MARCH 15, 2022

COLUMBIA PACIFIC CCO

2022 TQS

Contents

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 80: Trauma Informed Network

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

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 Columbia Pacific CCO'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 and improved resilience that buffers the health and social effects of adversity.

Outreach, recruitment, and community education about the trauma informed networks continued throughout 2021. By January 2022, 26 organizations in Clatsop County and 34 in Columbia County had formally joined the networks by signing a letter of commitment. Columbia Pacific CCO continued to facilitate participative processes in each county to support the member organizations to continue to design the network by finalizing the steering committee responsibilities, launching the sector workgroup and working together to roll-out the community launch events (see below).

In April 2021, Columbia Pacific CCO supported leaders in both networks to formally launch the networks in public virtual launch events. Launch events in both counties included speakers and action planning and raised awareness of adverse childhood events (ACEs), childhood trauma and resilience as well as the aims of the networks to combat these issues in the larger community. The launch events were publicized in local media, social media channels and through each of the service providers and community organizations that belong to the networks and serve OHP members. We also coordinated with the Clatsop and Columbia Community Advisory Councils to invite OHP members to these special events. Spanish language interpretation was offered. In Columbia County, the launch event also included a panel discussion with representatives from similar initiatives from around the Pacific Northwest who shared their experiences implementing trauma informed approaches and resiliency initiatives. Additionally, Columbia County hosted a special evening parent night to support parents to help children manage their emotions. Network members requested this special event to offer immediate support to children and their parents in light of the emotional challenges brought by the COVID-19 pandemic. To prepare for the launch, Columbia Pacific CCO supported network members to identify core teams within each member organization who will lead the TIC and resiliency initiatives for that organization (2021 Activity 1 successfully completed).

Following the launch events, each network also launched four sector workgroups, one for each of the following sectors: healthcare, education, child welfare and community. Each sector workgroup is 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 were developed which include the sector workgroup purpose, goals, procedures, roles and responsibilities and member assignments. Each sector workgroup met regularly in 2021 and set up a monthly meeting schedule for 2022. Additionally, each sector workgroup examined priority areas in their sector from the strategic plan and developed a timeline for 2022 to prioritize what they will be working on together so they can all be on the same page with their goals and plans for moving forward (2021 Activity 2 completed).

2021 Activity 3 postponed until Spring 2022: While the trauma informed, ACEs and resiliency building trainings were postponed due the ongoing challenges related to COVID-19, they are currently scheduled to take place in April 2022. In particular, the health care sector in Clatsop and Columbia counties was overwhelmed by the surge of local COVID-19 cases in the summer/fall of 2021. Additionally, many of our member organizations, particularly in the health care and education sectors, struggled throughout 2021 to adapt to changing conditions, staffing challenges, and increased workloads, making it more difficult to take on additional commitments. At the same time, TIC has become even more important due to the collective trauma endured by children, families and communities in 2020 and 2021 due to the extended pandemic, and compounding existing traumas that, unfortunately, affected those already at-risk to a greater degree. Columbia Pacific CCO responded by providing additional support and slowing down when necessary, allowing the networks to help communities recover from the trauma inflicted by the COVID-19 pandemic without overwhelming them. We hope to involve all network members in these cross-sector trainings in 2022, with a special focus on community organizations serving underserved populations in the health care, education, child welfare and community sectors.

Please note that the Clatsop County network postponed their planned examination of the intersection of childhood trauma and racism due to COVID-19 pandemic related overwhelm.

Gaps identified: most participative processes involved organizations that serve OHP members rather than OHP members directly with the notable exception of the launch events. In 2022, Columbia Pacific CCO will support community organizations to adopt trauma informed processes and approaches that will help them better support and engage vulnerable community members including OHP members. For example, one of the elements of the trauma informed approaches taught to the community organizations in the workshops proposed for 2022 includes community participation and creating feedback loops to hear directly from those who are most vulnerable and those who utilize the services including OHP members. Columbia Pacific CCO will help member organizations develop plans to implement these tenets in their organizations.

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 Community Health Improvement Plan (CHIP) priorities. Of the 147 people who voted across the 15 events, 55% voted that trauma-informed care should be Columbia Pacific'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 CHIP and in practice as well, often supporting trainings and events, but desiring a more systematic response. Though Behavioral Risk Factor Surveillance System (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, and the Department of Education, among others. 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 and nurturing relationships with community partners in Clatsop and Columbia counties.
- Working with partners to build strategic plans that highlight data as the basis for action and establish strategies, interventions, desired outcomes, and indicators of success.
- Collecting initial baseline data to measure progress against the indicators in the strategic plan. Some indicators will utilize existing data sources including Oregon Health Authority, Oregon Department of Education and DHS. However, due to the limited nature of county level data for Clatsop and Columbia counties, network member organizations will need to collect some of the needed data themselves. Columbia Pacific CCO hopes to complete this baseline in 2022 so that member organizations can begin strategic plan projects.
- 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. For example, the 2022 baseline data collection will be coordinated in the sector workgroups that were formed in 2021.

In supporting network member organizations during the COVID era, the following lessons were learned:

- Trauma-informed efforts already underway in some sectors in the target communities; instead of replicating work, build on what has already been done
- Use a framework to structure collaborations (i.e., collective impact)
- Identify and invest in developing TIC champions across sectors
- Create a common language for cross-sector collaboration
- Some sectors don't recognize the importance of adopting TIC approaches

Since the project inception, Columbia Pacific CCO facilitated a process in each county to support member organizations to design the networks including bringing together member organizations for collective impact visioning and designing network architecture. Network architecture 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.

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. Both networks approved their strategic plans in 2020.

As described in section A, in 2021 Columbia Pacific CCO supported the networks to hold community launch events in both Clatsop and Columbia Counties and establish 8 sector workgroups (health care, education, child welfare and community). The trauma informed, ACEs and resiliency building trainings were postponed until 2022 due to the pandemic.

E. **Brief narrative description**:

In 2022, 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 workgroups 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. In 2022, with Columbia Pacific CCO support, the networks will roll out a series of trainings to help member organizations implement trauma informed approaches in their respective organizations and develop two websites for community awareness raising and communication.

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 2022					
1.	Astoria School District	11.	Clatsop County	20.	Helping Hands
2.	Awakenings by the Sea	12.	Clatsop Juvenile Department	21.	Jewell School District
3.	Clatsop CASA Program, INC.			22.	Knappa School District

4. Clatsop Behavioral Health 5. Clatsop Community Action 6. Clatsop County Public Health 7. Columbia Memorial Hospital 8. Sunset Empire Park and Recreation District 9. The Harbor 10. Warrenton-Hammond School District	13. Coastal Family/Yakima Farm Workers Clinic 14. Columbia Pacific CCO 15. Consejo Hispano 16. Department of Human Services (District #1) 17. Riverside Community Outreach/Every Child 18. Seaside Public Library 19. Seaside School District	23. Northwest Oregon Housing Authority 24. Northwest Regional Education Service District 25. Oregon State University Extension (Clatsop County) 26. Providence Seaside Hospital
Columbia County Childhood Trauma Informed Network Member Organizations January 2022		
1. Adventist Health Tillamook Medical Group, Vernonia Clinic 2. Amani Center 3. CASA for Children of Multnomah, Washington and Columbia Counties 4. City of St. Helens 5. Clatskanie School District 6. Columbia Community Mental Health 7. Columbia County 8. Columbia County District Attorney's Office 9. Columbia County Public Health 10. Columbia County Treatment + Courts	11. Columbia Pacific CCO 12. Columbia Pacific Food Back 13. Columbia River Fire + Rescue Scappoose Rural Fire Protection District 14. Community Action Team 15. Department of Human Services (District #1) 16. Iron Tribe Network 17. Legacy Medical Group St. Helens 18. Northwest Oregon Housing Authority 19. Northwest Regional ESD 20. Oregon Health & Science University Scappoose Clinic 21. Oregon Law Center	22. Rainier School District 23. Riverside Community Outreach/Every Child Columbia 24. SAFE of Columbia County 25. Sandee School of Horsemanship 26. Scappoose Public Library 27. Scappoose School District 28. St. Helens School District 29. Tillamook County Transportation District/NW Rides 30. United Way of Columbia County 31. Vernonia School District 32. WildFlower Play Collective 33. Youth Era 34. Columbia Health Services

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 ACEs, the work for the networks – including raising awareness of ACEs and childhood trauma among service providers – inherently benefits these populations.

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. Efforts are collaborative across sectors as community organizations partner together towards a common goal.

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

Activity 1 description: Offer trauma informed, ACEs and resiliency-building training across sectors with a special focus on member organizations and service providers who serve vulnerable populations in Clatsop and Columbia counties. The training will be held virtually due to current pandemic conditions. As such, it will be possible to hold just one training and reach both counties.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Add text here			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
O trainings	1 training held	06/2022	One training held for both counties; 50 people trained in TIC in each county; increase knowledge of trauma informed care and NEAR science in target counties	06/2022

Activity 2 description: Offer 8 workshops to trauma informed care champions and core teams within network member organizations to help them implement trauma informed approaches in their own organizations with a special focus on member organizations and service providers who serve vulnerable populations in Clatsop and Columbia counties. These practical follow-up trainings will support member organizations to develop their own plans to adopt trauma informed practices.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Add text here			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 workshops held	8 workshops held	12/2022	8 workshops held, 4 in each county; 32 champions trained; increase practical knowledge of adopting and implementing	12/2022

			trauma informed approaches	

Activity 3 description: Develop and establish the Trauma Informed Care (TIC) and Resilience Fund. The purpose of the TIC and Resilience Fund is to help the trauma informed networks in Clatsop and Columbia counties move towards becoming self-sufficient and sustainable. The TIC and Resilience Fund will support projects from the network strategic plans. Columbia Pacific CCO will contract with a foundation to administer the Fund and will coordinate together closely to put the fund infrastructure into place. Columbia Pacific CCO will support each steering committee to develop a clear and transparent grant review process and to serve as the grant review committee for their county.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Add text here			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 TIC and Resilience Funds	1 TIC and Resilience Fund created	12/2022	Columbia Pacific CCO board of directors invested resources to create the TIC and Resilience Fund; clear and transparent grant review process developed; invite network member organizations to apply for grants	12/2022

Activity 4 description: Develop two websites, one for each network, to facilitate the work of the networks in each county and to help community members and organizations connect with and learn about the networks, childhood trauma and building resilience.

☒ Short term or ☐ Long term

Monitoring measure 4.1	Add text here			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0	2 websites developed	12/2022	Websites developed for	12/2022

			each network	

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 74: Equity Data Guidelines

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

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?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ 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.

Columbia Pacific CCO uses population level data to guide strategy, improve population health, and inform program development. Without an equity-informed approach to data, we run the risk of furthering disparities as opposed to addressing and eliminating health disparities, which is our mission. It is vital to improve the comprehensiveness and reliability of our equity-informed data; but data alone cannot achieve health equity. The power of data depends on our ability to wield it in a way that identifies disparities and interrupts harmful patterns. Toward this end, we had directed our 2021 TQS attention and effort on the following activities:

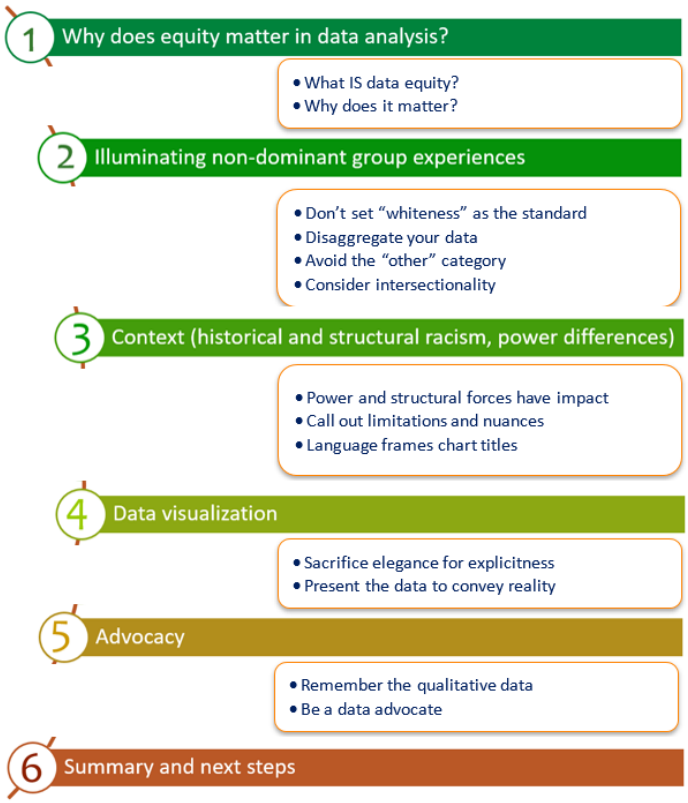
1. Develop a Data Equity Guide and train staff on equity-informed data practices.
2. Support our provider network with technical assistance on equity-informed data practices and disaggregation.

Develop a Data Equity Guide and train staff on equity-informed data practices.

In early 2021, through a collaborative effort of the quality improvement team, and championed by CareOregon's Health Equity Advisor, an initial version of the Data Equity Guide was drafted with recommendations for integrating equity principles into data analysis and data visualization.

To add additional perspective, the Data Equity Guide, was next vetted through several CareOregon internal committees including the Equity Diversity & Inclusion (EDI) Steering Committee, the Data Governance Committee, and a community of practice for analysts and developers. After this internal feedback process, in April 2021, the Data Equity Guide received a final review from the consultant who inspired the work, Tusk Consulting, and the Guide was shared with the Alliance of Culturally Specific Providers.

Topic Areas



CareOregon's EDI Steering Committee further advised that the Guide become an official CareOregon reference document and approved the development of a companion data equity video training to be accessible through CareOregon's staff training portal, CareU. By the end of 2021, the Data Equity Guide was fine-tuned, and the companion Data Equity Training was developed, recorded, and underwent two pilots with separate groups of CareOregon staff. The Data Equity Guide and Training has been sent to CareOregon's marketing department for editing. This draft recording will then be reviewed by CareOregon's executive leadership team. Pending feedback, the next step was to finalize all materials and upload them into CareU to be available for all staff in early 2022.

CareOregon's Chief EDI Officer has been briefed on the Data Equity Guide and endorses implementation. CareOregon analysts who have received the Data Equity Guide and Training have already reported implementing the recommendations. Substantial excitement and curiosity about this resource and training opportunity has been expressed by a variety of teams across the organization. The Peer Review Tableau Dashboard Certification process developed by the CareOregon analytics team will also include a checklist to verify that dashboards have applied recommendations from the Data Equity Guide.

All analysts and staff who use or present data (Population Health Manager and Medical Director), who support Columbia Pacific CCO have completed the Data Equity Training (2021 Monitoring Activity 1 completed). This training as well as a more comprehensive data equity curriculum will be explored for all Columbia Pacific CCO staff, in order to support more equitable and inclusive data practices. 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. Towards the end of 2021, these recommendations were applied to our COVID-19 vaccination graphics and for all data sharing with internal and external partners working to improve vaccine access for our members; this helped us to develop targeted outreach efforts tailored to specific communities.

