDDLE WAY HEALTH CARE	Tillamook	Tier 3	184	1%
TILLAMOOK COUNTY COMMUNITY HEALTH CENTERS	Tillamook	Tier 4	2309	8%
VANDER WAAL, STEVEN C	Clatsop		166	1%
WIMAHL FAMILY CLINIC INC	Clatsop	Tier 3	116	0%
Total CPCCO Members				30,728

When assigning new members our algorithm looks at distance and history of visits as 1<sup>st</sup> priorities, then PCPCH assignment to ensure members are pointed towards PCPCH clinics. We have considered reassigning members away from clinics who do not participate in PCPCH but our rural network is already limited and many of the patients have long establish PCP relationships we do not want to break. Instead we focus on making offers of PCPCH support to our clinics who have not attested or need to re-attest

**D. Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Columbia Pacific CCO views the excel file monthly to assess whether the practices are re-attesting on time due to the prior expiration dates listed. The information also provides CPCCO the status of each practice that is contracted with the region. This could be whether the practice is no longer recognized or recognized, have re-attested and applied for the next iteration of PCPCH recognition on time, and more importantly if the Tier level has changed.

CPCCO reaches out and provides guidance to re- apply **at least 3** months prior to the due date of re-attestation for the clinics and manages follow ups to keep the practice up to date on any changes with the PCPCH program and their need to re-attest. In addition to the guidance we offer direct support to help with submission in our outreach. This direct support includes things like sample policy and procedures from other clinics, navigation support of the application or support for their EMR systems to pull data. The offer for support is open and has led to varied technical assistance.

In 2020 CPCCO directly reached out to 9 clinics to support 1<sup>st</sup> time attestation or re-attestation. Near unanimous response was lack of time due to COVID-19 and an ask to reach back out in 2021. We were able to share resources to support A Natural Path Integrated Health and The Middle Way clinic who successfully submitted in 2020.

In addition to the direct offer of support, Columbia Pacific also utilizes the CPCCO Quality Improvement Workgroup (QIW) to provide PCPCH support and learnings. QIW at CPCCO is comprised of practice administration, quality

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

improvement staff and/or clinical providers to also inform re-attestation deadlines and resources to complete state recognition status. Communication was sent to all recognized practices in QIW for information regarding the new PCPCH 2020 standards when they were released. The communication included the deadlines to use the PCPCH 2017 standards instead of the 2020 standards. The following dates are updates that CPCCO shared with QIW in 2020 as reminders.

**October 2020:** PCPCH email coming out, new 2020 standards

**November 2020:** PCPCH new standards beginning January 2021; please re-apply before your due date and we (CPCCO) would be reaching out to each practice.

### E. Brief narrative description:

In 2021 we will continue to monitor PCPCH re-attestation dates and follow up with clinics who were stretched thin in 2020. We will have a specific focus on Seaside and Vernonia as well as helping our School Based Health Centers (SBHCs) in Columbia County. Our hope to have Adventist Vernonia, Columbia Memorial Primary Care Astoria, and Seaside (2 separate clinics), and SBHC Vernonia (not currently getting patient assignment) newly attested by the end of the year. You can see in the table above that those clinics (highlighted on table) completing attestation will increase member enrollment in PCPCH by 6%.

In addition, we will work to support SBHC Rainier Health Center, SBHC Sacagawea Health Center with re-attestation as they proactively requested it upon hearing about changes in QIW. The QIW will discuss new PCPCH standards in Q3 2021 with the group and have Coastal Family Health Center in Astoria share a little about the 5-star attestation process.

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

**Activity 1 description** (continue repeating until all activities included): Maintain clinic level participation at QIW

Short term or  Long term

**Monitoring activity 1 for improvement:** QIW as a main vehicle for clinical improvement and tier advancement

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
7 Organizations and 16 clinics participating in QIW	18	12/31/2021	18 clinics still participating in QIW	12/31/2022

**Activity 2 description:** Newly attested clinics in 2021

Short term or  Long term

**Monitoring activity 2 for improvement:** Addition of new clinics for 2021 in Seaside and Vernonia area in PCPCH program

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	3	12/31/2021	3	12/31/2021

### A. Project short title: [Project 79: SPMI – Regional Care Team](#)

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

# OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

If continued, insert unique project ID from OHA: 79

## B. Components addressed

- i. Component 1: Serious and persistent mental illness
- ii. Component 2 (if applicable): Choose an item.
- iii. Component 3 (if applicable): Choose an item.
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?
  - Economic stability
  - Education
  - Neighborhood and build environment
  - Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

## C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The CPCCO Regional Care Team (RCT) is a multi-disciplinary team which hosts regular, county-specific case conferences (also called huddles) including Primary Care, Community Mental Health and Community Paramedicine (Columbia county only) to address cross-system collaboration, reduction in duplication of effort, increased insight into who is involved with the member and improved workflows. On February 24, 2020 a Collective data deep dive was completed by the CPCCO Regional Care Team (RCT) Triage Coordinator to better understand members with EDMI flag and their patterns of ED utilization as well as primary care and network engagement. It was decided an “ED disparity” flag would be placed on the RCT referral form for the county case conference/huddle to identify these specific members who meet criteria for the EDMI flag.

Regional Care Team
CLATSOP
COLUMBIA

Huddle Date: 3/18/20
CLATSOP
COLUMBIA

Name	NEXT STEPS	
52588 NE SAWYER ST APT B6 Scappoose 503-575-8853 503-440-6123	Action Items	Person Responsible
DMAP		
DOB: [REDACTED] Age: 37 Male		
Primary Care		
OHSU Scappoose last visit 1/14/20		
Referral to Pharmacy		
Yes		
BH/MH/SUD		
Bipolar II, Alcohol Dependence with Intoxication, Social Phobias/panic attacks, SI, Unspecified Mood DO,		
Drivers of Utilization		
MH Crisis, Alcohol – see below		
Needs/Concerns		
Went to Willamette Family RTC February 2020, Unity ED after dc 3/13/20 – see below		
ED Disparity		

**Collective Utilization**

Providence St. Vincent Medical Center	1
Adventist Health Portland	1
Unity	4
Peacehealth University District	3
<b>Total</b>	<b>9</b>

The first community huddle to incorporate this step occurred on 2/26/20 during which we also socialized this project to the internal RCT and larger community team. Larger community team is comprised of primary care, hospital, and behavioral health staff for our network clinics who are supporting care coordination for member. Tracking of these members was done through the end of March. At that point, the focus and prioritization of members quickly pivoted to support impacts of Covid-19. Formal tracking of the EDMI flag put on hold at that point.

	Columbia	Clatsop	Tillamook
February	4	3	1
March	13	6	2

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

**D. Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

The CPCCO Regional Care Team (RCT) is a multi-disciplinary team which hosts regular, county-specific case conferences including Primary Care, Community Mental Health and Community Paramedicine (Columbia county only) to address cross-system collaboration, reduction in duplication of effort, increased insight into who is involved with the member and improved workflows. During case conferences, the multi-disciplinary, multi-system team reviews several member cases, creates or reviews existing care plans, determines priority areas of need and identifies a lead person to conduct the follow up and outreach. In March 2020, the RCT quickly pivoted its prioritization as the COVID-19 pandemic created urgency to connect to members who may be at greater risk of health decline, hospitalization, or death due to COVID-19 infection and/or the effects of social isolation and stress on the behavioral health needs of members. A cross-regional outreach protocol was organized and implemented. The RCT and CPCCO Panel Coordinators completed proactive outreach calls aimed at holistically assessing medical, behavioral, pharmacy, and social health needs for members identified as high-risk due to either physical or behavioral health conditions. Beyond proactive outreach efforts, the RCT also expanded the typical transitions of care workflow to include and prioritize support for members who experienced an inpatient or emergency room visit related to symptoms or diagnosis of Covid-19 in order to ensure they have access to needed services (social, BH or clinical) and connection to their PCP to achieve the best possible outcome and recovery to health. This continues to be a priority for the RCT team.

Early on in the pandemic, RCT Care Coordination staff partnered with county level Public Health and Incident Management teams to create a process for providing support to members who underwent testing for COVID-19 and were awaiting results or had a known positive test and were unable to quarantine due to experiencing homelessness or inadequate housing. The RCT provided support with lodging, food, basic hygiene items, clothing, and connection to NEMT. These services were later handed off to local CBOs by OHA contract.

Note: This project is a shared quality improvement project with our D-SNP affiliate. CPCCO is affiliated with CareOregon Advantage, a FBDE D-SNP plan that is owned and operated by its parent, CareOregon. CareOregon Advantage has just over 13,300 members, but only 400 reside in Columbia and Tillamook counties (CareOregon Advantage does not operate in Clatsop County) and most members live in the Portland metro area. This project is applicable for our entire CCO and D-SNP membership, but we will be able to monitor progress across both plans.

**E. Brief narrative description:**

The Regional Care Team (RCT) provides members with a consistent care team who collaborate across disciplines to develop and implement a member-centric care plan through telephonic, electronic, or community-based interventions to resolve identified needs and to promote healthy outcomes. The RCT and its individual care coordinators, including intensive care coordinators, ensure continuous care management for all members and develop individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with complex needs, including those with serious and persistent mental illness (SPMI).

RCT care coordinators utilize evidence-based and innovative strategies within the service delivery system to ensure coordinated and integrated person-centered care for members including regular cross-system county-specific huddles. These huddles were born out of a desire to increase communication and partnership between CCO care coordination and our valued community partners. Interdisciplinary team meetings are a forum to describe the clinical interventions to the larger treatment team, discuss progress toward care plan goals, identify coordination gaps and strategies to improve care coordination with the member's service providers, develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring, align with the member's individual care plan, and identify Social Determinant of Health barriers or needs as well as appropriate community resource referrals.

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The RCT supports referrals from multiple sources in alignment with CCO 2.0 contract requirements, Oregon Administrative Rules as well as regional clinical strategic initiatives. The CPCCO RCT creates cohorts and uses tags in Collective to help monitor and support these populations. The EDMI tag in Collective was created as a result of knowing that members with serious and persistent mental illness (SPMI) have poorer outcomes when it comes to physical, social, and mental health in addition to higher rates of utilization across the health care delivery system. We also know that members with SPMI diagnoses have comorbid physical health conditions that are poorly managed. This cohort, along with others are reviewed by the RCT's Triage Coordinator to identify individuals who may benefit from an interdisciplinary review. The Triage Coordinator writes up a summary (see component prior year assessment section) and presents to the group at the CCO-hosted county-based huddles.

To ensure the RCT is supporting our SPMI population, the ED Disparity Measure will be prioritized when proactively case finding using Collective cohorts for RCT and County specific huddles. These huddles occur weekly (Columbia county), bi-weekly (Clatsop county) and monthly (Tillamook county). While member level care, intervention and needs are the priority for these discussions, the huddles also provide an opportunity to track barriers being experienced more broadly by various populations. This creates an opportunity to strategize, support and respond with a more upstream approach to the needs of specific populations, the larger community and service level gaps. To that end, this project proposes a first step of identifying and tracking how many members brought to the huddle are from the ED disparity measure to better understand specific needs of this population and subsequent opportunities to address gaps in care.

UniteUs/ Connect Oregon is being launched in our region in Feb 2021. This platform will provide many opportunities for closed-loop resource referrals. Data within the system will allow CPCCO to perform a gap analysis per county for the community at large as well as potentially for specific member populations. This next year will provide opportunity to better understand how our data can be aligned to this end. As we do not yet understand how data from various platforms (EHR, Collective, UniteUs platform) will speak to each other, we will use this year to build a foundational understanding from which we will be poised to better integrate data with care coordination efforts moving forward.

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

**Activity 1 description** (continue repeating until all activities included): Prioritize members for county case conferences who are part of Collective's ED Disparity measure

Short term or  Long term

#### Monitoring activity 1 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Tracking abandoned in March 2020 to refocus RCT response to impacts of Covid-19. Still need to establish baseline.	Standardize prioritization and tracking of members from ED disparity cohort with inappropriate ED utilization being brought to county case conferences for team review	Not yet met	175 unique members identified as part of ED disparity cohort will be brought to county case conferences for review	12/2021

**(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)**

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

### A. Project short title: [Project 80: Trauma Informed Network](#)

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

If continued, insert unique project ID from OHA: 80

### B. Components addressed

- i. Component 1: Social determinants of health & equity
- ii. Component 2 (if applicable): Choose an item.
- iii. Component 3 (if applicable): Choose an item.
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?  
 Economic stability  Education  
 Neighborhood and build environment  Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

### C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In 2018 CPCCO's Board of Directors voted to hire a Senior Program Development Specialist to establish county-level networks tasked with finding interdisciplinary approaches to building resilience and implementing trauma-informed policies, programs, and best practices across sectors at a community level. One of the long-term goals of the network is to improve quality of care and services to improve outcomes for children and families, but the goal is improved resilience that buffers the health and social effects of adversity.

Outreach, recruitment, and community education about the trauma informed networks continued throughout 2020. By January 2021, 24 organizations in Clatsop County and 32 in Columbia County had formally joined the networks by signing a letter of commitment. Please see the list of member organizations for each county, attached as Appendix A and B. Columbia Pacific CCO facilitated a process in each county to support the member organizations to design the network. Network infrastructure in each county includes a charter, roles and responsibilities, trauma informed principles, vision, mission, and values. Each network created a design plan with action items in each of the following key areas: leadership and strategic planning, membership and citizenship, network activities, resources, and communication and knowledge circulation.

In early 2020, Columbia Pacific CCO worked closely with member organizations in each county to finalize the strategic plans developed in collaborative community workshops held in December 2019 in each county. These participatory processes engaged local health service providers, school districts, community organizations, non-profits, local government agencies and community members in determining the most pressing needs and priority areas for trauma informed and resiliency building efforts in each county. The network in Columbia County approved their strategic plan in February 2020 and the network in Clatsop County approved theirs in September 2020 (2020 Activity 2 successfully completed).

While the formal network launch (2020 Activity 1) was postponed due to the COVID-19 pandemic, it is currently scheduled for April 2021. In response to the COVID-19 pandemic and stress felt by member organization representatives, who were scrambling to adjust to rapidly changing conditions, each network utilized our existing relationships to support each other during this challenging time. Specifically, Columbia Pacific CCO rolled out an online collaboration platform, facilitated virtual network meetings to share pandemic responses, brainstorm solutions to learn from each other, while working together on shared projects to reduce childhood trauma. For example, Columbia Pacific CCO facilitated the rollout of "Handle with Care" in Clatsop County in close collaboration with local law enforcement agencies and school districts. It will also be rolled out in Columbia County in 2021. The Handle with Care program is a national model that helps children exposed to a traumatic event. Additionally, in response to community needs



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identified by member organizations, Columbia Pacific CCO facilitated a network discussion in Columbia County on the intersection of race and childhood trauma during which we developed strategies to address racism and updated our strategic plan to reflect these.

Gaps identified: participative processes mostly involved organizations rather than OHP members specifically although limited outreach was conducted to invite community members, especially those from vulnerable communities. For example, community members were invited to the strategic planning workshop to identify priority strategy areas for the networks. In 2021, more community level outreach will take place with additional opportunities to involve OHP members. For example, Columbia County will offer a parent night to support parents to help children manage their emotions as part of the launch event. Spanish language interpretation will be offered and network member organizations that serve OHP members will participate in outreach. The launch will be publicized in local media, social media channels and through each of the service providers who belong to the networks.