Support our provider network with technical assistance on equity-informed data practices and disaggregation.

The Columbia Pacific Quality Improvement Workgroup (QIW) is comprised of practice administration, quality improvement staff, and providers/navigators from primary care and behavioral health clinics in the Columbia Pacific CCO region. In 2020, each monthly meeting included a discussion topic with the group around data equity. To build off this

learning momentum, in 2021 we were intentional in sharing disaggregated data with the group and incorporating additional time and space for discussion to explore and understand the data using an equity lens.

In Q1 2021, we shared disaggregated data and facilitated discussions about the data using an equity lens during every monthly meeting at the QIW (January, February, and March) and with our multi-disciplinary Clinical Advisory Panel (CAP) in February. The conversation that unfolded during these discussions illuminated that many of our clinics have a limited understanding of why data disaggregation is important, and how it presents an opportunity to improve health equity.

As the COVID-19 pandemic continued to strain our network, and the Delta and Omicron surges intensified the acuity of need and scarcity, CCO quality metrics and other resource-intensive asks of our clinical network were put on hold in Q2-Q4 2021. Similarly, the focus of technical assistance offered to clinics shifted from metrics and data equity to more immediate concerns related to the COVID-19 such as addressing staffing challenges and member access issues. Despite these barriers, we kept a focus on data equity by ensuring that any COVID-19 data we shared with our network was stratified by race, ethnicity, and language to expose disparities and support targeted improvement efforts (2021 Monitoring Activity 2 partially completed).

We still believe the QIW is a productive venue to work on equity and data disaggregation with our network. In 2022, we will return to using the QIW to offer technical assistance to providers and organizations on stratifying performance and monitoring metrics using REAL D data and using data equity practices to identify and respond to disparities. To-date, two providers have presented stratified performance data at the QIW as part of our network learning experience. We hope that with continued learning, technical assistance, and encouragement, additional providers will be equipped and able to also share disaggregated data in 2022. We also intend to leverage the new OHA Social-Emotional Health Metric as another opportunity to illustrate the importance of data disaggregation in identifying disparities in healthcare services and health outcomes for our members.

Increasing accuracy of demographic data

CareOregon, and by extension Columbia Pacific CCO, has historically been challenged with access to accurate, complete, and high-quality demographic data for our members. According to findings from a series of tests on the REAL D/834 data fields received from OHA, a significant percentage of members have incomplete demographic data available. In addition, the structure of this data is inconsistent and often misaligned with REAL D standards.

These gaps and limitations substantially challenge our ability to use current member data to meaningfully analyze health disparities across REAL D demographic categories. In response, CareOregon has implemented two strategies to acquire the most complete and accurate demographic data possible for our Columbia Pacific members:

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

Identify and create a prioritization hierarchy of data sources based on reliability.

Throughout 2021, the data analytics and reporting team worked to map OHA-provided member data from end to end—member application to internal databases and data tables—and presented findings including issues, use cases, and next steps to internal stakeholders. Of specific focus was the race and ethnicity and language fields available in the 834 Enrollment Data File. Future work will address disability data as well as examine pathways for collecting and reporting sexual orientation and gender identity (SOGI) data available through other sources. The analytics and reporting team created standards and an analytics guide for use of these fields including a Peer Review Tableau Dashboard Certification process prior to dashboard publication. These findings and the 834 REAL D User Guide and Standards were presented to the CareOregon Analytics Community of Practice in a recorded meeting on August 17, 2021 achieving our goal to have all analysts trained on the 834 User Guide by the end of 2021. This training and companion 834 REAL D User Guide will be added to an analyst onboarding document currently in development for use in 2022. These standards have already been applied to 13 existing data dashboards where stratified member data is informing programmatic work in several departments.

Before Getting Started: Guidelines for Data Usage

This section includes any important recommendations or standards for using data at CareOregon. For example, consistent and appropriate grouping and labeling of member demographic data is outlined.

Data Equity and REALD

The below information is in addition to the CareOregon Data Equity Guide training available in CareU. This document contains more details into the standards created by CareOregon.

Additional resources:

- CareOregon
- Tableau No Harm Guide – Tableau provided a presentation and this document at the October Tableau User Conference

Race and Ethnicity Standardization

Race/Ethnicity Grouping

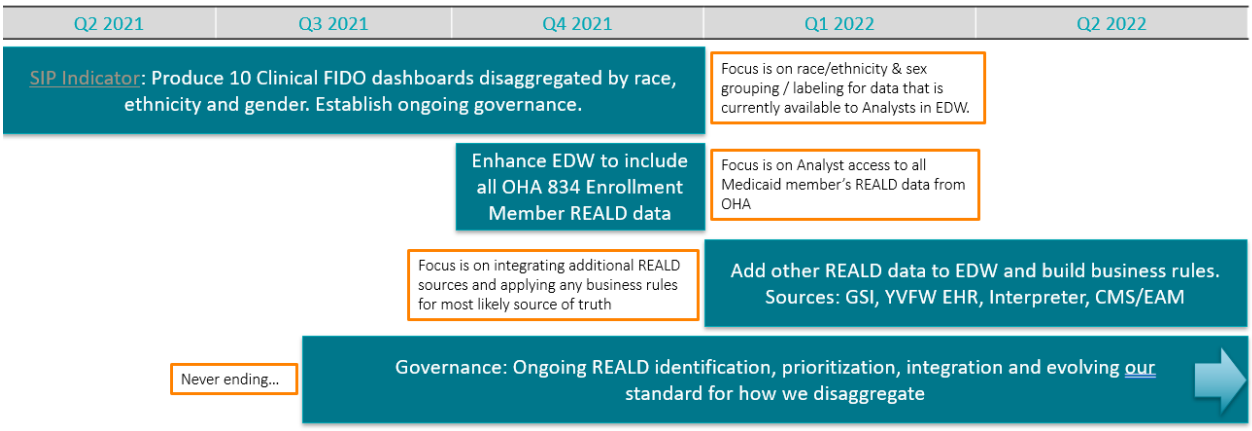
Currently, these recommendations cover data that is available for CareOregon members, from the QNXT system. As more data becomes available and we become better informed, additional standards will be developed.

Recommended Groupings and Labels for Analysis and Reporting	Raw data available in CareOregon data system(s)
American Indian or Alaska Native	American Indian or Alaskan Native
	Native American
Asian, Native Hawaiian, Pacific Islander	Asian or pacific Islander
	Asian Pacific American
	Native Hawaiian
	Pacific Islander
	Subcontinent Asian American
Black or African American	Black or African American
	Black or African American (Non-Hispanic)
Hispanic or Latina/o/e/x	Hispanic
Not Provided	NO ETHNICITY
	Not Provided
	Not Applicable

Build a Data Table that allows multiple data sources to feed one demographic field.

In Q1-Q3 2021, the analytics and reporting team worked with member-facing teams to identify a variety of REAL D data collection points and create a roadmap for ingesting and reporting that data into one member data table. In addition, an analytics workgroup began identifying issues with coding and data mapping of REAL D data for resolution in 2022. The next steps for 2022 are to publish an analytics data table with the most updated and disaggregated member REAL D data available to the CCO.

Developing tools and trainings are effective only if they are supported by culture change and incorporated into regular practice. The goal we are ultimately hoping to achieve through these TQS activities is to change how data is used to improve health equity. Summarized below, is an account of our progress on each activity toward this overarching goal.



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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.

Develop a Data Equity Guide and train staff on equity-informed data practices.

Data has power: It is what we use to tell stories, drive strategic plans, and determine resource allocation. Defaulting to common data analysis and consumption practices can lead to inequities if we don't challenge the status quo.

In 2020, CareOregon staff from multiple departments participated in a third-party training provided by Tusk Consulting. This training, "Embedding Equity into your Data Analysis", was designed specifically for the needs of analysts. Training focused on how white supremacy influenced the development of research practices, and how systemic racism and bias continue to show up in research and analysis. As a result of this training, staff returned to work with increased awareness, knowledge, and inspiration to start doing something different in their analysis. The inspiration for the Data Equity Guide was to spread these learnings across the organization to change how data is used to improve equity.

The Data Equity Training equips those who analyze and consume data with an understanding of how to present, question, and think about data through an equity lens. The Data Equity Guide is a document of practical recommendations for integrating equity into data analysis and data visualization. The guide is referred to as a set of recommendations, rather than best practices because there will always be room for improvement. We expect our understanding of how to embed equity into data analysis to change over time as our discussions and learning continue. The Guide will primarily be used as a training and reference guide for staff who work with data. However, we are all consumers of data, and the content will be useful to everyone who works with, asks for, or consumes data.

Competing focus areas in 2021 (COVID-19), and substantial staff turnover have created internal barriers to broader uptake of the Data Equity Guide. Additionally, because we wanted to be intentional about the development and input process for the Guide and companion training, the building of these tools was a slow process. We have targeted early 2022 for a release of the companion training in our CareU platform to make these tools available to everyone in the organization. Columbia Pacific is also considering identifying specific roles that may be required to complete the training on an annual basis. Once the training is available, CPCCO will encourage all staff to complete the course. Furthermore, CPCCO's Justice Equity Diversity and Inclusion (JEDI) Data and Continuous Quality Improvement Workgroup will assess staff data equity training needs and develop a tiered set of training standards for various job roles. Once these standards are established, CPCCO leadership will work on incorporating the training standards into annual training requirements and new staff onboarding. This training as well as a more comprehensive data equity curriculum will be explored for all CPCCO staff to support more equitable and inclusive data practices. 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.

Support our provider network with technical assistance on equity-informed data practices and disaggregation.

Columbia Pacific CCO has substantially improved its internal abilities and expectations for stratifying data by patient race, ethnicity, and language for internal analysis. However, realistically, we cannot disaggregate data—nor is it meaningful to do so—for every single external partner meeting. Therefore, in 2021 we did more thinking about what is meaningful and supportive toward our end goal of improving equity. For example, we have shared stratified COVID vaccination data in focused workgroups with external partners to identify opportunities to reduce disparities in access and availability. On the other hand, we chose not to present disaggregated overall metric performance data to our Board of Directors because this content and audience would not position us to act toward improving inequities. Columbia Pacific staff who analyze and present data have begun creating guidelines for what data should be shared, with whom, and when. Reflecting on when data is the most meaningful and productive has shifted our approach and practices. Thus, in 2022 and beyond, rather than striving for a goal to share disaggregated data in every meeting, we are

trying to be more intentional about sharing disaggregated data in spaces where it will be used to identify problems and make decisions.

Furthermore, through trainings and discussions with our network in the last couple years, we have developed a better appreciation for where our network is in terms of understanding why data disaggregation is important and how it can be used it to advance health equity. If we offer technical assistance to our clinics to support them in disaggregating data, but our clinics do not recognize the value and opportunity created by this practice, then it won't make a difference, or could cause harm. Disaggregating data will not advance health equity unless our providers can use that information to develop interventions which will reduce disparities. Toward this end, we will develop our external data equity training approach for the Quality Improvement Workgroup and one-on-one clinical meetings to prioritize understanding why data disaggregation is essential.

Increasing accuracy of demographic data:

Identify and create a prioritization hierarchy of data sources based on reliability.

Our ability to identify and address disparities is often limited by the data we have available to us. As we began doing more intentional work stratifying performance by REAL D data, we realized not all our data sources included the same level of granularity or reliability. Therefore, one of our early tasks in this work was to identify and create a prioritization hierarchy of data sources based on reliability and to establish structures to prioritize data collected directly from members and/or data that is more recent and more frequently updated. Furthermore, we needed to upskill our analysts to use the most reliable data and to aggregate or disaggregate where needed. This necessitated the development of a REAL D Data User Guide for all analysts in our organization. This training and companion 834 REAL D User Guide will be added to an analyst onboarding document currently in development for use in early 2022. These standards have already been applied to 13 existing data dashboards where stratified member data is informing programmatic work in several departments. New dashboards published in 2022 will need to follow the same standards before approval to publish. The development of this hierarchy has already helped our organization more quickly identify and communicate patterns in negative COVID-19 outcomes as well as vaccination status across several internal and external teams.

Build a Data Table that allows multiple data sources to feed one demographic field.

Once we identified the multiple sources of REAL D information, we identified the need to build a data table that allows those sources to feed one demographic field based on a hierarchy. Our intent in developing this data table is to provide the most accurate and up-to-date member data which in some cases may come from OHA's 834 File and in some cases may come from our direct interactions with members. In either case, we want to ensure new data doesn't get overwritten by older or less granular data so that we can more accurately identify and address current health service and outcome disparities among our members. Investment in building this data table has been a great focus for our growing language access work.

Click or tap here to enter text.**Brief narrative description**:

E.

CareOregon, and by extension Columbia Pacific CCO, has historically been challenged with access to accurate, complete, and high-quality demographic data for our members. According to findings from a series of tests on the REAL D/834 data fields received from OHA, a significant percentage of members have incomplete demographic data available. In addition, the structure of this data is inconsistent and often misaligned with REAL D standards.

These gaps and limitations substantially challenge our ability to use current member data to meaningfully analyze health disparities across REAL D demographic categories. In response, CareOregon has implemented two strategies to acquire the most complete and accurate demographic data possible for our Columbia Pacific members:

1. Identifying and creating a prioritization hierarchy of data sources based on reliability—prioritizing data collected directly from members and/or data that is more recent and more frequently updated.

2. Building a Data Table that allows multiple data sources to feed one demographic field, providing the most accurate and up-to-date member data.

It is vital to improve the completeness and reliability of our data; but data alone cannot achieve health equity. The power of data depends on our ability to wield it in a way that illuminates disparities and interrupts harmful patterns. Toward this end, we will continue to direct our TQS attention and effort on the following activities:

3. Develop a Data Equity Guide and train staff on equity-informed data practices.
4. Support our provider network with technical assistance on equity-informed data practices and disaggregation.

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

Activity 1 description: Develop a comprehensive Data Equity Training Curriculum and establish tiered data equity training standards for Columbia Pacific staff.

☒ Short term or ☒ Long term

Monitoring measure 1.1	CCO staff that receive Data Equity Guide and complete companion Data Equity Training.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
5 Columbia Pacific taff completed training.	22 Columbia Pacific staff complete training (50%)	12/2022	40 Columbia Pacific staff complete training (90%)	12/2023
Monitoring measure 1.2	Establish tiered data equity training standards for Columbia Pacific staff.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No data equity training standards in place.	Tiered data equity training standards developed and vetted by CCO leadership.	12/2022	Establish tiered data equity training standards for Columbia Pacific staff and incorporate into onboarding and ongoing learning requirements.	12/2023

Activity 2 description: Provide technical assistance to provider network on equity-informed data practices and disaggregation.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Clinics in core network (12 primary care, 3 behavioral health) trained on updated data equity practices.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0 primary care clinics trained.	9 primary care clinics trained.	06/2023	All 12 primary care clinics and 3 behavioral health clinics trained.	06/2024
Monitoring measure 2.2	Clinics in core network (12 primary care, 3 behavioral health) that present stratified member data at QIW to identify health disparities as part of quality improvement plans.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2 primary care clinics have presented.	6 primary care clinics have presented.	06/2023	All 12 primary care clinics and 3 behavioral health clinics have presented.	06/2024

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 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

If continued, insert unique project ID from OHA: 73

B. **Components addressed**

i. Component 1: Grievance and appeal system
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? 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.