**D. Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

In 2018, community engagement staff at Columbia Pacific CCO facilitated a roadshow of the findings of its community health assessment at events where participants from a range of backgrounds including OHP members and Community Advisory Council members were asked to vote on what the CCO should set as their CHP priorities. Of the 147 people who voted across the 15 events, 55% voted that trauma-informed care should be CPOCCO's number one priority, which is more than double the share of the vote of the second highest priority. The Community Advisory Councils have consistently recommended it be a chief priority in the CHP and in practice as well, often supporting trainings and events, but desiring a more systematic response. Though BRFSS data related to Adverse Childhood Experiences are not reported regularly by region or county and not systematically collected in other venues, we suspect that the BRFSS estimate that one in five (1:5) Oregonians have experienced four or more ACEs is a low estimate both statewide and in our region. This suspicion is based on what social and health data we do have access to.

As a community-based, partner-reliant strategy, these networks must be built "at the speed of trust" to be effective. As such, the time since Board approval and specialist hire in 2018, time has been spent doing trust-building work including:

- Gathering national, state, and local data from sources such as BRFSS, the DHS County Data Books, the Department of Education, and more. This data focused on what is known around specific Adverse Childhood Experiences, as well as known signs that ACEs are prevalent such as health and social outcomes.
- Gathering community input from a variety of local viewpoints representing needs across sectors.
- Sharing resources, data, and research about the importance of building resilience and the impact of ACEs locally.
- Building relationships with community partners in Clatsop and Columbia counties that could lay the foundation for initiating the networks.
- Working with partners to build strategic plans and logic models that highlight data as the basis for action and establish strategies, interventions, desired outcomes, and indicators of success. These logic models are currently being revised and will be updated in future TQS reports.

This body of work takes a long view because by its nature it is an intervention that focuses on upstream strategies and interventions. This means it may be multiple years, or even generations, before the benefits of the work are demonstrated by population-level or CCO-level data. As such, a variety of process measures are mixed in with longer-term indicators chosen to help demonstrate progress and included in the logic models.

As explained in Part C, last year's benchmarks and targets were pushed back due to COVID, and these activities are prerequisites to being able to move to quantitative monitoring or concrete activities. This is because the logic model's

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

strategies and interventions will need refining once the networks are launched. In slowing down, the following lessons were learned:

- Activities that are highly relational must be done more slowly and thoughtfully in a virtual environment.
- During a crisis, being willing to slow down and be flexible are vital to the longer-term success of upstream work.

### E. Brief narrative description:

In 2021, Columbia Pacific CCO will continue to work across sectors with member organizations in Clatsop and Columbia counties to build a trauma informed network in each county. Sectors represented in each network include healthcare, education, child welfare, criminal justice, business, and community. Each network has a steering committee and six sector work groups made up of local volunteers from member organizations or the community at large. Within the steering committee and the sector workgroups, member organizations work together to advance the initiatives in the strategic plan, reduce childhood trauma, heal ACEs, and build resilience in children and families. Member organizations commit to adopt trauma informed practices and to support each other on this journey.

The mission of the Clatsop County network is to “build capacity across sectors and within the community to adopt trauma informed practices, increase protective factors and prevent and heal childhood trauma in children, families and communities.” The mission of the network in Columbia County is to “increase cross-sector collaboration, strengthen capacity of organizations and promote community awareness to prevent and heal childhood trauma and build resilience in children and families for a healthier Columbia County.” Please see the list of member organizations for each county, below.

#### Resilient Clatsop County Member Organizations

\*\*\*January 2021\*\*\*

- |   |   |
|---|---|
| 1. Astoria School District                    | 14. Jewell School District                        |
| 2. Awakenings by the Sea                      | 15. Knappa School District                        |
| 3. Clatsop CASA Program, INC.                 | 16. Northwest Oregon Housing Authority            |
| 4. Columbia Pacific CCO                       | 17. Northwest Regional Education Service District |
| 5. Department of Human Services (District #1) | 18. Providence Seaside Hospital                   |
| 6. Clatsop Behavioral Health                  | 19. Riverside Community Outreach/Every Child      |
| 7. Clatsop Community Action                   | 20. Seaside Public Library                        |
| 8. Clatsop County Public Health               | 21. Seaside School District                       |
| 9. Clatsop County                             | 22. Sunset Empire Park and Recreation District    |
| 10. Clatsop Juvenile Department               | 23. The Harbor                                    |
| 11. Columbia Memorial Hospital                | 24. Warrenton-Hammond School District             |
| 12. Consejo Hispano                           |   |
| 13. Helping Hands                             |   |

#### Columbia County Childhood Trauma Informed Network

##### Member Organizations

\*\*\*Updated January 2021\*\*\*

- |   |                                       |
|---|---------------------------------------|
| 1. Amani Center   | 5. Columbia Community Mental Health   |
| 2. CASA for Children of Multnomah, Washington and Columbia Counties | 6. Columbia County                    |
| 3. City of St. Helens   | 7. Columbia County Public Health      |
| 4. Clatskanie School District                                       | 8. Columbia County Treatment + Courts |
|   | 9. Columbia Health Services           |

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

10. Columbia Pacific CCO
11. Columbia Pacific Food Bank
12. Columbia River Fire + Rescue Scappoose Rural Fire Protection District
13. Community Action Team
14. Department of Human Services (District #1)
15. Iron Tribe Network
16. Legacy Medical Group St. Helens
17. Northwest Oregon Housing Authority
18. Northwest Regional ESD
19. Oregon Health & Science University Scappoose Clinic
20. Oregon Law Center
21. Rainier School District
22. Riverside Community Outreach/Every Child Columbia
23. SAFE of Columbia County
24. Sandee School of Horsemanship
25. Scappoose Public Library
26. Scappoose School District
27. St. Helens School District
28. Tillamook County Transportation District/NW Rides
29. United Way of Columbia County
30. Vernonia School District
31. WildFlower Play Collective
32. Youth Era

Columbia Pacific CCO has reached out to every culturally specific organization and all organizations that serve systemically underserved and vulnerable communities that we have been able to locate to date. We are continuously seeking to reach out to underserved communities and will continue that outreach to determine if there are any culturally specific community organizations not yet involved in the networks. As studies show that vulnerable groups are more likely to report higher numbers of ACEs, the work of the networks – including raising awareness of ACEs and childhood trauma among service providers -- inherently benefits these populations. The Clatsop County network will specifically examine the intersection of childhood trauma and racism in 2021.

The target populations are children and their families in Clatsop and Columbia counties with a special focus on vulnerable and underserved populations who are more likely to bear the burden of higher ACEs.

This project is participatory and grew out of a community initiative based on a felt community need: leaders in Clatsop and Columbia counties contacted Columbia Pacific for support in developing trauma informed networks. Columbia Pacific CCO has supported leaders in Clatsop and Columbia counties to design and establish the trauma informed networks with the end goal being to embed them into each community. Current network initiatives were prioritized and developed in a participatory community strategic planning workshop and will be further developed together with partners in each sector workgroup.

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

**Activity 1 description** Launch trauma informed networks in Clatsop and Columbia counties: support networks to be launch-ready by identifying core teams within each member organization to help the organization adopt trauma informed practices, finalizing steering committee membership through the signing of formal agreements outlining steering committee membership responsibilities, developing outreach materials, and planning the launch event. Please see Appendix E for visual detail of the structure. In both Columbia and Clatsop counties, the launch event will include community awareness building about the network, ACEs, childhood trauma and resilience, as well as action planning where organizations will discuss their role and how they can advance strategic plan initiatives. In Columbia County, the launch event also includes a keynote speaker and panel discussion with similar collective impact initiatives from around the Pacific Northwest as well as an evening parent program with translation available in Spanish. Launch planning includes widespread community outreach including to local media, local social media, faith-based groups, grassroots organizing and outreach to the populations served by each member organization. Spanish language translation will be

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

available for the evening parent program in Columbia County. After the launch event, community members will also be invited to participate in the sector workgroups.