In 2019 CareOregon conducted a study that indicated non-white, non-English speakers submitted grievances and appeals at a rate disproportionate to the distribution of members belonging to these demographic groups. The same year, CareOregon conducted a study that analyzed two years of grievance data for dually eligible members, grouped by age, ethnicity, and when available, primary language. The findings from this study revealed that non-white, non-English speakers submitted grievances at a rate disproportionate to the distribution of members belonging to these demographic groups.

CareOregon's 2019 study examined dually eligible members from the Portland area but did not focus on data specific to Columbia Pacific CCO. The rich information gleaned by CareOregon's study inspired Columbia Pacific to review grievance and appeals data submitted by our members, in order to understand whether the same patterns existed in our region. This was the impetus behind the 2021 TQS Monitoring Activity 1, to analyze Columbia Pacific grievance and appeals data to understand if lower rates of grievances and appeals are submitted by Columbia Pacific members with Limited English Proficiency (LEP).

In 2021, we successfully pulled Columbia Pacific grievances data from Q4 2020 to Q3 2021, disaggregated by race, ethnicity, and language, to directly examine the distribution of grievances compared to the REAL D demographics of our members (2021 Activity 1 successfully completed).

Race/Ethnicity	Columbia Pacific Membership %	Grievances %
American Indian or Alaskan Native	1.6%	0.9%
Asian, Native Hawaiian, Pacific Islander	1.1%	0.9%
Black or African American	0.8%	0.0%
Hispanic or Latina/o/e/x	9.6%	5.6%
Not Provided	19.1%	18.5%
Other Race or Ethnicity	1.3%	1.9%
White	66.5%	72.2%

Language	Columbia Pacific Membership %	Grievances %
English	93.8%	100.0%
Spanish	4.8%	0.0%
Undetermined	1.3%	0.0%
Other	0.1%	0.0%

As you can observe in the tables above, discrepancies emerged between the distribution of race/ethnicity and language of Columbia Pacific's membership compared to that of the grievances received from Columbia Pacific's members. Specifically:

- 66.5% of Columbia Pacific members identify as white, but 72.2% of grievances were submitted by white members.
- Members who identify as Hispanic or Latina/o/e/x comprise 9.6% of Columbia Pacific's membership, but only account for 5.6% of the grievances received.
- All grievances received from Columbia Pacific members were submitted in English while nearly 5% of our member data indicated a preferred language other than English.

Pulling data is important but bringing data to audiences that can do something with the information is vital too. Thus, our 2021 targets for Activity 1 were:

- To share Columbia Pacific REAL D grievance and appeals data with the Columbia Pacific Network & Quality Committee of the Board, Community Advisory Councils (CACs), Clinical Advisory Panel (CAP), and full Board of Directors (BOD); and
- To establish a regular cadence of reporting REAL D grievance and appeals data with the Network & Quality Committee, CACs, CAP, and BOD.

We partially met both these targets in 2021. The Columbia Pacific grievance data was presented to the Network and Quality Committee of the Board of Directors in November 2021. This Committee also agreed to reviewing this data on

an annual basis to monitor the distribution of grievances submitted compared to the REAL D demographics of our Columbia Pacific membership.

This data was not shared with the CACs, CAP, or full BOD in 2021. Since this would be the first time these groups would see this data and consider this topic, we wanted to ensure there would be ample time to explain the data, offer context, and allow for questions. However, at year end when this data was available, the agendas for these meetings were already filled with other annual activities and topics related to the Omicron surge.

In 2022, we intend to bring this data to the CACs, CAP, and full Board, and we aspire to incorporate year-over-year data so we can monitor longitudinal trends by race, ethnicity, and language. In addition to sharing and monitoring this data with and across our governing bodies, Columbia Pacific has also incorporated a success indicator into our 2022-2024 strategic plan that is specifically focused on language access of our grievances and appeals process: *Increase by 10% grievance and appeals submitted in Spanish over 2022 baseline*. This multi-pronged approach to accountability and monitoring is one way we are addressing CLAS Standard 9: *Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.*

Also of note, in 2021 we only pulled grievances and not appeals data disaggregated by race, ethnicity and language. We discovered that the labor required to pull appeals data is more manually intensive than the process to pull grievances data. Since plenty of opportunities have presented with only the grievances data, we are extrapolating that our appeals data likely reflects comparable patterns to what we observed in our grievances data, and we plan to improve both processes accordingly, while we streamline a process to regularly pull appeals data too.

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

Coordinated Care Organizations are contractually obligated to provide linguistically appropriate information to members about their rights to submit grievances and appeals. CareOregon and Columbia Pacific CCO are consistently compliant with OAR and CCO 2.0 contract requirements related to the accessibility of information related to our grievances and appeals process. However, satisfying contractual requirements does not always translate to an optimal experience for people that access these services. We recognized the need to understand patterns in the submission of our grievances and appeals via data. However, CPCCO historically had no standard processes in place to pull, analyze, or report the REAL D distribution of our grievances and appeals data. Columbia Pacific

In 2019 CareOregon conducted a study that analyzed two years of grievance data for dually eligible members, grouped by age, ethnicity, and when available, primary language. The findings revealed that non-white, non-English speakers submitted grievances at a rate disproportionate to the distribution of members belonging to these demographic groups. CareOregon's 2019 study examined dually eligible members from the Portland area but did not focus on data specific to Columbia Pacific CCO.

For this reason, Columbia Pacific set a goal for 2021 to confirm whether the same pattern of lower rates of grievances submitted by members with LEP would also be observed for members in our region.

2021 was the inaugural year that grievances data was pulled for Columbia Pacific, disaggregated by race, ethnicity, and language. The data confirmed a disparity between the percentage of grievances filed by non-white and non-English speaking members, compared to the distribution of race/ethnicity and language of Columbia Pacific's entire membership. These discrepancies may imply that structural and institutional barriers are adversely impacting access to our grievances and appeals process by Columbia Pacific members, particularly our Spanish-speaking and/or Latina/o/e/x members.

Now that we have observed a disparity in the percentage of grievances that are submitted in a language other than English and by non-white members, we see two components to our improvement work:

1) Regular and ongoing monitoring of disaggregated grievances and appeals data to maintain accountability for outcomes and assess the effectiveness of our process interventions.
2) Explore, identify and address barriers that may disproportionately impact non-white members or those with LEP in regards to grievances and appeals

We anticipate this to be a multi-year project as there may be many opportunities to assess and improve our grievances and appeals system, ranging from relatively simple interventions, to more complex institutional change.

E. **Brief narrative description**:

The two activities we will be focusing on for this project in 2022 are:

1. Monitor longitudinal trends in grievances and appeals data by race, ethnicity, and language; and
2. Assess internal grievances and appeals process and identify institutional barriers impacting linguistic accessibility for members with LEP.

Monitor longitudinal trends in grievances and appeals data by race, ethnicity, and language.

The Network and Quality Committee of the Board has agreed to review data on an annual basis to monitor the distribution of grievances submitted compared to the REAL D demographics of our Columbia Pacific CCO membership. For future reporting of this data, we hope to incorporate year-over-year data so we can monitor longitudinal trends by race, ethnicity, and language as we attempt to make our system more accessible.

Since this data was not shared with the CACs, CAP, or full BOD in 2021, we will engage these groups in 2022 around this data.

To monitor our success for this activity, we have chosen a monitoring measure of the quality, cadence, and target audience of grievance and appeals data reports. By the end of 2022, our targets are to be sharing grievances and appeals data that reflects longitudinal trends; and to expand our audience for this data to include the CACs, CAP, and full BOD.

Assess internal grievances and appeals process and identify institutional barriers impacting linguistic accessibility for members with LEP.

When we submitted our TQS report in 2021, we believed that our best next step would be to conduct focus groups with members from historically marginalized groups to better understand their experience with and barriers to our grievances and appeals process. This was reflected in Activity 2 from 2021: *Collect feedback from members and communities from historically marginalized groups to create more equitable processes.*

This 2021 Activity included two monitoring targets:

- Complete one focus group (06/2022); and
- Establish processes and structures to regularly collect feedback from members and communities from historically marginalized groups (12/2022).

At this time, given the ongoing trauma of COVID-19, and the acuity of other priorities for communication, engagement of our members, we have made the decision to postpone this activity and instead focus our efforts internally.

Toward this end, the second 2022 Activity for this project will focus on assessing and addressing internal institutional barriers to our grievances and appeals process to make it more linguistically accessible to members with LEP.

Columbia Pacific CCO's grievances and appeals process is administered by staff from many departments across CareOregon, which makes it difficult to fully understand and identify areas that may be creating barriers for our members. Thus, our effort will begin by convening stakeholders across the CareOregon enterprise to create a value stream map of our grievances and appeals process from beginning to end. After mapping the process, we will apply an equity-informed language access lens to identify institutional barriers and create action plans to address those barriers.

Through this process, we look forward to identifying barriers we were unaware of, and in some cases, we already suspect barriers and plan to implement interventions, such as:

1) The development and implementation of a bilingual form to enable members or others representing members with LEP to file grievances directly in Spanish; and
2) Conduct an anonymous consumer or "secret shopper" study of CareOregon's customer service lines to assess potential barriers that hinder Spanish speaking members' access to the grievance and appeals process.

To monitor our success for this activity, we have chosen the following monitoring measures:

1. Completion of an end-to-end process map for submitting grievances and appeals; and
2. The identification of institutional barriers impacting linguistic accessibility for members with LEP.

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

Activity 1 description: Monitor longitudinal trends in grievances and appeals data by race, ethnicity, and language.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Quality, cadence, and target audience of grievance and appeals data reports.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2021 grievance data presented to N&Q Committee of the BOD.	Annual G&A data depicts year-over-year data to monitor trends over time.	12/2022	Annual G&A data shared with CACs, CAP, and full BOD.	12/2022

Activity 2 description: Assess internal grievances and appeals process and identify institutional barriers impacting linguistic accessibility for members with LEP.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Map the end-to-end process for submitting grievances and appeals.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
End-end processes not documented.	Map and document G&A processes.	12/2022		

Monitoring measure 2.1	Identify institutional barriers impacting linguistic accessibility for members with LEP.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

No barriers documented.	Internal barriers identified and documented.	12/2022	Action plans in place to address barriers.	06/2023.

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**: Meaningful Language Access

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

If continued, insert unique project ID from OHA:

B. **Components addressed**

i. Component 1: Access: Cultural considerations
ii. Component 2 (if applicable): Health equity: Cultural responsiveness
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? 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.

Throughout 2020 and 2021 Columbia Pacific CCO has deepened our work related to improving language access for our members that we began in 2017-18. In 2020 and 2021, CPCCO assessed our network's ability to provide meaningful language access to our members. We did this via three methods: 1) conducting anonymous consumer assessments, 2) retrospective chart reviews of our network to assess gaps and opportunities related to meaningful language access, and 3) including a scored narrative assessment into our Primary Care Payment Model.

Language Spoken	Distinct count of Member ID	% of Total Distinct count of CPCCO Member ID along Table (Across then Down)
ENGLISH	31,472	94.41%
SPANISH	1,488	4.46%
UNDETERMINED	316	0.95%
CHINESE	20	0.06%
ARABIC	8	0.02%
KOREAN	6	0.02%
HINDI	4	0.01%
TAGALOG	3	0.01%
PORTUGUESE	3	0.01%
THAI	2	0.01%
SIGN LANGUAGES	2	0.01%
RUSSIAN	1	0.00%
GUJARATI	2	0.01%
VIETNAMESE	1	0.00%
ROMANIAN; MOLDAVIAN; MOLDOVAN	1	0.00%
JAPANESE	1	0.00%
INDONESIAN	1	0.00%
GERMAN	1	0.00%
CENTRAL KHMER	1	0.00%
BURMESE	1	0.00%
BOSNIAN	1	0.00%

In 2020 and 2021 Columbia Pacific CCO exceeded our 2021 TQS monitoring goal by conducting 18 baseline assessments for various clinical sites amongst the 12 core organizations that comprise our network. The assessments were conducted by a certified interpreter who posed as a Spanish speaking patient seeking an appointment. These were done virtually, and only for scheduling due to the COVID-19 pandemic. The organizations were notified that these assessments would be taking place and the results were shared with clinic leadership. Upon completion of the assessments, we discovered the following themes:

- Single points of failure – Clinics may have one employee they rely on for providing interpretation/in language assistance.
- Language competency testing for staff is needed
- "No, no, no Spanish." – Some of the first words out of receptionist mouth when scheduling
- Call Disconnected – After long periods of being on hold or after various transfers the call would be disconnected
- Call Transfers – Moving from caller to caller until someone speaks Spanish
- Not offering language assistance when appointments are scheduled
- Providers that speak "some Spanish"
- Phone Trees that go through English messaging, and English-speaking receptionists
- Inability to communicate and schedule

We also conducted retrospective chart reviews of 2019 claims that had an interpreter flag to assess whether members who required interpretation services in fact received them. Due to the pandemic, our team was only able to review charts for clinics that they had preexisting EMR access to but we were still able to review 484 encounters for 172 unique patients. The review revealed that only about 30% of the charts had evidence of an interpreter visit. We also learned that most charts revealed a general lack of documentation, with the exception of interpretation refusals, and that many EMRs have reportable fields for interpreter name and ID that were being underutilized.

The final component of our network assessment was the inclusion of a scored narrative assessment within our Primary Care Payment Model (PCPM). It included the following components:

Narrative described how clinic offers language assistance
Narrative described how the clinic ensures LEP patients know services are offered at no cost

Narrative described how the clinic informs individuals of the availability of language assistance services verbally and in writing
Narrative described how the clinic ensures competence of language assistance providers
Narrative identified one area of improvement and an improvement plan

Of the 9 organizations that participate in our PCPM, 8 submitted the narrative and only two fully passed all the components. Common reasons for not meeting the criteria included:

- A lack of detail around workflows or processes
- Certified interpreters named by the organization were not able to be found on the interpreter registry
- Skipping the question entirely

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

The cumulative learning from the three activities above has been vital to understanding how Columbia Pacific CCO can support our network in providing meaningful language access to our members. For this new TQS project we are focusing on increasing access to and improving the quality of interpretation services, as well as improving our ability to collect accurate data on interpretation services within our network.