Short term or  Long term

**Monitoring activity 1 for improvement:** Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0 events	2 launch events	05/01/2021	N/A	05/01/2021

**Activity 2 description:** Launch sector workgroups with a focus on the healthcare, education, and child welfare sectors. Each sector workgroup will be headed by two co-chairs, one who is elected by the sector workgroup and one who is the sector representative to the steering committee. Sector workgroup charters will be developed which will include the sector workgroup purpose, goals, procedures, roles and responsibilities and member assignments. Sector workgroups will examine priority areas in their sector from the strategic plan and work together to prioritize and implement these strategies in close coordination with other sectors and the steering committee.

Short term or  Long term

**Monitoring activity 2 for improvement:** Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0 sector workgroups launched	3 sector workgroups launched in each county (6 total)	12/31/2021	In each county: 3 active sector workgroups meeting regularly; charters developed; co-chairs in place	12/31/2021

**Activity 3 description:** Offer trauma informed, ACEs and resiliency building trainings across sectors with a special focus on member organizations and service providers who serve vulnerable populations in Clatsop and Columbia Counties. Whether the training is in-person or virtual will depend on pandemic conditions and participant comfort levels.

Short term or  Long term

**Monitoring activity 2 for improvement:** Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0 trainings	2 trainings held	12/31/2021	One training held in each county; 75 people trained in TIC in each county; increase	12/31/2021

# OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

			knowledge of trauma informed care and approaches in target counties	
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## A. Project short title: Project 70 Improving SUD Access: MAT Collaborative and County-Level Coordination

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

If continued, insert unique project ID from OHA: 70

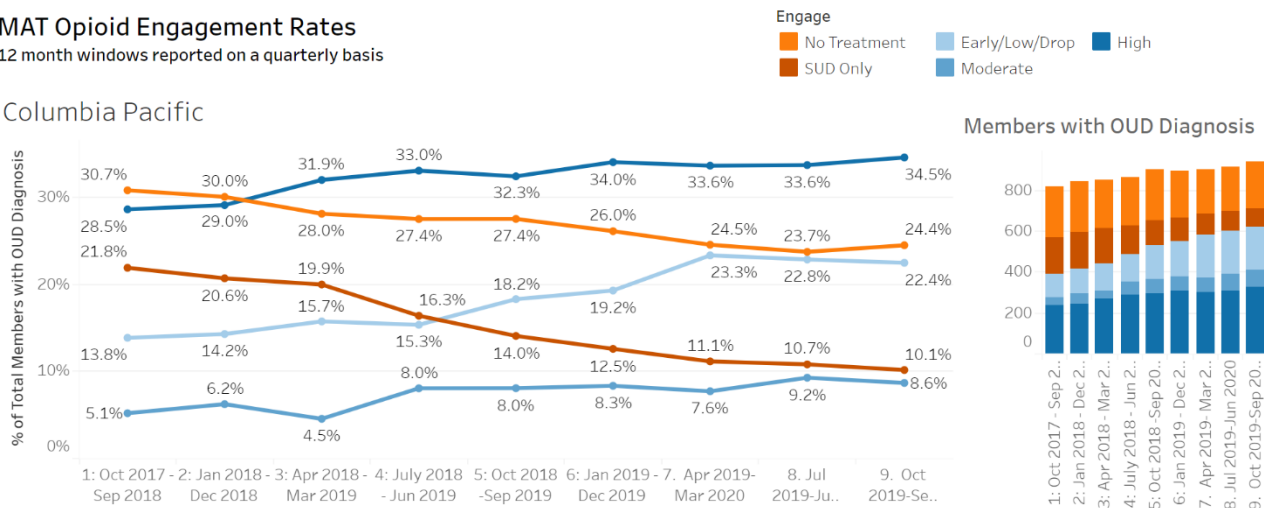
## B. Components addressed

- i. Component 1: Behavioral health integration
- ii. Component 2 (if applicable): Utilization review
- iii. Component 3 (if applicable): Access: Quality and adequacy of services
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?
  - Economic stability
  - Education
  - Neighborhood and build environment
  - Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

## C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

1. Number of members who are highly engaged in Medication for Opioid Use Disorder treatment as monitored by their medication possession ratio (MPR): **34.5%** (target 36.5%)
  - While many clinics have reported drop outs from MAT programs at rates as high as 40% in some regions of the state due to COVID (based on OHSU ECHO faculty reports), CPCCO did see a slight increase in the rate of members with high engagement over 2020.

**MAT Opioid Engagement Rates**  
12 month windows reported on a quarterly basis



2. The cumulative number of attendees at the MAT Learning Collaborative: **196** (target 210)
  - Due to the development of a virtual MAT Learning Collaborative in partnership with another region (see below), some attendees from the Southern Oregon region are counted in the above figure.

**D. Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

CPCCO hosted one full-day, in-person MAT Learning Collaborative focused on Behavioral Health Core Competencies which included Primary Care and BH prescribers, clinical pharmacists, behavioral health clinicians, nurses, peer recovery specialists, Opioid Treatment Program staff, and other care team members. COVID-19 led to a pause in hosting in-person sessions, so CPCCO worked to develop an online learning series in collaboration with Jackson Care Connect CCO with sessions that follow the ECHO format including: shorter didactics from local and state experts, collaborative discussions to provide opportunities for integration, and case-based learning for creating regional standards. CPCCO hosted three virtual sessions in 2020: *Trauma-Informed Care and the Neurobiology of Addiction*, *MAT 101: Medication Basics and Reducing Stigma*, and *Team-Based Care Part 1: MAT Role and Responsibilities*. CPCCO staff also worked directly with primary care and BH clinics who have not yet started providing MAT services to provide TA in developing programs to treat addiction.

To support and reinforce learning from the MAT Learning Collaborative, CPCCO started a monthly SUD Clinical Directors meeting to gather leadership from primary care, BH, and our OTP to understand how these regional standards are being implemented. One major focus of the meeting has been to improve bi-directional referral pathways between network partners, including the newly opened OTP in the region. From this meeting, partners have identified how they can support other regional programs; one such connection led to a primary care clinic sharing prescriber time through telehealth services with a CMHP in another county who has limited access to prescribers. This has significantly increased the number of patients being seen for MAT inductions in BH.

While the MAT Learning Collaborative focuses on clinical needs, CPCCO operates and partners in SUD Taskforces in each county that bring in the voice of the community, jails, and law enforcement along with clinical partners to work toward shared goals. One of the primary goals of these taskforces is to spread harm reduction services and naloxone distribution programs to reduce overdose deaths. SUD Taskforce goals in 2020 that were operationalized in at least one of our counties include: implementing a peer-led overdose response program, building collaborative relationships with Peer Recovery teams and EMS, spreading naloxone and harm reduction supplies to community-based organizations, providing MAT from emergency departments, and equipping jails and law enforcement staff with naloxone.

CPCCO continues to measure access to MAT through a medication possession ratio (MPR) that can determine how engaged a member is in treatment with buprenorphine over time. As new injectable medications for addiction have come into the market, including Sublocade, other indicators for engagement in treatment must be developed. CPCCO worked with clinic partners in 2020 to determine the populations for whom Sublocade may be appropriate and crafted prior authorization criteria inclusive of these members. Patients with SPMI, houselessness, pregnancy, violence, or safety issues, or who are struggling to stay in recovery despite access to sublingual buprenorphine may benefit from Sublocade. CPCCO made changes to Sublocade PA criteria three times in 2020 to be more inclusive of focus populations. In late 2020, we submitted a proposal to allow for a significant increase in access to this medication and further open PA criteria, which will go into effect in April of 2021. For members using Sublocade, we will be doing an in-depth analysis of claims data to determine if our utilization criteria are reaching the members we want, keeping members engaged in treatment, and reducing inappropriate utilization of other high-acuity services.

**E. Brief narrative description:**

Our region, like many others, has seen an increase in overdose deaths, attrition from MAT programs, increases in return to use, and a significant increase in members in crisis since the start of the COVID pandemic. CPCCO continues to develop addiction services with a “no wrong door” approach, working with all its partners including hospitals, primary care clinics, CMHPs, OTPs, recovery agencies, harm reduction programs, law enforcement, and jails to provide access to lifesaving medication for addiction and medication to reverse overdoses, naloxone.