We have learned that many of our networks do not bill our CCO interpretation vendors when they provide that service within their clinics, which affects the accuracy of the data we receive. This was either due to not realizing they could, despite also having a contract with the same vendor, or due to having their own interpretation vendor they can use for all patients regardless of their insurance plan. We have worked with our clinic partners to build awareness of their ability to be reimbursed for interpretation when they do have the same vendor but also recognize that the data we receive via those reimbursements would never be fully illustrative of the need or use of interpretation services. For this reason, we have built a phased approach to collecting data into our PCPM. For the first-year clinics will be paid for reporting interpretation data, to incentivize them to begin building out the report infrastructure needed to gather this data. The PCPM component will require submission of aggregate data with an optional ability to submit member level data. The aggregate data report will need to include:

- Numerator
- Denominator
    i. CareOregon provides clinics a member roster – patients that have an interpreter flag according to MMIS/834 file and have had a visit in the measurement year. However, if the clinic adds additional members to the denominator who have self-identified needing an interpreter but was not captured in MMIS/834 file the clinic could potentially earn “extra credit”.
- Exclusions
    i. Refused interpreter and why (New field added for 2022 - four predetermined values)

Member level data will be optional in the first year but will be a requirement for future years.

The incentive provided by our PCPM to encourage our network to submit interpretation data creates a foundation upon which we can layer on our technical assistance support for the broader processes required to provide high quality clinical services for members who require/prefer services in a language other than English. From our assessments in previous years we have been able to identify which clinics in our region are high performers. We intend to work with

those clinics to assess their policies and procedures for providing interpretation, as well as learn from other best practices throughout the state/nation. We plan to develop a tool kit as well as process map from the patient perspective that would be all inclusive of the interpretation experience including such things as:

- Scheduling
- Phone call
- In person visit and all the touch points
- Offering of interpreter consistently
- Materials
- Data capture
- Documentation in EHR

Using the above as our vision we would work with our clinics to map out their current state using the information we collected via our previous assessments and their knowledge of their operations. Via this collaboration we would seek to identify:

- What are the areas of opportunity?
- What do the clinics want to focus on first?
- What do the clinics need to do for their process also related to meeting the OHA quality measure?
- What are their training needs?

This would enable us to collaborate with them on PDSA cycles for further improvement towards the identified ideal state.

E. **Brief narrative description**:

This project will build off the past few years of learnings we have acquired related to our network's ability to provide meaningful language access to our limited-English proficiency members. It focuses on building an infrastructure to collect data on interpretation services as well as improve the quality of accessing those services.

Data Collection

We have built a phased approach to data collection into our Primary Care Payment Model that will help incentivize our clinics to begin building and refining their ability to report on their interpretation services. The first year will be a graded submission on their ability to report data with no expectation of accuracy or improvement. This will allow us to build up to the ability to have a benchmark and improvement target in future years.

Quality Improvement

We plan to collaborate with our network to create a shared understanding of best practices for interpretation provision and to map out an ideal state. We will then use our previous learnings from past anonymous consumer assessments, chart reviews, and self-report narratives from our clinics to inform our approach to helping clinics map out their current state. That current state will inform the focus of PDSA cycles that we will support our clinics in conducting.

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

Activity 1 description (continue repeating until all activities included): Building an infrastructure to collect data on interpretation services as well as improve the quality of accessing those services.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Collect data on interpretation services for Columbia Pacific CCO members from 7 out of the 9 clinic systems			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0	7 clinic systems	3/2023	TBD based on data	

Activity 2 description: Assess and begin to improve interpretation services workflows within the Columbia Pacific CCO primary care network

☒ Short term or ☐ Long term

Monitoring measure 2.1	Collaborate with network to map current state of individual clinic interpretation workflows and processes			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0	4 clinic systems	12/2022		

Activity 3 description: Assess and begin to improve interpretation services workflows within the Columbia Pacific CCO primary care network

☒ Short term or ☐ Long term

Monitoring measure 3.1	Development of clinic-level interpretation toolkit			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Toolkit not available	Toolkit developed	12/2022	Toolkit developed	

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**: Oral Health Services in Primary Care

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

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

B. **Components addressed**

i. Component 1: Oral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this 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.

Oral health integration has focused on stabilization to ensure continuity and feasibility of programs to sustain efforts. While the pandemic continued to impact healthcare access and workforce shortage issues, our focus on oral health awareness and navigation to dental services within physical health settings has remained steadfast.

- Pregnant members remained a priority population throughout the pandemic's impact on dental access. Columbia Pacific's First Steps prenatal incentive program continued to share maternity lists for dental plan care coordination.
- Throughout the year, we continued to share monthly diabetes dashboards with medical claims denominator and dental claims numerator along with actionable lists of members with diabetes with dental plan partners. Columbia Pacific's messaging emphasized patients with diabetes as a priority population for access and utilization even during COVID. Additionally, Columbia Pacific CCO's embedded panel coordinator within our largest FQHC clinic in Tillamook successfully integrated outreach for patients with diabetes to include key messaging on the importance of oral health and navigation to dental.
- Columbia Pacific CCO's integrated internal team champions both dental and primary care innovations specialist staff working together as subject matter experts. This collaboration allowed for oral health conversations during PCP partner meetings, resulting in additional sites moving forward with initial First Tooth readiness assessments.
- Virtual oral health trainings and presentations took place to support primary care teams with integration efforts. Previously trained First Tooth sites nearing their three-year recertification period engaged in team trainings for workflow quality improvement and program sustainability.
- The CareOregon Provider Portal's Dental Care Request form for dental navigation continued to be utilized by previously trained primary care clinic partners.
- A portfolio of diabetes oral health educational and navigational materials was developed for both primary care providers and members. Materials have been shared with partners and the provider resource has been added to the Columbia Pacific website.

To date, we have enhanced the state's First Tooth training curriculum with readiness assessment and workflow development tools. We have developed a dental care request mechanism via the Provider Portal to ease navigation to dental. We have provided First Tooth trainings to 5 primary care and pediatric health systems with multiple sites using our integrated method. Even with our additional technical assistance and resources, data indicates that preventive dental services in primary care settings are administered at a low rate, therefore making this a priority area of focus for our oral health integration TQS. Year to date December 2021 data shows that 4.1% (364/8852) of children between the ages of 1 to 14 received a Preventive Dental Service by a medical provider; these rates may change with full claims run-out in 2022.

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

Dental caries is recognized as one of the most common chronic childhood diseases. It is transmittable and almost entirely preventable. According to the 2017 Oregon Smile Survey, children from lower income homes have nearly twice the decay rates as children from higher income homes. The findings also indicate health disparities and higher rates of dental decay, untreated decay, and rampant decay for Hispanic/Latinx children. Columbia Pacific CCO values the provision of oral health services and additional access points for members beyond traditional dental settings. One of the most impactful integration efforts may lie in well-child visits. Due to the frequency of wellness visits, there are more

opportunities for primary care and pediatric teams to support children and their families by discussing the importance of oral health. All members of the care team from before birth through adolescence play a crucial role in oral health education, dental navigation, and providing prevention services where possible.

This project is composed of two main components:

1) Providing basic oral health screenings, fluoride varnish application and referrals in primary care.
    - Upskilling primary care provider teams to provide prevention services in primary care settings such as:
        - oral health assessment or screening
        - fluoride varnish application
    - Enhancing the coordination of member needs through our dental care request process and other mechanisms that support care coordination efforts to ensure children establish a dental home.

2) Sharing member dental health information with primary care and integrated behavioral health through HIT.
    - Providing PCPs with basic dental health data points of their empaneled members through our primary care dashboard. This will further strengthen integration efforts and allow PCPs to discuss dental visit adherence and identify gaps in care.

Component One—bolstering oral health in primary care:

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 clinical partners. By creating integration and dental navigation tools, and providing targeted trainings, we aim to advance the knowledge and awareness of primary care teams on the importance of oral health for children ages 0-14 years. To incentivize this work, we have implemented a two phased approach to pediatric oral health integration into our Primary Care Payment Model (PCPM). Columbia Pacific CCO only has one pediatric clinic in our service region so we have asked all Family Medicine clinics whose pediatric population comprises at least 20% or more of their assigned population to focus on the oral health integration work on pediatric care. This will result in 12 of the 16 clinics that participate in our PCPM focusing on the approach described below.

<u>Phase 1: Narrative Report focused on designing clinical workflows & strategies:</u>

During Q3 of 2022 we will ask our clinics to submit an attestation of their ability to submit claims for fluoride varnish application and a narrative report with scoring criteria that focuses on:

- Design and document referral pathway(s) to dental services for all Medicaid members in target groups (kids ages 1-14 <u>and</u> diabetic patients)
- Design and document pediatric screening or assessment and patient education workflow
- Design and document fluoride varnish application workflow for Medicaid members in target group – Ages 1 to 10.

We believe this phase will incentivize our clinics to pursue First Tooth trainings during the first part of 2022. The narrative report will also guide the technical assistance we will be able to provide our clinics during the latter half of 2022.

<u>Phase 2: Metric Measurement & additional process information:</u>

The first reporting phase will set us up to begin collecting data on the next report submission cycle, which will be in Q1 of 2023. The second phase will require participating clinics to demonstrate improvement of Fluoride Varnish application over prior year baseline with a benchmark. We will also collect data on clinic use of our dental referral portal and ask clinics to include an attestation of self-reported referral volume for dental patients.

Component 2—HIT to support oral health information sharing with primary care & integrated behavioral health

We also aim to improve dental navigation and dental visit adherence with the ultimate goal of increasing dental utilization and lowering the incidence of dental caries. Now that we have current and historical claims and dental care request data from multiple partners, we are in the position to implement thorough and meaningful data analysis practices for quality improvement with an equity lens. The PCP children's preventive dental services dashboard is our own health information technology tool designed to further strengthen integration efforts. This dashboard transmits basic dental health data points to PCPs and includes information on their members' dental needs they did not previously have easy access to. Training on the use of the dashboard, with oral health messaging and dental navigation tools, will be designed to make the data actionable for partners and support member outcomes. Continued PCP training, utilization, and spread of the dental care request form builds communication pathways for care coordination with dental plans. This support addresses 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 children 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 for data-driven conversations and improvement activities with PCP and dental plan partners on timely access to care. Analysis of First Tooth oral assessment and fluoride varnish claims data to understand variability in data and determine strong and underperforming clinics will allow for shared learning and additional technical assistance. The development and spread of our robust pediatric oral health integration toolkit, including oral screening tools for the newly added D0190 dental screening code for primary care, will support these efforts for both internal CareOregon departments and external partners.

E. **Brief narrative description**:

This project is focused on supporting Columbia Pacific CCO members in receiving oral health services within a primary care setting and upskilling our primary care clinics in collaborating on oral health. We strive to achieve this by focusing on the following components:

1) Providing basic oral health screenings, fluoride varnish application and referrals in primary care.
    - Upskilling primary care provider teams to provide prevention services in primary care settings such as:
        - oral health assessment or screening
        - fluoride varnish application
    - Enhancing the coordination of member needs through our dental care request process and other mechanisms that support care coordination efforts to ensure children establish a dental home.

2) Sharing member dental health information with primary care and integrated behavioral health through HIT.
    - Providing PCPs with basic dental health data points of their empaneled members through our primary care dashboard. This will further strengthen integration efforts and allow PCPs to discuss dental visit adherence and identify gaps in care.

We will support these above components by integrating oral health into our Primary Care Payment Model, creating toolkits and other supportive materials, and providing First Tooth trainings along with ongoing technical assistance to our primary care clinics.

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

Activity 1 description (continue repeating until all activities included): Oral Health in Primary Care: Develop and share a robust pediatric oral health integration toolkit for CCO staff and network providers
☐ Short term or ☒ Long term

Monitoring measure 1.1	Development of comprehensive integration toolkit			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Toolkit not available	Toolkit developed	04/2022	Toolkit developed	04/2022
Monitoring measure 1.2	Distribution of integration toolkit with technical assistance			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No toolkits distributed	Toolkits distributed and technical assistance provided to 4 provider sites	04/2023	Toolkits distributed and technical assistance provided to 4 provider sites	04/2023

Activity 2 description: Enhancing HIT: Add dental engagement data to PCP dashboards. Data to include dental visit information, preventive dental services metric data and dental plan/clinic assignment

☐ Short term or ☒ Long term

Monitoring measure 2.1	Addition of actionable dental data on PCP dashboards			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Dental data not on PCP dashboard	Dental data added to PCP dashboard	10/2022	Dental data added to PCP dashboard	10/2022
Monitoring measure 2.2	PCPs trained on the use of the actionable dashboard			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No provider sites trained	4 provider sites trained	04/2023	4 provider sites trained	04/2023

Activity 3 description: Enhancing HIT: Work with the analytics team to determine the number and percentage of children 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.

☐ Short term or ☒ Long term

Monitoring measure 3.1	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	12/2022	Dashboard created	12/2022
Monitoring measure 3.2	Analyze and monitor the number and percentage of dental care requests for children that result in a completed dental visit within 30, 60, and 90 days of the request.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline not available	Determine 2022 baseline and future	04/2023	Baseline determined and	04/2023

	improvement target set.		future improvement target set.	

Activity 4 description: Oral health outside of dental settings: Analysis of dental services in physical health claims for quality improvement

☐ Short term or ☒ Long term

Monitoring measure 4.1	Determine baseline performance at the PCP-level of sites applying fluoride varnish in primary care and determine an improvement target for fluoride varnish applications in 2023.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline performance data not available	Baseline determined	3/2023 (to allow for claims runout)	Baseline determined	3/2023 (to allow for claims runout)
No improvement target set	2023 improvement target set	3/2023 (to allow for claims runout)	2023 improvement target set	3/2023 (to allow for claims runout)
Monitoring measure 4.2	Dental claims in physical health data analysis developed and reported			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data analysis	Data fully analyzed with accompanying findings and progress report	06/2023	Data fully analyzed with accompanying findings and progress report	06/2023
Monitoring measure 4.3	Deliver provider findings and resources for quality improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No findings available	Findings and resources delivered to 4 provider sites	12/2023	Findings and resources delivered to 4 provider sites	12/2023
Monitoring measure 4.4	Spread implementation of fluoride programs in primary care network			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
3 partners have developed and documented fluoride varnish application workflows	7 partners have developed and documented fluoride varnish application workflows	12/2022	7 partners have developed and documented fluoride varnish application workflows	12/2022

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**: Improving Behavioral Health Access: Expansion and Integration of Behavioral Health Services in Primary Care Settings

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

If continued, insert unique project ID from OHA:

B. **Components addressed**

i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Behavioral health integration
iii. Component 3 (if applicable): Access: Timely
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.