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CPCCO has developed a learning collaborative series describing the Learning Collaborative planning process) which aims to increase the number of CPCCO Network Primary Care Medical Homes and specialty behavioral health providers that provide MAT. The learning collaboratives also seeks to establish community standards for MAT and support care teams to build or expand sustainable, effective MAT programs so that the total number people receiving MAT is increased.

In 2021, the MAT Learning Collaborative will continue with seven additional sessions. This curriculum was designed in collaboration with OHSU ECHO SUD Faculty and includes many of their specialists as speakers for the series. The following topics will round out the Learning Series:

- |   |                      |
|---|----------------------|
| - Review of Current Best Practices: MAT in the Presence of Other Substances | Jonathan Robbins, MD |
| - Team-based Care Part 2: Sustainability, Billing, and Clinical Roles       | Stacie Andoniadis    |
| - The Intersection of Persistent Pain, OUD, and Buprenorphine               | BJ Lynch, MD         |
| - Policies, Procedures, Workflows, and EHR Tools                            | Stacie Andoniadis    |
| - Culturally Sensitive and Responsive Services and Care                     | Anthony Jordan       |
| - Pregnancy: Best Practices for OUD   | Kerri Hecox, MD      |
| - Harm Reduction in Primary Care and Behavioral Health Settings             | Melissa Brewster     |

Following the Learning Collaborative, CPCCO will continue to provide ongoing technical assistance to clinics interested in improving their initiation and engagement of members with OUD into treatment. Behavioral health integration, and the role of behavioral health to support MAT within primary care and/or hospitals is a major focus on the MAT collaborative, and technical assistance.

Additional activities for this project in 2021 include: completing a comprehensive claims analysis of members using Sublocade to determine if there is increased retention and engagement in treatment, partnering on county-level SUD taskforces to develop interagency workflows for preventing and responding to overdoses, and disaggregating SUD and MAT claims data by race, ethnicity, language, and disability to develop meaningful interventions to improve equity in care.

We also will be engaging our Clinical Advisory Panel more broadly around closed-loop referrals for Behavioral Health in June which has implications for IET and is relevant to MAT. Following that conversation, we will use our operational Quality Improvement Workgroup to investigate and improve upon SBIRT and BH referrals in primary care to address SBIRT, IET, and general BH bi-directional coordination. Finally, in the last 2 quarters of 2021 we will be working directly with CMHPs to assess current state and improve upon closed loop referrals for BH in the network with the potential for network level collaboratives between primary care and CMHPs specifically working on referrals.

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

**Activity 1 description:** Columbia Pacific CCO will host a monthly Learning Collaborative series with primary care, specialty behavioral health, and other community partners that focuses on operationalizing Medication for Addiction Treatment (MAT).

Short term or  Long term

**Monitoring activity 1 for improvement:** Percentage of members with a diagnosis of OUD who are highly engaged in MAT treatment as monitored by their medication possession ratio (MPR)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
34.5%	36.5%	12/2021	36.5%	12/2021

## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

### Activity 2 description: SUD Taskforces to Reduce Opioid Overdoses

Short term or  Long term

**Monitoring activity 2 for improvement:** Number of naloxone doses distributed through pharmacies or county harm reduction programs.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
1,730	2,500	12/2021	2,500	12/2021

### Activity 3 description: Sublocade Claims Analysis to Measure Efficacy and Engagement in Treatment

Short term or  Long term

**Monitoring activity 2 for improvement:** Percentage of members utilizing Sublocade who have shown sustained engagement in treatment (>3 months) or reduced utilization of high-acuity services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
N/A	50%	12/2021	50%	12/2021

#### A. Project short title: [Project 64: ABA Providers](#)

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

If continued, insert unique project ID from OHA: 64

#### B. Components addressed

- i. Component 1: Access: Quality and adequacy of services
- ii. Component 2 (if applicable): Special health care needs
- iii. Component 3 (if applicable): Choose an item.
- iv. Does this include aspects of health information technology?  Yes  No
- v. If this project addresses social determinants of health & equity, which domain(s) does it address?
  - Economic stability
  - Education
  - Neighborhood and build environment
  - Social and community health
- vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

#### C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Prior year-end assessment (2019) identified that there were no ABA providers delivering services in-region in the Columbia Pacific Service Region. GOBHI had previously been delivering a limited amount of ABA services in Columbia County in 2019, however they sunsetted their ABA program in Columbia County in 2019. This left the region with no locally-based ABA providers at the start of 2020. In 2020, CPCCO contracted with two providers to deliver this service in Columbia County, and later in the year two providers to deliver this service in Clatsop County. The initial service demand in Columbia County started at three youth members in the beginning of 2020 and expanded to six youth by the mid-point in the year – at which point contracts were expanded immediately to meet the additional demand. In Clatsop County, there was, again, an initial service demand for three youth, and total demand is not yet known. In Tillamook County, there is still no locally-based ABA provider and members are receiving this service via out-of-network providers located in Forest Grove and Hillsboro.



## OHA Transformation and Quality Strategy (TQS) CCO: Columbia Pacific CCO

**D. Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

As discussed above, the progress to-date includes the contracting with providers to stand up new, community-based ABA programs in both Columbia and Clatsop Counties in 2020. Benchmarks were not clearly established (beyond developing this service type in every county) because the actual demand/need level of the service was not yet fully known. At this time, this work is continuing into 2021 in order to support measuring member need/available capacity so that CPCCO can continued scaling up the program in Clatsop County in order to meet the need. In Tillamook County, there were two ABA referrals in 2020, so the demand level is lower, however it is important to develop a sustainable pathway for meeting member demand for this service in Tillamook. The need will also increase, as we continue the work to develop systematic processes related to developmental screening and follow up.

### **E. Brief narrative description:**

The target population for this intervention includes children/youth CPCCO members with an Autism Spectrum Disorder diagnosis, residing in one of the three counties in the CPCCO service region, for whom Applied Behavioral Analysis is a recommended treatment intervention.

In 2021, the primary activity for this project in Columbia County involves monitoring the following on a quarterly basis: the referrals for ABA treatment; the total number of ABA assessment authorizations; the total number of ABA treatment initial authorizations; and the total number of ABA re-authorizations (past 6 months). Additionally, providers will be asked to report quarterly on number of members served (to compare against initial referrals/ABA authorizations per county) and to report on wait times for services. The measurable goal in Columbia County is for wait times for ABA services to not exceed two weeks past the date of initial ABA authorizations.

Additionally, in 2021 It is anticipated that services will need to be expanded in Clatsop County as the true level of need for this service for CPCCO members is made clear via referrals. It is highly likely that more than three members meet the clinical criteria for ABA services. Again, providers will be asked to report quarterly on number of members served (to compare against initial referrals/ABA authorizations per county) and to report on wait times for services. Given that expanding in-county services is contingent upon available workforce, the measurable goal is that wait times for ABA services do not exceed two weeks (if there is available capacity) and if additional FTE is needed, that the wait time does not exceed 60 days.

Lastly, the focus for 2021 will include quantifying the ongoing demand level for these services in Tillamook County and determining the strategy/strategies to best deliver the services in that county, including developing in-network contracts in neighboring counties and working with provider(s) to stand up new ABA services in-county. This process will include gathering quarterly data on referrals, and the total number of ABA assessment and ABA treatment authorizations to quantify the level of in-county demand to better understand the feasibility of providers starting up new programs in-county.

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

**Activity 1 description** Monitor services demand levels; access; and wait times in Clatsop County for ABA services – use this data to inform if increase in capacity if needed.

Short term or  Long term

#### **Monitoring activity 1 for improvement:**

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
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Referrals beyond current capacity for ABA may have wait times beyond two weeks.	Wait times for all referrals for ABA will have wait times of two weeks or less	12/31/2021	12/31/2021	12/31/2021
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**Activity 2 description:** Monitor services demand levels; access; and wait times in Tillamook County for ABA services – use this data to inform contract execution and develop additional capacity if needed.

Short term or  Long term

### Monitoring activity 2 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Referrals are currently served by non-participating providers and ABA may have wait times beyond two weeks.	Execute contracts out of area providers and evaluate feasibility of in county services to ensure that wait times for ABA will not exceed two weeks.	12/31/2021	12/31/2021	12/31/21

## Section 2: Discontinued Project(s) Closeout

**(Complete Section 2 by repeating parts A through D until all discontinued projects have been addressed)**

- A. Project short title: Food Roots
- B. Project unique ID (as provided by OHA): 81
- C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):  
During the 2019-2020 and 2020-2021 school years, both our food and education systems have had to change the modes in which they offer essential services, as well as which services were prioritized. Food Roots is continuing their Garden Education Curriculum and Farm to School Activities virtually for now, meaning that they are currently relying on other programs for the delivery of food to Oregon Health Plan members and students, and do not need support from the CCO to provide education. Due to this shift, the CCO has prioritized funding other urgently needed services such as the school food programs which deliver daily meals for children through age 18, and mobile delivery of food boxes through Food Roots and other organizations. We do not anticipate that the original program will resume soon.

- A. Project short title: Project 71 Internal Language Access Assessment
- B. Project unique ID (as provided by OHA): 71
- C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes

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D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Columbia Pacific CCO and CareOregon completed the internal language access assessment in 2020. The assessment went through each department to complete the assessment jointly, the assessments proved helpful in completing language access CCO metric assessments. Once assessments were completed they went to the CareOregon Equity Committee for review of areas for improvement opportunities. The Equity Committee made two important recommendations: hire a staff member explicitly directed to manage a language access plan and create a Request for Proposal (RFP) for language access vendors that outlines specific data needs for evaluation and monitoring. The position was posted in Q4 2020 to manage the language access plan and has been hired in Q1 2021. The RFP plan is in process and will open in Q3 of 2021 for vendors to apply; it is intended to launch in 2022. Given the completion of the assessment and the plans in the works for RFP this project has met its intended outcomes.

A. Project short title: Project 69: Dental Vans

B. Project unique ID (as provided by OHA): 69

C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work

D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):

CPCCO covers a large geographical region with widely dispersed dental clinics. The Dental Van project was designed to increase the use of mobile dental vans to make dental services more convenient and accessible for members.

When the project started, one mobile dental clinic was available in Columbia County two days a week at Legacy St. Helens. In 2020, the mobile clinic was increased to include one day a week at OHSU Scappoose. The mobile clinic was previously rented by CPCCO from Medical Teams International (MTI). It is now owned and operated by CPCCO's dental plan partner, ODS (Arrow Dental). This transition greatly improved the sustainability of the mobile clinic and is largely considered a success.

Additional mobile van pilots are starting in Clatsop and Tillamook Counties to replicate the success in Columbia County. CPCCO and CareOregon Dental financially invested in a mobile health clinic to be operated by the local Tillamook FQHC. This mobile clinic has since become operational and the local FQHC is currently developing a strategy to bring mobile services to the broader Tillamook community. In addition, CPCCO is working with MTI in Clatsop County to share data and collaborate on the mobile dental work they are doing in the county. Due to COVID, some of this work has been delayed or reprioritized, so CPCCO has chosen to discontinue this TQS activity. CPCCO, however, does plan to continue this work.

A. Project short title: Project 63: Quality of Care Pilot

B. Project unique ID (as provided by OHA): 63

C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes

D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Quality of Care Pilot concluded at the end of Q1 2020 with 3 of 5 clinics meeting pilot targets. The pilot program had a substantial reach as the 5 clinic participants accounted for nearly half of CPCCO's membership. Furthermore, these pilots served as a tool to engage with clinics and staff that CPCCO may not regularly engage with, for example, a dietitian at Tillamook County Community Health. We believe this opportunity

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to engage with clinics around quality improvement (QI) efforts and to support practicing QI skills will impact quality of care beyond these pilots. In evaluating the program, the CCO identified needs for more structured coaching for participants and progress reviews throughout; broadening the QI topics; and addressing the barrier of limited staff time and resources. Although coaching was available through the CCO's Primary Care Innovation Specialist, this support wasn't often utilized for the pilot and could have been promoted more. Participating clinics were interested in QI topics other than the CCO incentive metrics, however, because the program was funded through Quality Pool dollars, the focus was limited to those metrics. If additional funding were available this program could be broadened to cover additional QI topics. Finally, conducting structured QI projects requires substantial staff time and resources – both of which are limited in some of the CCO's smaller clinics creating a barrier to participation that should be addressed in future efforts. Lessons learned were shared in a monthly Quality Improvement Workgroup newly created to focus on QI efforts more systematically.

- A. Project short title: Project 66: NEMT Improvement Plan
- B. Project unique ID (as provided by OHA): 66
- C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Add text here

The COVID 19 pandemic has had a significant impact on our NEMT brokerage. The initial months of the pandemic resulted in a major decrease in NEMT utilization that put the brokerage at risk of maintaining staff and drivers. The brokerage also had to create many new policies and procedures to adjust safety needs. All of these variables have required the NEMT brokerage to shift their resources to remain stable throughout the year. In addition, CPCCO has seen various parts of our network need to adjust to the impact of the pandemic and has chosen to pivot our resources towards stabilizing our overall healthcare network during this time.

- A. Project short title: Project 76 Cultural Responsiveness Training
- B. Project unique ID (as provided by OHA): 76
- C. Criteria for project discontinuation: Project fails to meet TQS guidance in requirements for the chosen component(s) based on OHA feedback and/or written assessment
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):  
Columbia Pacific CCO will continue offering cultural responsiveness training to our network. To date we have had 9 different organizations adopt our training across physical, behavioral, and public health. We have received positive feedback and intend to look at other offerings for future years. Our CAC and Board members will complete the training early in 2021 and CPCCO will gather feedback. As an online training, Quality Interactions has the benefit of being very accessible for rural areas. However, we know that greater learning and growth can occur with customized organizational discussion and analysis. If we continue to offer an online training option, we plan to augment this experience with follow-up discussions to continue this important learning and work. Given that many organizations already have existing trainings available on cultural responsiveness, CLAS and unconscious bias, we also plan to seek input from our provider network about other needs and opportunities to further learning regarding care for specific populations, such as people who identify

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as LGBTQIA+, Hispanic/Latino/a/x or other communities that have been marginalized. Although we can continue this work it is clear upon closer inspection of TQS components that it does not fit well in chosen areas.

- A. Project short title: Project 75 Interpreter Utilization
- B. Project unique ID (as provided by OHA): 75
- C. Criteria for project discontinuation: Project fails to meet TQS guidance in requirements for the chosen component(s) based on OHA feedback and/or written assessment
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Language access and understanding interpreter utilization it still a priority for Columbia Pacific CCO. We will continue to work to increase % of visits with interpretation for members that note need for assistance. We are in the process of ingesting vendor data into the Enterprise Data Warehouse (EDW) so we can merge with claims for dashboard monitoring in a timelier fashion, our hope is this will go live in Q3. In a parallel process we are working with one local clinic to pilot EMR data ingestion for language access in Q2 2021. Although the work and focus will continue it was clear upon review of OHA 2020 TQS assessment that this project does not fit into the components well.