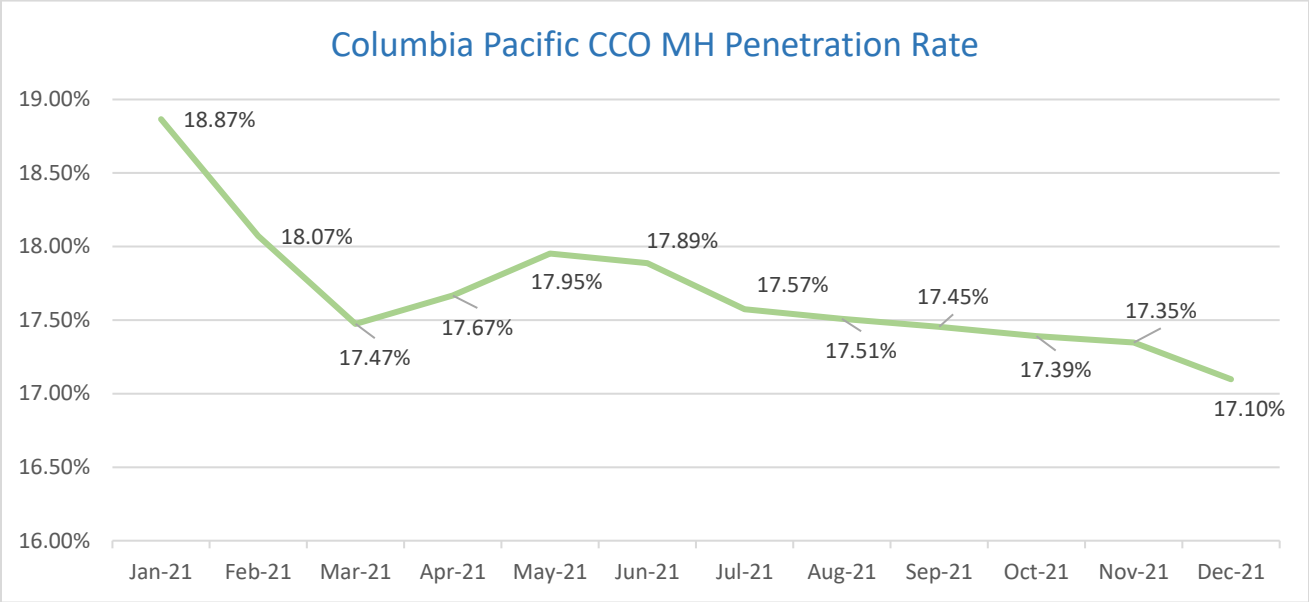
According to Columbia Pacific's 2021 Delivery System Network (DSN) Evaluation, we meet all rural travel time and access standards for adult and pediatric mental health and substance use services. Only 7% of our pediatric and adult populations that reside in areas of our region designated as "urban" do not meet the travel time and access standards for substance use treatment, but still meet the rural standards.

Table 3—DSN Time and Distance Analysis—Service Categories Below 100 Percent Access—Urban

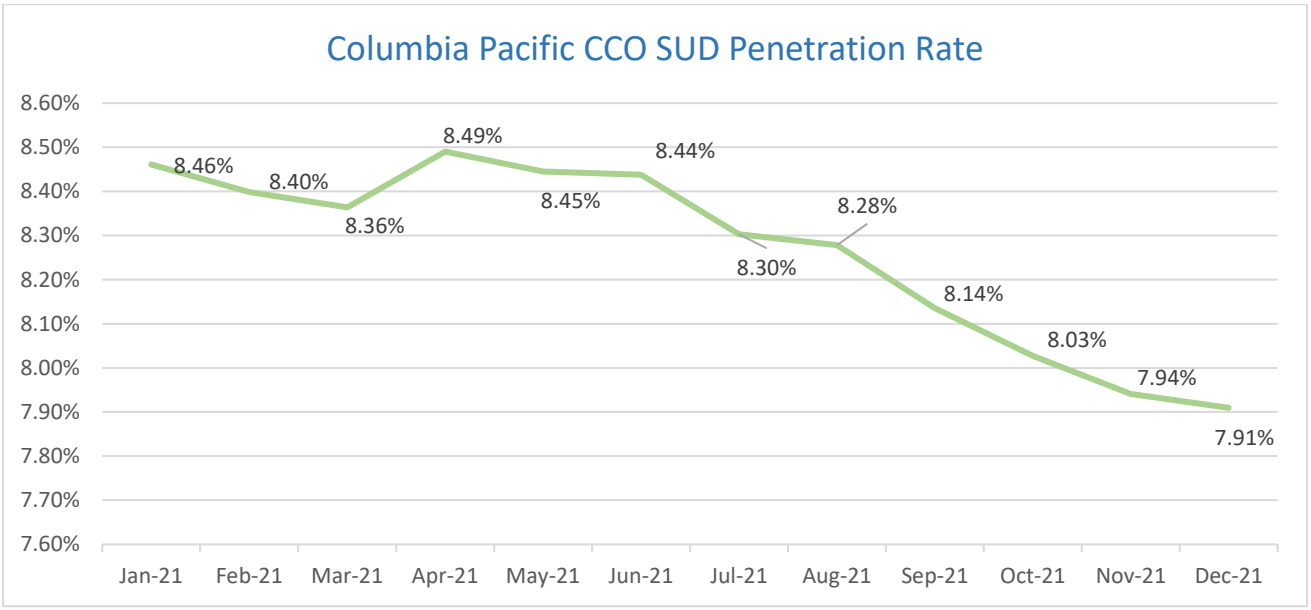
Service Category	Access Standard	Members Without Access	Percentage of Members With Access (%)
SUDPA	1 in 30 miles or 30 mins	166	93.1

Despite this, we know that an increasing number of our members are not accessing behavioral health services largely due to the behavioral health workforce shortage that has impacted our in-area behavioral health providers particularly negatively. Self-report data from each county's Community Mental Health Provider (CMHP) indicates that there can be a waiting period (for some members) for appointments with individual therapists following discharge from acute care. Wait times appear to be increasing, especially for members under the age of 18, but this has resulted in a decrease in overall behavioral health utilization by our members:

1. Number of unique members receiving mental health (MH) services (including primary care) compared to the total number of member months in the same period.



2. Number of unique members receiving substance use disorder (SUD) services (including primary care) compared to the total number of member months in the same period.



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

Timely access for members to receive quality behavioral health services has remained a challenge for the region. The rates of unique members receiving behavioral health services decreased as the COVID-19 pandemic progressed and was especially noticeable in the 2021 data sets. The data above shows a year-over-year decline of approximately 1.77% in the rate of unique members receiving mental health services. Additionally, there was a year-over year decline of approximately 0.55% in the rate of unique members receiving substance use disorder services.

There are a multitude of factors that influenced these trends including, but not limited to: the temporary shift to outpatient services being solely available via telehealth (due to the pandemic); the addition of new members in 2021

who access services at reduced rates, compared to previous member cohorts; and the behavioral health workforce crisis, which has limited available capacity.

For many years, CareOregon and Columbia Pacific CCO have funded an integrated behavioral health model as part of our Primary Care Payment program with primary care. This model focused on short "touches," and addressing a "behavioral health issue that is affecting a physical health condition. Over the past many years, we grew to understand our network and member's needs for increased behavioral health services beyond this. Many primary care clinics were offering our members counseling services out of need, but not getting paid for them.

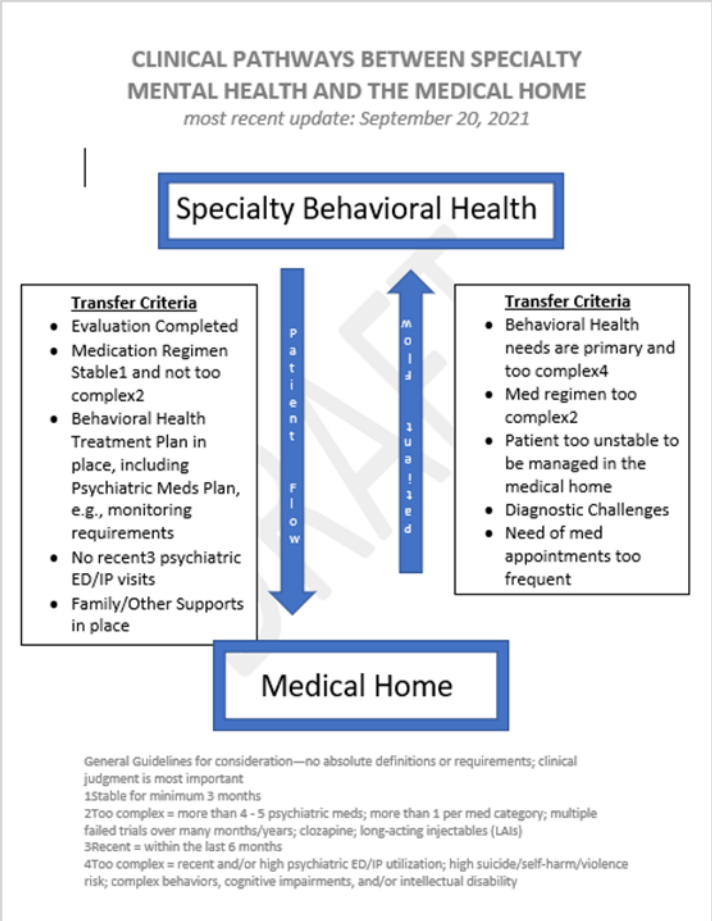
During the prior year (2021), Columbia Pacific CCO executed contract amendments with multiple Primary Care providers to reimburse for behavioral health services (such as therapy and case management) delivered in those settings. These contract amendments put primary providers in a position where they can now receive reimbursement for these critical services. Even with these new contracts in place, Columbia Pacific CCO has not observed that this factor alone resulted in a meaningful improvement relative to region-wide access to behavioral health service in 2021.

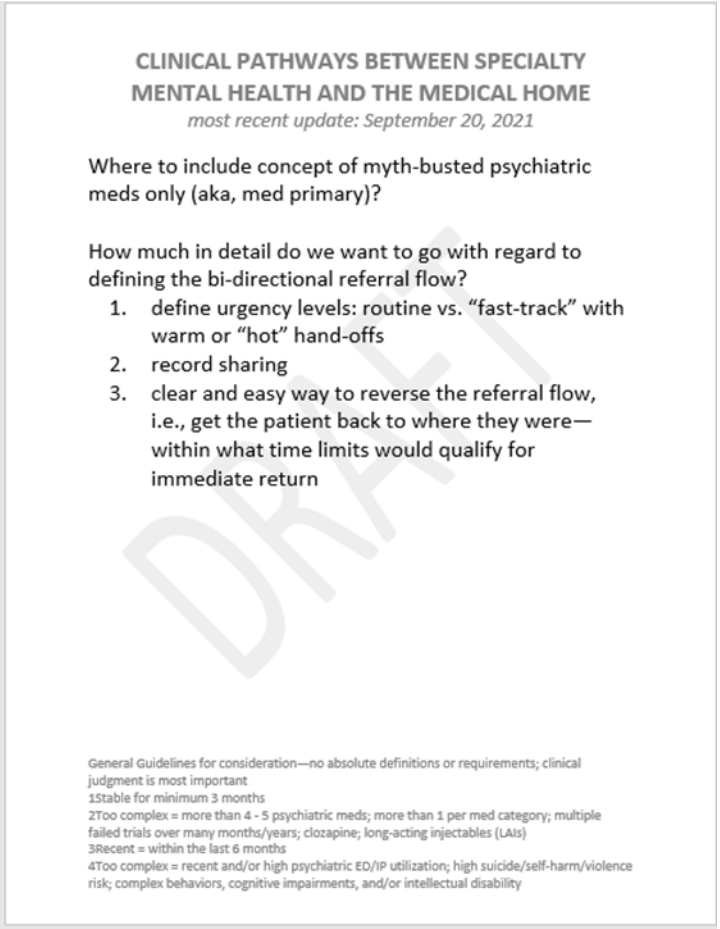
In 2022, we seek to build off of our strong partnerships with primary care and our Community Mental Health Programs (CMHPs) to develop a shared clinical model to actually expand behavioral health services in primary care beyond current state. We hope to identify certain populations on which to focus (ie members with DM and depression, teen members with depression as an attempt to prevent suicide, or members needing Autism assessment and diagnoses etc.), as well develop a bidirectional referral pathway between primary care and CMHPs. In addition, we will develop a toolkit illustrating the model and processes to help primary care implement it. By providing focus and scoping, we hope to support primary care in expanding their ability to provide needed behavioral health services to our members in a timely and high quality way, where they are already receiving care. This project may also include ways to build capacity of the behavioral health workforce in primary care if we collectively find this is required.

E. **Brief narrative description**:

After taking all factors listed above into consideration, Columbia Pacific CCO recognized an opportunity to further expand the delivery of behavioral health services in Primary Care. The high-level goals of this project include: 1.) promoting the integration of physical and behavioral health services in Primary Care settings; 2.) increasing the availability and accessibility of behavioral health services throughout the region. 3.) further refining both the criteria and pathways for bi-directional referrals for specialized behavioral health services between Primary Care and outpatient behavioral health providers.

The first phase of the project includes defining target populations and clinical considerations for members receiving behavioral health services in primary care. In this phase, Columbia Pacific CCO will expand upon and refine the Four Quadrant Clinical Integration model to specify which populations are emphasized for behavioral health services in primary care based on physical and behavioral health risk factors and complexity. The work to refine this model will also result in providing greater clarity for primary care providers on when to refer outside of primary care to more specialized behavioral health services. This information will be incorporated into technical assistance offerings to primary care to support them as they continue to operationalize behavioral health integration and bi-directional referrals. We have already started a draft of the clinical referral model:





The second phase of the project involves developing a glidepath for new alternative payment model(s) which support the delivery of behavioral health services in primary care. The objective in this phase includes: 1.) reviewing past/current payments to primary care providers for behavioral health services 2.) evaluating projected costs associated with supporting provider expansion of behavioral health services 3.) identifying and selecting the most viable alternative payment methodology for funding the expansion of behavioral health services in primary care.

The third phase of the project will be focused on the implementation of the first and second phases in collaboration with primary care providers. In this phase, technical assistance on priority populations and bi-directional referral processes will be made available to all primary care organizations who are opting in to expanding behavioral health services. In addition, the phase will include finalizing and executing new alternative payment agreements with identified primary care partners which will result in the expansion of behavioral health services. Throughout this project we will continue to monitor our number of unique members receiving mental health and substance use services. Due the workforce shortage we do not believe there is any easy way to restore those services to a pre-pandemic baseline but believe that as we execute new contracts with primary care partners we should begin to see service utilization increase.

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

Activity 1 description (continue repeating until all activities included): Define priority population focus for behavioral health services in primary care and build technical assistance toolkit for providers to implement population-driven strategies for delivering direct behavioral health services and supporting bi-directional referrals to more specialized outpatient behavioral health services.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Define population strategy with priority populations and clinical cut-offs for retaining members in behavioral health services in primary care versus referring to specialized outpatient behavioral health services.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No strategy with clinical referral criteria No priority populations identified on which to focus BH service expansion in primary care.	Priority populations identified and agreed upon by network Established strategy with identified priority populations and clinical criteria for referral	12/2022		
Monitoring measure 1.2	Develop toolkit to support behavioral health integration and bi-directional referral process			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No clinical model or toolkit developed to support primary care in implementation	Clinical model developed (focusing on above priority populations) and toolkit developed	12/2022		

Activity 2 description: Research and develop alternative payment glidepath to support the expansion of behavioral health services in primary care

☒ Short term or ☐ Long term

Monitoring measure 2.1	Evaluate current state of payments for behavioral health services in primary care			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No evaluation complete	Payment evaluation complete	12/2022		
Monitoring measure 2.1	Develop alternative payment glidepath for behavioral health in primary care			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

No alternative payment model	Alternative payment model created	12/2022		

Activity 3 description: Research and develop alternative payment glidepath to support the expansion of behavioral health services in primary care.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Deliver technical assistance support to primary care organizations on behavioral health integration/expansion using newly developed toolkit			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No clinics receiving technical assistance	4 clinics receive technical assistance	12/2022		
Monitoring measure 3.2	Execute new contracts for alternative payments to primary care providers delivering expanded levels of integrated behavioral health services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No contracts executed	2 executed contracts	3/2023		

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**: Expanding Transition Support to Observation Patients

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

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

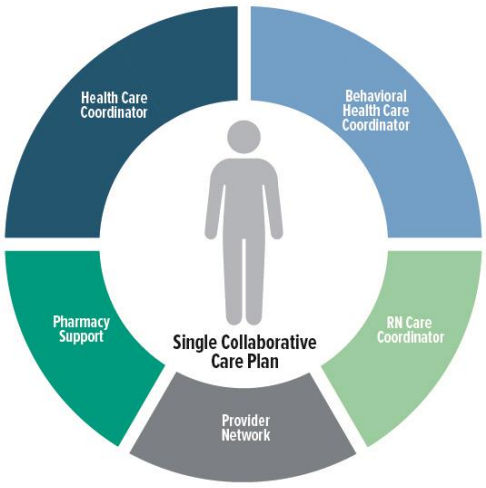
B. **Components addressed**

i. Component 1: SHCN: Full benefit dual eligible
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this 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.

Over the past year due to the workforce shortage, staffing and resource constraints and other repercussions of the COVID-19 pandemic, we have noticed observation stays occurring at equal if not increased rates of inpatient hospital stays. Knowing individuals in observation status face similar risks and health challenges as those with an inpatient

status, the CCO's Regional Care Team (RCT) will be offering the same transitions support to all members with a hospital stay categorized as observation status.



In 2021 19% of hospitalizations for Columbia Pacific members discharged from observation status, representing a portion of our population that did not receive extra transitions assistance. With our Dual population continuing to grow (we've had a 10.7% increase in Full Benefit Dual Eligible (FBDE) members in our service region this year) this expansion of support will ensure members with special health care needs facing a time of vulnerability will now have a member of the RCT assigned to coordinate services between settings of care, including appropriate discharge planning for short-term and long- term hospital and institutional stays that reduce duplication of assessment and care planning activities. It will also ensure each member with SHCN experiencing a transition will have an ongoing source of care appropriate to their needs and a person designated as primarily responsible for coordinating appropriate and services for and alongside them.

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

Transitional care is a core function within our care coordination services and comprehensively plans a member's care by incorporating their goals, preferences, and clinical status. Evidence based interventions are utilized to meet the needs of all members transitioning in and out of facility-based care settings, including emergency departments, acute care hospitals, skilled nursing facilities and other long-term care settings. Hospital discharge is a complex process representing a time of significant vulnerability for members. Due to this, transitions support is currently provided to all FBDE members experiencing hospitalization with an Inpatient status related to a physical health or psychiatric health exacerbation or crisis. This work reflects best practice in member care, improves health outcomes and supports meaningful reductions in readmission rates

The transitional interventions are based on evidence of current best practices, incorporating elements from Eric Coleman, the Naylor Transitional Care Model, and practices gleaned from high-performing organizations (in particular, Community Care of North Carolina).

The 4 pillars of Eric Coleman's transition model are medication reconciliation, understanding red flags (member education), access to member's health record and timely follow-up with provider.

- Medication Reconciliation: the RCT Care Coordinator, and in some cases the CCO clinical pharmacist, partners with the member's PCP to assure medications post discharged are reconciled with pre-discharge medication regimens.
- Understanding red flags (member education): the Care Coordinator reviews health education information shared with the member throughout the transitions period.
- Access to member's health record: the Care Coordinator verifies that the member receives and understands their discharge summary. Additionally, the Care Coordinator encourages and assists members to enroll in a patient portal with their PCP if able.
- Timely follow-up with provider: the Care Coordinator assures the member has a post-hospitalization follow-up visit scheduled (with PCP or other providers if necessary) and works with the member to make it to their appointment(s).

The assigned Care Coordinator is the point of contact for the member, legal representative/caregiver, providers and others involved in the member's care throughout the transitions process. The Care Coordinator reaches out to introduce themselves and maintain involvement throughout the observation period/length of stay and discharge from the facility. The Care Coordinator is responsible for facilitating the process from admission through discharge to ensure continuity of care and promote transitions into the most appropriate, independent and integrated community-based settings.

Transitional care support includes but is not limited to:

- Comprehensive needs assessment
- Care plan development and distribution
- Discharge planning
- Post-discharge outreach, and
- Case management

The comprehensive assessment identifies needs related to physical health, behavioral health, oral health, medication management and social determinants of health to create the individualized care plan. During this process, the care coordinator works with the member's current primary care team, behavioral health team (when applicable) , primary dental provider (when applicable), and the facility treatment team to identify gaps in the member's current provider list and determine if an alternate or specialty provider is needed. Upon identifying gaps, the Care Coordinator works to find alternate providers and secure timely follow-up services upon discharge. The Care Coordinator assists with connecting members to appropriate providers regardless of whether they are in-network or out-of-network.

E. **Brief narrative description**:

This project will expand our current evidence-based transition support workflow to include observation admissions/discharges along with physical health inpatient and behavioral health inpatient stays for all SHCN-FBDE members. During this first year we will focus on tracking the percentage of observations admissions/discharges that receive transitions support as evidenced by completion of a transitions assessment and/or enrollment in transitional support program. We will also track our overall re-admission rate for observation admissions/discharges in alignment with tracking of the CCO quality metric for all-cause readmissions.

The overarching goal of this year's project is to establish a baseline workflow and intervention for this previously missed and vulnerable population from which we will be able to innovate meaningfully and creatively. Potential future expansion may include but is certainly not limited to specific and responsive chronic condition interventions or precise focus and utilization of Connect Oregon in response to specific social determinant of health trends observed in population data.

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

Activity 1 description (continue repeating until all activities included): Tracking % transitions for observation hospital events

☒ Short term or ☐ Long term

Monitoring measure 1.1	Track percentage of observational stays that receive full transitions support			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0	100%	12/31/22	100%	12/31/22

Monitoring measure 1.2	Add text here			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current report	Develop monthly report to track percent of observation stays that receive transitions support	12/31/22	Include additional detail in monthly report to include care plan issue types (SDoH, BH, chronic condition) and/or admitting diagnosis info to better understand areas of opportunity for population intervention	12/31/23

Activity 2 description: Statewide quality metric for CCO: All-cause readmissions

☐ Short term or ☒ Long term

Monitoring measure 2.1	Establish baseline for readmission rate for Observation status			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current data	Baseline determined	12/31/22	% reduction from current rate year over year	12/31/23

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**: Special Health Care Needs- Non-Dual Medicaid: RCT psychiatric transitions tracking

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

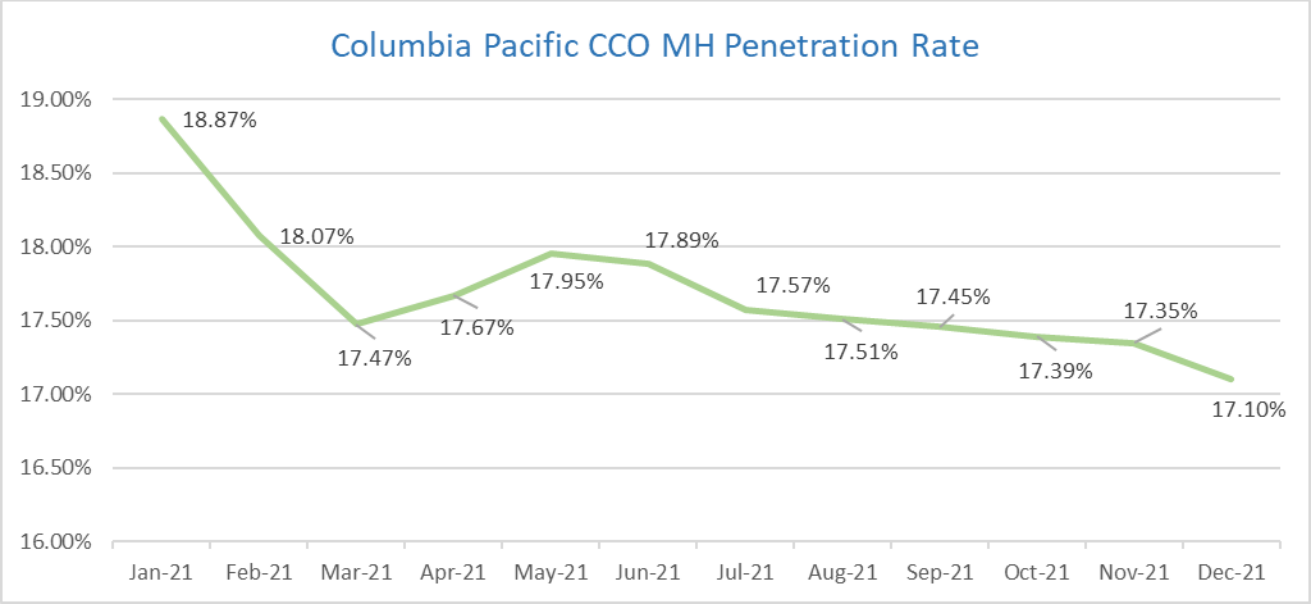
If continued, insert unique project ID from OHA: Add text here

B. **Components addressed**

i. Component 1: SHCN: Non-duals Medicaid
ii. Component 2 (if applicable): Serious and persistent mental illness
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this 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

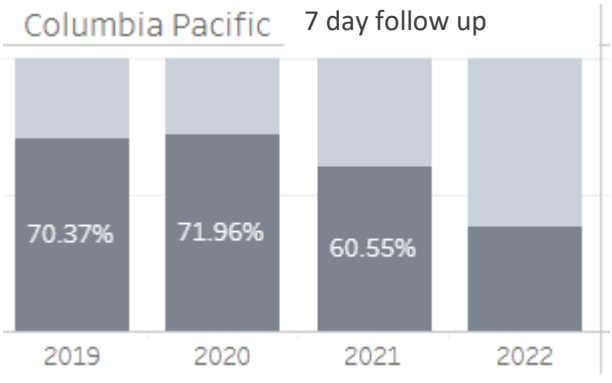
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Columbia Pacific CCO does not have any psychiatric hospital beds within our service region. This results in our members needing to seek services outside of our region resulting in 64% of our population not meeting the rural access standard of services being available within 60 minutes or 60 miles. The map to the left illustrates where these members are concentrated. Out of area hospitalizations increases the risk that members will not receive adequate supports as they return to their communities. This is exacerbated by the behavioral health workforce shortage that has impacted our in-area behavioral health providers particularly hard. Self-report data from each county's Community Mental Health Provider (CMHP) indicates that there can be a waiting period (for some members) for appointments with individual therapists following discharge from acute care. Wait times appear to be increasing, especially for members under the age of 18, but this has resulted in a decrease in overall behavioral health utilization by our members:



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

The state quality measure of Follow-Up after Hospitalization for Mental Illness*, i.e. Seven Day Follow Up Metric*, provides one standard way of assessing the effectiveness of our current network and the ability to meet the needs of our most vulnerable populations. Additionally, we know that meeting this standard timeline reflects best practices in client care, improves health outcomes, and supports meaningful reductions in readmission rates.



The graph to the left shows a decrease in the percentage of members who received follow-up within seven days of a hospitalization in 2021. Currently our network is facing significant access and capacity constraints which have an impact on members who would benefit from timely follow up after such a significant life event. This current state leads to members engaging with other parts of our system, including emergency departments, at a higher frequency while they attempt to have their needs meet in the interim.

The increase in wait times at our partner agencies have had a direct impact on our Intensive Care Coordination (ICC) teams and their ability to coordinate follow up appointments for our members.

Transitional care is a core function within our care coordination services and comprehensively plans a member's care by incorporating their goals, preferences, and clinical status following a hospitalization for mental illness. Hospital discharge is a complex process representing a time of significant vulnerability for members. Due to this, transitions support is currently provided to all members experiencing psychiatric hospitalization. This work reflects best practice in member care, improves health outcomes and supports meaningful reductions in readmission rates. The goal is to connect the member to the right care at the right time in the right place.

The assigned Care Coordinator is the point of contact for the member, legal representative/caregiver, providers and others involved in the member's care throughout the transitions process. The Care Coordinator reaches out to introduce themselves and maintain involvement throughout the length of stay and discharge from the facility. The Care Coordinator is responsible for facilitating the process from admission through discharge to ensure continuity of care and promote transitions into the most appropriate, independent and integrated community-based settings.

Transitional care support includes but is not limited to:

- Comprehensive needs assessment
- Care plan development and distribution
- Discharge planning
- Post-discharge outreach, and
- Case management
- Supporting connection to community-based outreach/engagement teams

The comprehensive assessment identifies needs related to physical health, behavioral health, oral health, medication management and social determinants of health to create the individualized care plan. During this process, the care coordinator works with the member's current primary care team, behavioral health team (when applicable) and the facility treatment team to identify gaps in the member's current provider list and determine if an alternate or specialty provider is needed. Upon identifying gaps, the care coordinator works to find alternate providers and secure timely follow-up services upon discharge. The Care Coordinator assists with connecting members to appropriate providers regardless of whether they are in-network or out-of-network. However due to access issues, this is becoming more difficult resulting in members staying engaged with care coordination longer.

Anecdotal information from ICCs indicate members are staying on caseloads longer due to lack of long-term community-based supports available which impacts caseload sizes and ultimately the team's ability to touch all members who would benefit from Intensive care coordination support.

E. **Brief narrative description**:

The goal of this project is to improve timely access to follow up care after a hospitalization for our most acute and vulnerable members living with Special Health Care Needs. Columbia Pacific CCO must ensure we are able to pull accurate data to aid in current understanding and development of on-going improvement targets. First, our data team will work to reconcile three data sources, to create an accurate and reliable psychiatric transitions report for those members requiring a seven-day follow-up and coordination on discharge. Provider performance on meeting 7-day

follow-up timelines will be shared with contracted network partners in order to identify targeted areas for improvement.

Ensuring that we can accurately track the current status of follow up timelines in our network will allow us to highlight current agencies that would benefit from workflow improvement assistance. Workflow improvement will build upon our existing care coordination efforts for this population.