- A. Project short title: Project 75 Alternative Payment Methodology (APM) Equity Narrative
- B. Project unique ID (as provided by OHA): 75
- C. Criteria for project discontinuation: Project fails to meet TQS guidance in requirements for the chosen component(s) based on OHA feedback and/or written assessment
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): The inclusion of the equity narrative report for clinics participating in the 2020 Primary Care Payment Model (PCPM) program was intended as the beginning of a glide path toward more meaningful language access reporting in alignment with the Metrics & Scoring Committee's recommendations. Although 2020 was the anticipated start for collecting the Language Access Equity narratives, the CCO decided to postpone this element due to the COVID-19 pandemic in support of reducing reporting burden on providers. Therefore, the first time PCPM-participating clinics will submit this narrative is February 2021. The expectation from CPCCO is to increase accountability for improving language access over the next few reporting cycles by adding the collection of quantitative data alongside narrative responses and creating targets. The CCO anticipates gaining valuable information from these narrative reports to inform network focus areas for improvement and will continue to include elements of this narrative in the PCPM program. However, the current iteration of this project does not meet the specific requirements for inclusion in the TQS Access: Quality and Adequacy of Services domain and is therefore being removed.

- A. Project short title: Project 65: Seaside Recovery Center
- B. Project unique ID (as provided by OHA): 65
- C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Add text here

The Seaside Recovery Center (a program of CODA) opened in January 2020 with a complete complement of staff and full availability for intake/access for treating opioid use disorder (OUD). The program offers assessment and medication management services as well as individual and group treatment services for

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members with OUD. The Center leadership (with the support of CPCCO staff) communicated the availability of Opioid Treatment services (Methadone) broadly throughout the CPCCO region. The client census grew quickly to slightly over 100 clients in February and early March. By mid-March, the impact of COVID was affecting service delivery and member's willingness to be involved in treatment. The Center remains open and continues services, but the census did have a small dip in attendance. During the early months of the pandemic, census recovered to pre-pandemic levels and has remained at about 100 active clients through the year. The Center is fully functioning and stable despite the system shocks of 2020. CPCCO believes the service is established and poised to grow to its target census of 250+ clients as COVID restrictions continue to ease.

- A. Project short title: Project 84: Special Health Care Needs: ASQ Follow Up
- B. Project unique ID (as provided by OHA): 84
- C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): The project was focused holding a series of learning collaboratives in partnership with Oregon Pediatric Improvement Program (OPIP) focused on social developmental screening and follow up. The learning series was delayed due to the COVID pandemic and when the CCO and OPIP team convened to discuss next steps and feasibility of holding the series virtually, it was determined that the best course of action was to cancel the learning series and then revisit to determine what the need or opportunity might be in late 2020. At this time, we are no longer focused on a learning collaborative and are actively partnering in the transformation center learning collaborative on the HAKR social developmental metric.

- A. Project short title: THW Plan
- B. Project unique ID (as provided by OHA): 81
- C. Criteria for project discontinuation: Project fails to meet TQS guidance in requirements for the chosen component(s) based on OHA feedback and/or written assessment
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): At this time the THW utilization and integration plan has been developed and includes member and community feedback. The plan aims to support social needs at a community level through building a robust THW workforce but does not explicitly address the four key SDOH-E domains.

- A. Project short title: Cost and Utilization Steering Committee
- B. Project unique ID (as provided by OHA): 85
- C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): The CCO submitted the initial PROM action plan to OHA according to deliverable due date. At this time work explicitly related to MEPP (previously known as Prometheus) are shifting to focus on how MEPP can support existing strategies and bodies of work by integrating MEPP as a tool versus a standalone platform or project.

- A. Project short title: OUD Prescribing – Buprenorphine

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- B. Project unique ID (as provided by OHA): 86
- C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Our SUD work has matured and this work with combined into the project 70 on SUD access. CPCCO continues to measure access to MAT through a medication possession ratio (MPR) that can determine how engaged a member is in treatment with buprenorphine over time. As new injectable medications for addiction have come into the market, including Sublocade, other indicators for engagement in treatment must be developed. See Project 70 for more detail. In 2021, the MAT Learning Collaborative there will be focused topics on Buprenorphine including "The Intersection of Persistent Pain, OUD, and Buprenorphine." Following the Learning Collaborative, CPCCO will continue to provide ongoing technical assistance to clinics interested in improving their initiation and engagement of members with OUD into treatment.
- A. Project short title: Community Wellness Investment Funds
- B. Project unique ID (as provided by OHA): 83
- C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes
- D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Add text here:  
CPCCO has a fully developed process for Community Advisory Councils to review, rate and recommend investments at the community level for projects that support the goals of the CPCCO Regional Health Improvement Plan's (RHIP) eight priority areas: Trauma-Informed Care/Practices; Access to Care: Medical, Behavioral and Dental; Access to Social Safety Net Services; Housing; Chronic Disease Prevention; and Suicide Prevention. . There is an annual review of the grant funds allocation and procedures to assure continual process improvement.  
All Community Wellness Investment fund (CWIF) grants are due in the early summer each year and there is a 90-day process in place to support advisory council members to make informed decisions about approving proposals. CWIF grants are reviewed and decided by the local and regional Community Advisory Councils, giving the CAC members an important, and state-required, role in supporting investments in local communities to address social determinants of health and other health improvement priorities.

### Section 3: Required Transformation and Quality Program Attachments

- A. REQUIRED: Attach your CCO's Quality Improvement Committee documentation (for example, strategic plan, policies, and procedures as outlined in TQS guidance).

The CPCCO Board of Directors oversees the implementation of the strategic plan for CPCCO and is accountable for setting performance expectations for the CCO, which include metrics for quality and transformation. The Clinical Advisory Panel (CAP), at the direction of CPCCO Board's Network and Quality Committee, provides the strategic leadership and direction for clinical transformation, including the projects for the TQS. The CAP ensures CPCCO's clinical transformation efforts and quality priorities are strategically aligned with those of its constituent organizations, the CPCCO community advisory councils as well as the CPCCO board, and that these efforts have the active support of clinical and executive champions at the highest organizational and community levels. The CAP has developed a strategic approach to quality that combines the CPCCO Board's strategic plan, the state mandated TQS components, clinical priority initiatives, the Regional Health Improvement Plan, and Performance Improvement Projects (PIPs) into a defined set of well-articulated goals to improve and transform the health and wellness of the

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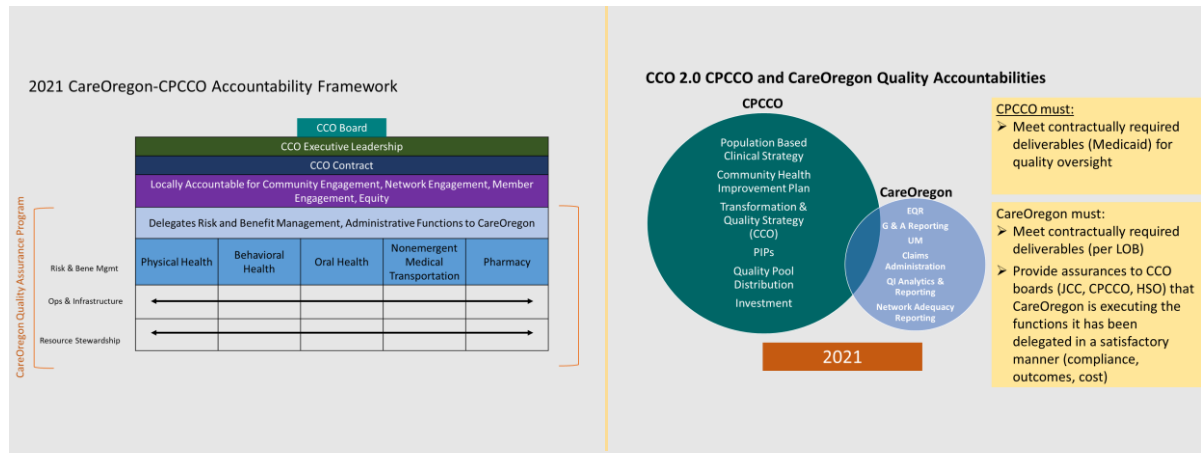
CPCCO population.