Currently any Columbia Pacific CCO member who is admitted to inpatient acute care is automatically screened by one of our Intensive Case Coordinators on the Regional Care Team (RCT). The RCT helps connect Members to the most appropriate outpatient supports and ensures that members receive a follow up appointment with a new or their established behavior health provider. The ICC team has difficulty connecting members to care in a timely way, resulting in reoccurrence of ED utilizations and exacerbation of presenting problems. Additionally, access contractions have led to longer service periods for ICC coordination, and a decline in the number of members that have access to this level of service intensity.

The data team will build a monthly report including initial 12-month lookback period that will track caseload size and member days in engaged status for care coordination programs: member provider support and Intensive Care Coordination. Accurately understanding caseload sizes and timelines trends will allow us to better understand how our care coordination resource is being utilized, the community's need for intensive levels of support and allow us to assess staffing and resources needs on the care coordination team. In doing so, we will better be able to serve our members' needs by expanding coordination services if needed, or focusing time and resources where there is greatest impact.

The final aim of this project will be focused on decreasing days to first available appointment for each agency identified through our internal access data. We hope to partner with the identified agencies to strengthen workflows, improve inter-agency collaboration, and increase member satisfaction for this population. Columbia Pacific is working on implementing new access reporting measures in 2022 that will provide data on wait times to next available mental health and SUD appointments, as well as wait-times to access evidence-based mental health services for individuals with an SPMI diagnosis (e.g. Assertive Community Treatment).

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

Activity 1 description (continue repeating until all activities included): Ensure internal accuracy in reporting of seven-day metric

☒ Short term or ☐ Long term

Monitoring measure 1	CareOregon's data team will reconcile data from three unique sources to create reliable data from which to track.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently data tracking seven-day follow up is not available, outside of agency self-report	CareOregon is able to produce the seven day follow up data in house accurately and reliably to inform	12/2022		

	provider performance			

Activity 2 description: Review of data to determine list of partner agencies where access is currently most prohibited

☐ Short term or ☒ Long term

Monitoring measure 2.1	Identification of current partner agencies who' access timeline exceed the seven day follow up target			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
One-time self-survey of agencies	Ongoing surveys and tracking of timeline across agencies	12/2022		

Activity 3 description (continue repeating until all activities included): Ensure clear understanding of ICC caseload size and duration of member engagement

☐ Short term or ☒ Long term

Monitoring measure 1	Build monthly report (including 12 month lookback) that captures each ICC's caseload size and length of member status: engaged for two care coordination programs: Member provider support and Intensive care coordination.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Self-report information only	CareOregon is able to produce a monthly caseload size report including member time in engaged status	12/2022		

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**: Monitoring the Impact of the COVID-19 Pandemic on Deferred Care among the Pediatric Population

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

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

B. **Components addressed**

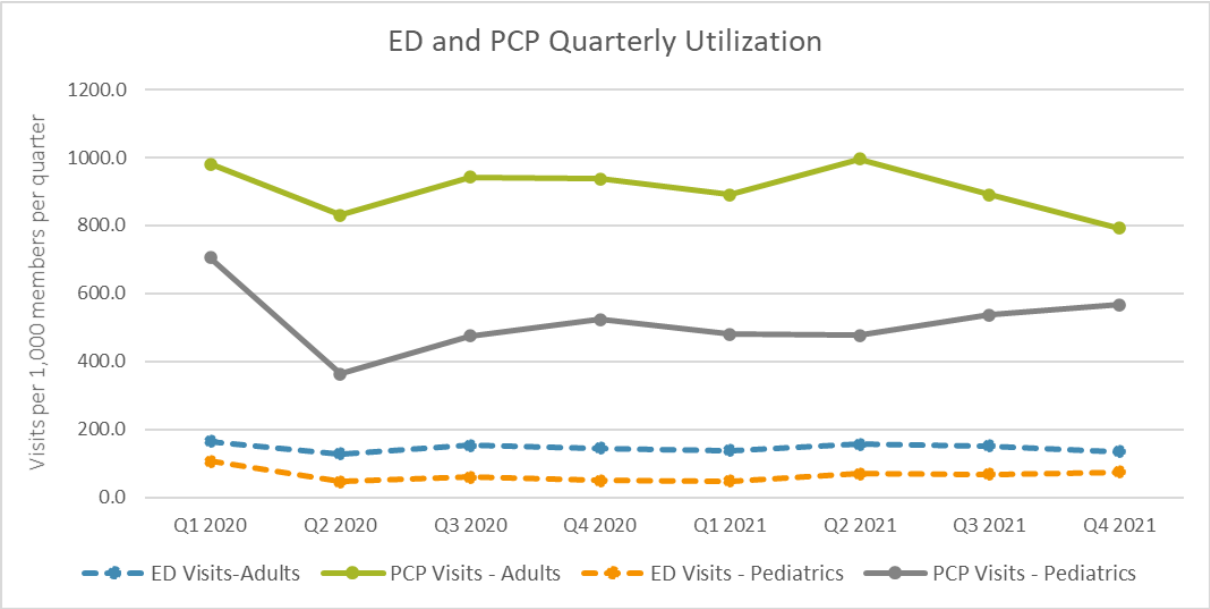
i. Component 1: Utilization review

ii. Component 2 (if applicable): Choose an item.

iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this 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.

Due to the COVID-19 pandemic, Columbia Pacific CCO saw a significant decrease in overall utilization of services. The concern regarding overall decrease in utilization of services is deferred care, which can lead to downstream negative health impacts for our membership, as well as a "rebound," increased utilization over time.



Columbia Pacific conducted an evaluation to assess whether the pandemic was causing members to forgo or delay seeking care. Our analysis showed more than 1 in 5 (21.4%) of members who had one chronic condition did not receive care from a primary care provider during the pandemic; this is compared to 1 in 10 (10%) of those with multiple chronic conditions during a 12-month period. While Emergency Department (ED) utilization decreased overall, as the pandemic persisted, we observed certain subpopulations continued to frequent the ED at higher rates compared to the population overall. One of those subpopulations included pediatric members who were largely presenting to the ED for concerns around respiratory issues. The prevalence of asthma among the CCO's pediatric population is 7.6% and asthma was the primary diagnosis for 67 Emergency Department visits in 2021 among pediatric Columbia Pacific members.

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

This project focuses on utilization management in 2 different ways:

1. Columbia Pacific CCO will develop a continual utilization monitoring to track and monitor decreased utilization due to the pandemic for our pediatrics members with chronic conditions and/or missed preventive care. By doing so, we will be able to identify various populations who may need direct outreach to improve health outcomes.
2. Given our ability to impact the health outcomes of the pediatric asthma population, we will develop a program to wrap services around this population, with a special focus on those with

asthma who required an ED or inpatient stay. We will also regularly track ED and inpatient utilization for this population, weekly.

Program components:

Columbia Pacific has a robust Regional Care Team (RCT), which includes a clinical pharmacist that can support medication review for pediatric members and their families or guardians. The RCT clinical pharmacist has established relationships with the primary care network and attends weekly case huddles with our network. The pharmacy team The RCT pharmacist will do a medication review and communicate any recommendations with the PCP and discuss an asthma action plan for the member. Columbia Pacific has invested in a Healthy Homes program that supports environmental home assessments and remediation for any living conditions that may aggravate or worsen a child or adolescents' asthma. Members will be referred to the Healthy Homes program. Given the availability of resources, we believe the pediatric asthma management program that has been developed will help reduce potentially avoidable utilization of the ED and IP admits related to asthma exacerbations.

E. **Brief narrative description**:

To monitor the impact of the pandemic on the reduced utilization we've experienced, a weekly Collective report of pediatric members aged 2 to 18 with asthma will be run to identify pediatric members who had an ED visit or IP admission in the prior week. This will help us to understand if our pediatric population is getting re-engaged with their primary care providers to complete routine preventive care and for chronic condition management and monitoring. The members in the weekly report will also be reviewed by our Regional Care Team, which includes a Clinical pharmacist, to determine if the admission was related to their asthma diagnosis. For those for whom it was determined asthma was a factor in their ED visit or IP admission, a case review will be conducted to assess potential drivers of their utilization and referrals to resources will be made, as well as enroll qualified members in the program described above. In addition, RCT care coordinators will support the parents/guardians in setting up a follow up visit with their PCP to help reestablish appropriate utilization of the health system as we move out of the pandemic.

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

Activity 1 description (continue repeating until all activities included): Development of weekly report listing all members with pediatric asthma with an ED visit or IP admit (Action Report). An outcomes report for those members who received an intervention will be developed to track any future ED visits or hospital admits, allowing the comparison of pre- and post-intervention utilization (Utilization Report).

☐ Short term or ☒ Long term

Monitoring measure 1.1	Action Report built in Collective			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No standard reporting on pediatric asthma ED visits or IP admits	Action report built in Collective listing all pediatric members with asthma with an ED visit or IP admit with an asthma	06/2022	Report will be run weekly for RCT to review and act upon.	09/2022

	related diagnosis (Action Report)			
Monitoring measure 1.2	Outcomes Report created			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No tracking of pediatric asthma related ED visits or IP admits	A report on those members intervened on by RCT, and the subsequent ED/hospitalizations post intervention, will be monitored quarterly (Utilization Report)	12/2022	Comparison of those members with, and without the intervention in the cohort will be used to determine impact of program on improving clinical quality outcomes and ROI3. Comparison of intervention types will be used to determine most effective tactics to reduced ED/Hospital utilization in this cohort.	12/2023

Activity 2 description: RCT clinical pharmacist review of members on weekly Collective report to review medications, assess medication adherence, and outreach where necessary to improve asthma control.

☐ Short term or ☒ Long term

Monitoring measure 2.1	RCT Clinical Pharmacist review of member hospital utilization event			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Medication review and reconciliation is not routinely done for pediatric hospital events related to asthma	50% of members in the weekly cohort report will have medications reviewed by RCT clinical pharmacist, with outreach to provider and/or member/family/guardians when opportunities for educational counseling to	09/2022	Outreach to member and/or parent/guardian/caregiver regarding: • Use of inhaler and spacers, if applicable • Review of proper inhaler technique	12/2022

	improve asthma control are found.		• Guidance on when to use maintenance vs. rescue inhalers	

Activity 3 description: Referral to Healthy Homes program for home environmental assessment for conditions that aggravate asthma and development of plan for remediation, as appropriate.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Referral to Healthy Homes program			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Pediatric members with an asthma-related ED visit or IP admit do not receive routine referrals to Healthy Homes program	50% of members in the weekly cohort report for whom asthma was confirmed as the cause for hospital utilization will have a referral to Healthy Homes	09/2022	50% of pediatric members who have a environmental home assessment finding impacting their asthma have the issue addressed or corrected.	12/2023

Activity 4 description: Develop ongoing monitoring of utilization patterns for Columbia Pacific CCO's members with chronic conditions or missed preventive care in order to identify population health strategies to improve health outcomes.

☐ Short term or ☒ Long term

Monitoring measure 4.1	**Utilization tracking method or dashboard developed**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline assessment/study of pediatrics members with chronic conditions or missed preventive care receiving care since the COVID-19 pandemic	Ongoing monitoring of potential under-utilization	09/2022		

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 78: PCPCH Supports

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

If continued, insert unique project ID from OHA: 78

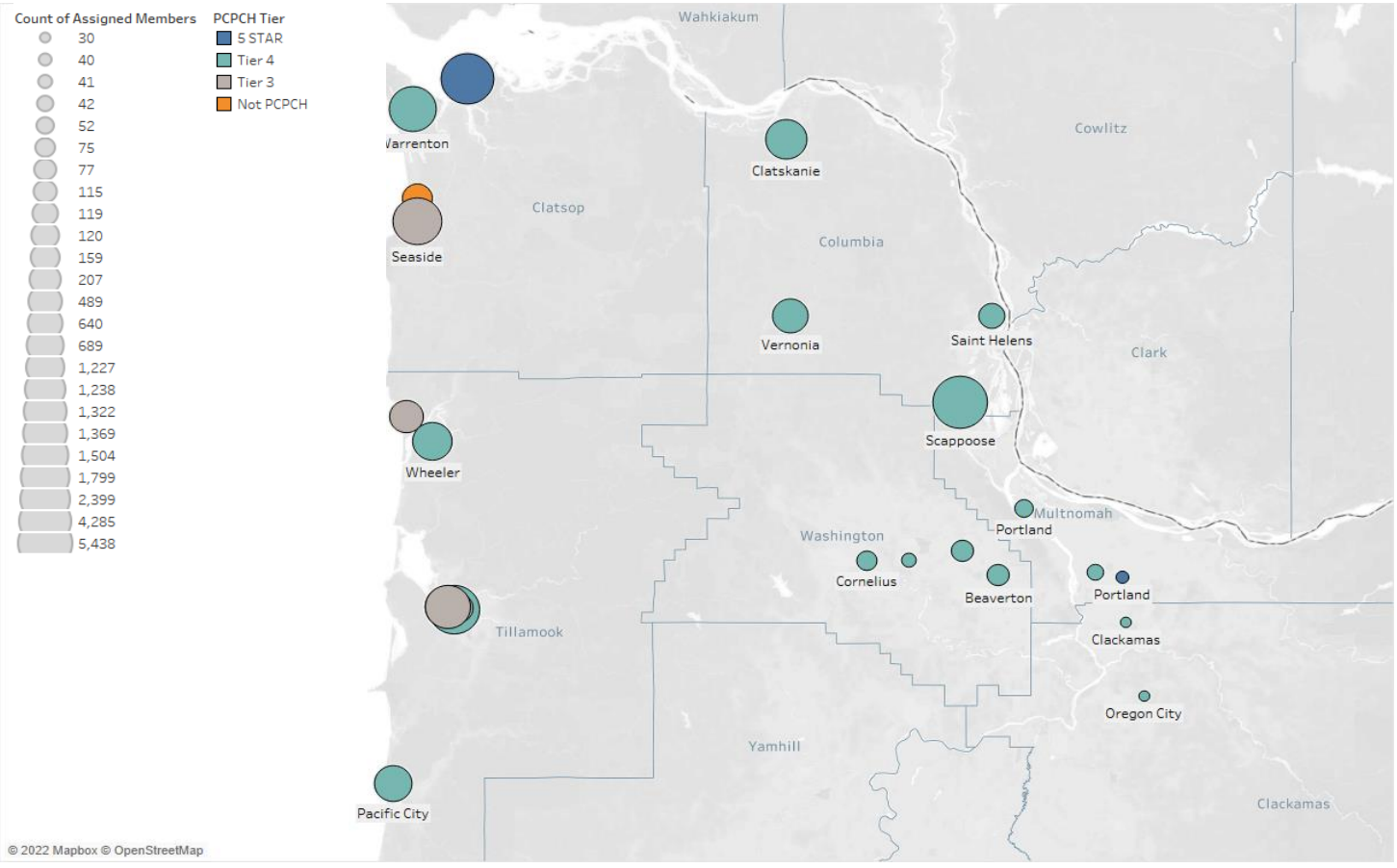
B. Components addressed

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?
☐ 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.