Figure 1

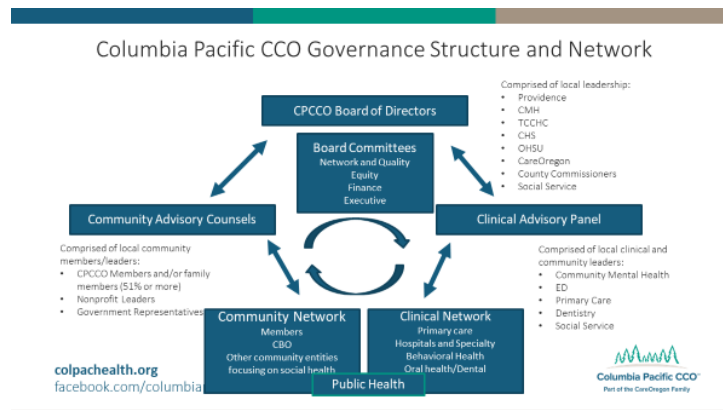


The annual CPCCO TQS process leverages the CareOregon quality governance structure and staffing to ensure CPCCO consistently meets its contractually required OHA deliverables (see #2).

Figure 2



Senior CareOregon staff partner with the CPCCO Leadership team to interpret the TQS requirements, establish timelines for completion, and ensure that TQS projects, programs, and performance improvement activities are aligned with the applicable OHA guidance and CCO contractual language. The CPCCO Project Manager is responsible for creating content and overseeing deliverables for programs included in the TQS. The TQS is reviewed and executed by the Columbia Pacific CCO Clinical Advisory Panel (CAP) and, for relevant work, CPCCO’s local Community Advisory Councils (CACs). The report is ultimately reviewed and approved for submission by the Network and Quality Committee of the CPCCO Board of Directors.



Columbia Pacific CCO (CPCCO) is a wholly owned non-profit subsidiary of CareOregon and has two contracts with CareOregon: one to provide administrative and health plan services to the CCO and the other to manage the insurance risk for physical and behavioral health services and NEMT. In the context of the Transformation and Quality Strategy (TQS), CPCCO is ultimately accountable for the submission of the TQS as a CCO contractual requirement, but responsibility for each of the TQS components is determined by the administrative agreements between CareOregon and the CCO. CareOregon administers the following health plan services to CPCCO for physical and behavioral health



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and NEMT: utilization monitoring, quality of care outcomes, member services including translation and interpreter services, grievance system inclusive of complaints, notices of actions, appeals and hearings, provider relations and quality monitoring, monitoring and enforcement of consumer rights and protections, and assessment of the effectiveness of the fraud, waste and abuse program. CareOregon also supports and administers the CPCCO IT infrastructure, assures and monitors network adequacy, and administers value-based payment models. CareOregon is responsible for ensuring that all CareOregon and CPCCO delegates are provided appropriate oversight and are operating in full compliance with state and federal regulations. The CPCCO Board, and/or the Network and Quality committee of the board, receives reports from CareOregon at least annually that include but are not limited to: Monitoring, Delegation Oversight status and any relevant Corrective Action Plans, outcomes of the state External Quality Review, DSN report outcomes, health plan operations compliance dashboard, and the progress of the TQS. The CPCCO Medical Director leads the CareOregon Quality Health and Outcomes Steering Committee, and partners closely with CareOregon Quality Assurance committees to provide alignment between CPCCO and CareOregon.

The CPCCO Network and Quality Committee of the board provides direct oversight of delegated activities, quality assurance activities, and transformation activities. As described above, at the direction of the board, the CPCCO Clinical Advisory Panel (CAP) is responsible for the guidance and development of transformation and quality strategies, which are also reviewed and approved by the Network & Quality Committee. The Network & Quality Committee reviews the CAP's quality and transformation recommendations for investment approval, and they are responsible for reviewing quality assurance reports, findings, and actions. Every attempt is made to take findings related to quality assurance reports, and develop quality improvement activities, to ultimately improve health outcomes and care delivered to CPCCO members. (see quality program graphic)

Network and Quality Committee		
<p><b>Regulatory Oversight</b></p> <ul style="list-style-type: none"> <li>- TQS Report</li> <li>- Quality Plan</li> <li>- External quality review Audit plan</li> <li>- Appeals and Grievances</li> <li>- DSN report findings</li> <li>- Utilization trends</li> <li>- Delegation of Dental Benefit to DCOs</li> </ul>	<p><b>Contract Deliverables to Clinical Strategy (CAP led)</b></p> <ul style="list-style-type: none"> <li>- HIT/UniteUs</li> <li>- Dental Clinical Strategy</li> <li>- Behavioral Health</li> <li>-Care Coordination</li> <li>- Social Determinants of Health</li> <li>-Improving access to care</li> <li>- Value Based Payments</li> <li>-Quality Metrics</li> <li>- Traditional Health Workers</li> </ul>	<p><b>Review and Recommendation to Board for Approval of Investment Related to Clinical Strategy</b></p>

## Quality Program



CPCCO conducts a quarterly review and analysis of all complaints and appeals received, including a focused review of any persistent and significant member complaints and appeals and ensuring compliance in the context of the grievance system report and grievance and appeals log with quality improvement standards as follows:

- a. Review of completeness, accuracy, and timeliness of documentation.
- b. Compliance with written procedures for receipt, disposition, and documentation; and
- c. Compliance with applicable OHP rules.

CPCCO's complaints and appeals are managed by CareOregon. CareOregon's Quality Assurance Manager, Clinical Operations conducts a quarterly review of CareOregon's grievance system report and grievance and appeals log to assure that CareOregon is meeting its timelines for receipt, disposition, and documentation, is compliant with applicable OHP rules as well as internal key performance indicators. In addition, the QA Manager conducts a monthly qualitative review of complaints to identify notable trends in types or sources of complaints, provide opportunities for follow up as needed, and identify service recovery opportunities where warranted; this review is done in conjunction with routine quality audits done by appeals and grievance coordinators staff and supervisors. The qualitative review further serves as a mechanism to identify variations that trigger a root cause analysis of negative trends or events, as well as potentially identify Quality of Care concerns that are escalated to the Peer Review Committee and the CPCCO medical director.

The Quality Assurance Manager, Clinical Operations is also responsible for reviewing and analyzing trends related to appeals. On a monthly basis, a collaboration between the Grievance & Appeals staff, Utilization Management Department, Medical Directors, conducts a monthly review of the reason for overturned medical appeals and identify opportunities for improvement.

Compliance with contractual timeliness and response standards is reported monthly on the Compliance Dashboard, and the CPCCO Network & Quality Committee will receive a quarterly summary of complaints and appeals by CPCCO members with year-end report summaries with trends and analysis presented to the committee annually.

Findings identified during the Compliance Monitoring Review are presented to the CPCCO Executive Director and the CPCCO Network & Quality Committee by CareOregon's Director of Quality Assurance, who is responsible for ensuring that corrective action plans are executed and implemented as outlined in submitted improvement plans. The

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CareOregon Director of Quality Assurance sits on the CPCCO Network & Quality Committee as a non-voting member to keep the committee informed of progress on corrective actions and escalate barriers when necessary.

CPCCO continually uses our quality program, and overall' quality improvement process to identify opportunities for improvement within our strategic initiatives, asks from the network/CAP/CAC, and/or because of findings related to regulatory requirements. Our Clinical Advisory Panel and Network and Quality committee of the board serve both to advise and approve clinical and quality improvement strategies, as well as to identify gaps in services, and opportunities for improvement.

Decisions to modify clinical practice guidelines or nationally recognized protocols are vetted through the CareOregon Quality & Health Outcomes Steering Committee (COQHO), on which the CPCCO Medical Director serves. If modifications are made, they are developed from scientific evidence or a consensus of health care professionals in a particular field. CPCCO would seek out opinions and guidance with applicable providers in the event of an exception to a guideline. Whenever possible, guidelines are derived from nationally recognized sources that are evidence based. The current guidelines, derived from Institute for Clinical Systems Improvement (ICSI), are reviewed, and approved by COQHO; at least every two years or when updates occur. All guidelines (modified or not) that are approved through COQHO are communicated to the CPCCO CAP and are made available through the CPCCO provider portal to all medical providers as needed.