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

We use this data to do proactive outreach to clinics in areas with no or few PCPCH recognized clinics represented by orange circles on the map. In 2021 we identified Seaside and Vernonia as areas to focus based on patient population density and assignment on the 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. All three clinics identified in Seaside and Vernonia are now PCPCH recognized as illustrated in the table below (2021 TQS Monitoring activity 2 complete).



We also incentivize tier recognition by requiring clinics to be PCPCH tier 3 to participate in our Primary Care Payment Model (PCPM) and requiring PCPCH recognition to get quality bonus payout for CCO metrics. Clinics that are in other value-based payment arrangements aside from our PCPM are incentivized by having their payment levels adjusted according to PCPCH tier status.

We currently have 93% of Columbia Pacific CCO members assigned to PCPCH recognized primary care clinics in our region. You can see this broken down in the tables below by Tier level and CPCCO membership.

Total Columbia Pacific Membership and Total PCPCH primary care clinicsMembers in Tier 1	Members in Tier 2	Members in Tier 3	Members in Tier 4	Members in Tier 5	Total Membership	Percent of CPCCO members assigned to PCPCH recognized clinics
-	-	4106	21740	4793	33033 *includes members whose primary care clinics are outside of our region	93%

Columbia Pacific PCPCH recognized clinics that serve the 30,753 members in our region

PCP Name	County	PCPCH Tier	# of Members Assigned	% of Columbia Pacific Membership
Adventist Health Bayshore Medical Pacific City	Tillamook	Tier 4	689	2%
Adventist Health Tillamook Med GRP Women's & Family Health	Tillamook	Tier 3	1370	4%

Adventist Health Tillamook Medical Group Manzanita	Tillamook	Tier 3	491	1.5%
Adventist Health Tillamook Medical Group Vernonia	Columbia	Tier 4	648	2%
Adventist Tillamook Medical Plaza	Tillamook	Tier 4	1326	4%
Columbia Memorial Hospital Primary Care Clinic	Clatsop	Tier 4	1338	4%
Columbia Memorial Hospital Medical Group & Urgent Care - Seaside	Clatsop	Tier 4	661	2%
Columbia Memorial Hospital Pediatric Clinic	Clatsop	Tier 4	1550	5%
Columbia Memorial Hospital Primary Care	Clatsop	Tier 4	1504	5%
Coastal Family Health Center	Clatsop	5 Star	4290	13%
Columbia Medical Services	Clatsop		121	0%
Community Health Center of Clatskanie	Columbia	Tier 4	1249	4%
Flewelling, Kathleen R	Clatsop	Tier 4	175	0%
Legacy Clinic St. Helens Internal Medicine	Columbia	Tier 4	1604	4%
Legacy Clinic St. Helens Pediatrics	Columbia	Tier 4	1193	4%
OHSU Family Health Center at Scappoose	Columbia	Tier 4	5438	16%
Providence Seaside	Clatsop	Tier 3	1799	5%
Rainier Health Center	Columbia	Tier 3	800	2%
Rinehart Clinic	Tillamook	Tier 4	1228	4%
Sacagawea Health Center	Columbia	Tier 3	93	0%

Saint Helens Internal Medicine	Columbia	Tier 4	119	0%
The Middle Way Health Care	Tillamook	Tier 3	208	0%
Tillamook County Community Health Centers	Tillamook	Tier 4	2404	7%
Vander Waal, Steven C	Clatsop		159	0%
Wimahl Family Clinic Inc.	Clatsop	Tier 3	116	0%
Total Columbia Pacific Members			30,573	

When assigning new members, our algorithm looks at distance and history of visits as 1st 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 established PCP relationships we do not want to break. Instead, we focus on PCPCH technical assistance to support 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 Columbia Pacific the status of each practice that is contracted with the region. This could be whether the practice is recognized or not or have re-attested and applied for the next iteration of PCPCH recognition on time, and more importantly if the Tier level has changed.

Columbia Pacific CCO 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 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 2021 Columbia Pacific directly reached out to 3 clinics to support 1st time attestation. Most clinics were attested or re-attested in 2020.

In addition to the direct support, Columbia Pacific CCO also utilizes the Columbia Pacific Quality Improvement Workgroup (QIW) to provide PCPCH support and learnings. Columbia Pacific QIW is comprised of practice administration, quality improvement staff and/or clinical providers to also inform re-attestation deadlines and resources to complete state recognition status. Communication will continue to be sent to all clinics in our region to help especially if new standards arise.

E. **Brief narrative description**:

As stated in 2021, we hoped to have Adventist Vernonia, Columbia Memorial Primary Care Astoria, and Seaside (2 separate clinics), and the School-Based Health Center (SBHC) Vernonia (not currently getting patient assignment), newly attested by the end of the year. We were able to confirm 3 of the 4 primary care clinics newly attested. Adventist Vernonia , Columbia Memorial Primary Care in Astoria , and Columbia Memorial Primary Care Seaside all attested at Tier

4. Even though we were successful for 3 clinics, unfortunately SBHC Vernonia did not attest due to closing. However, Adventist Vernonia is now serving members in that community, including those who would have been served in the SBHC. Additionally, we met our goal to maintain 18 clinics participating in QIW as our main venue for support.

In 2022 we will continue to monitor PCPCH re-attestation dates and follow up with clinics who were stretched thin in 2021 due to the COVID-19 pandemic. As you see above in the table for PCPCH recognized clinics, we will be focusing on the 2 clinics highlighted to apply for PCPCH recognition. Our goals would be to prepare the clinics for first time applications and others for re-attestation to reach higher tiers at their next attestation. We intend to do this in the following ways:

- In our Quality Improvement Workgroup, we will highlight the importance of attesting to guide the clinics in the process by providing guidelines to apply or re-apply, support specific questions (assistance) that they struggle to answer, help them identify how to use their electronic health record to answer PCPCH application questions and mostly to elaborate best practices for a primary care home model. Please note, most of our clinics who are recognized will not be due to re-attest until 2023 and 2024.
- In our individual clinic quality improvement meetings, we will align their needs with the requirements of PCPCH recognition so they can have individual assistance for their specific clinic parameters and ease of application. This primary care clinic engagement will also continue to support our 93%-member assignment in PCPCH recognized clinics.
- We also strive to focus our QIW and individual clinic meeting on ways our clinic partners can improve or expand quality care, and continually add services they may not have had previously (for example: integrated behavioral health, optimizing access, population level outreach etc.)

The 2 clinics highlighted above will receive notifications and outreach from our provider relations team and quality improvement team. We can leverage this communication by inviting the clinics to join more quality improvement workgroup sessions and offer individual technical assistance. For our membership who seek care outside of our region, due to the pandemic and members relocating, we believe that CareOregon's large network can still serve those Columbia Pacific CCO members with PCPCH recognized options. That said, we are going to assess the 7% of our population seeking care in other regions after the current public health emergency ends and OHA redetermination is complete.

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 measure 1.1	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)**
8 organizations and 19 clinics participating in QIW	9 organizations and 21 clinics	12/31/2022	9 organizations and 21 clinics participating in QIW	12/31/2022

Activity 2 description: Clinics not PCPCH recognized

☒ Short term or ☐ Long term

Monitoring measure 2.1	Outreach and provide technical assistance to clinics that are not PCPCH recognized			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0	2 clinics	12/31/2022	2 clinics	12/31/2022

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**: SPMI-Regional Care Team
B. **Project unique ID (as provided by OHA):** 79
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):** Though the community huddles are a pivotal piece of the Regional Care Team's (RCT) approach to creatively and comprehensively coordinating care for some of our most at risk members. These huddles continue however this year we dissolved this project to broaden our approach in response to barriers faced by our community partners related to the Behavioral Healthcare workforce shortage. The new focus is also broader tying together inpatient, emergency department and outpatient utilization and seeks to bolster supports so member needs are met at the right place, the right time, and with the right teams.

A. **Project short title**: ABA
B. **Project unique ID (as provided by OHA):** 64
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):** Both key objectives were met in the project – 1. Facility-Based provider contract added for Autism Footprints. 2. Pilot successfully implemented and bought to scale with Columbia Community Mental Health and Autism Footprints for Community-Based delivery of ABA services in Columbia County. Columbia Pacific is continuing to add ABA access throughout the service region by expanding contracts with existing providers and contracting with new providers.

A. **Project short title**: Oral Health Integration: Connecting Members with Diabetes to Oral Health Care
B. **Project unique ID (as provided by OHA):** 77
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):** In 2021, Columbia Pacific CCO made great progress on this oral health integration (OHI) project focusing on dental care coordination and the importance of oral care for adult patients with diabetes. We created and distributed a portfolio of oral health integration tools for both members and providers. Member dental data was added to primary care dashboards, and previously trained practices continued to utilize the dental care request form for adults. These tools, navigational pathways and provider trainings will continue to be spread and optimized in 2022 and beyond. Due to the limited scope of dental services within the adult physical health benefit to address the TQS goals of providing oral care services outside of traditional dental settings, Columbia Pacific has determined it would be best to reprioritize our OHI work and shift our OHI TQS project to another area of focus – preventive oral health services for children in primary care.

   Columbia Pacific also worked on stabilizing other existing oral health integration programs and projects while focusing on the 2021 OHI TQS project. This work included oral health and maternity initiatives and First Tooth program virtual training and implementation. During this time, we determined that further prioritizing early childhood preventive oral health care was central to advancing our oral health strategic initiatives. Although Columbia Pacific has chosen to discontinue the adult diabetes dental care coordination OHI TQS project in 2022, we will continue to advance this work.

A. **Project short title:** Baseline Assessment (Anonymous Consumer)
B. **Project unique ID (as provided by OHA):** 72
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**): Throughout 2020 and 2021 Columbia Pacific CCO completed 18 baseline assessments of interpretation services, exceeding our TQS monitoring goal of 10 assessments. The assessments were conducted by a certified interpreter who posed as a Spanish speaking patient seeking an appointment. The organizations were notified that these assessments would be taking place and the results were shared with clinic leadership. Due to the pandemic and the strain on resources within our network we were not able to meet our second monitoring activity of creating improvement plans for 6 clinics. However, we will carry this work forward in our new Meaningful Language Access project that has been included in this year's submission.

A. **Project short title:** Interpreter Training
B. **Project unique ID (as provided by OHA):** 67
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):** Throughout 2021 we continued to offer scholarships for interpreter trainings and will continue to do so in future years. We also included a narrative submission component of our Primary Care Payment Model during 2021 that required clinics to describe their processes and identify any certified interpreter they have on site. The learnings from that submission and the baseline assessments mentioned above have been synthesized into our new Meaningful Language Access project that we are submitting with our 2022 TQS. We will continue to provide scholarships for certification when potential applicants are identified via that project.

A. **Project short title:** Improving SUD Access: MAT Collaborative & County-Level Coordination
B. **Project unique ID (as provided by OHA):** 70
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):** Columbia Pacific was able to successfully complete our MAT Learning Collaborative and has continued to support county-level coordination of services. However, the impact of the pandemic on our provider network and the resulting workforce shortage has made us have to reprioritize our efforts towards rebuilding services and increasing access.

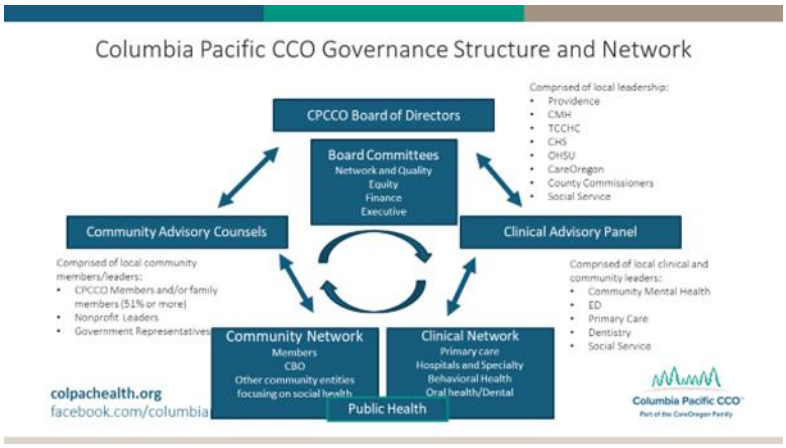
Section 3: Required Transformation and Quality Program Attachments

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

The narrative below describes the Columbia Pacific quality program and approach, the role of its Network & Quality Committee relative to quality oversight and governance as well as clinical transformation and the TQS, and details about utilization review oversight, practice guidelines, and member rights. Supplemental documents include:

- Network & Quality Committee Charter and Work Plan
- Clinical Advisory Panel Charter
- CareOregon Enterprise Quality Work Plan

Overall Columbia Pacific CCO Quality Program and Approach Description:

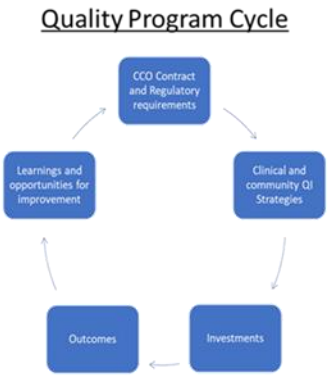


As outlined in the CCO Governance Structure and Network graphic, the **Columbia Pacific Board of Directors** oversees the implementation of the strategic plan for Columbia Pacific CCO and is accountable for setting the CCO's performance expectations, which include success indicators and metrics for quality and transformation. The **Clinical Advisory Panel (CAP)**, at the direction of **Columbia Pacific Board's Network and Quality Committee**, provides the strategic leadership and direction for clinical transformation, including the projects for the TQS. The Network and Quality Committee provides direct oversight of the quality assurance aspects of the quality program. The CAP ensures Columbia Pacific's clinical transformation efforts and quality priorities are strategically aligned with those of its governing bodies of the CCO and its constituent organizations, 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 Columbia Pacific Board's strategic plan, the state directed contract requirements and 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 Columbia Pacific population (see figure below).

Figure 1

The Columbia Pacific Network and Quality Committee provides direct oversight of delegated activities, quality

assurance activities, and transformation activities. The Network & Quality Committee reviews the CAP's quality and transformation recommendations for investment approval, and it is 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 Columbia Pacific members (see quality program graphic below).



Our approach is to identify opportunities for improvement, through findings determined in regulatory quality submission processes, through continual data review, or through network and community input, and subsequently develop process improvement initiatives or programs to address these issues. The identification and review of the concerns/opportunities is reviewed with the Columbia Pacific Board's Network and Quality Committee, as well as the CAP. For large scale improvements, requiring broader resources and programmatic development, opportunities are also presented, and developed within the CareOregon Quality and Health Outcomes (COQHO) structure of CareOregon (details follow). In this way, we honor the space between quality assurance and quality improvement in service to improving health outcomes for our membership and addressing disparities.

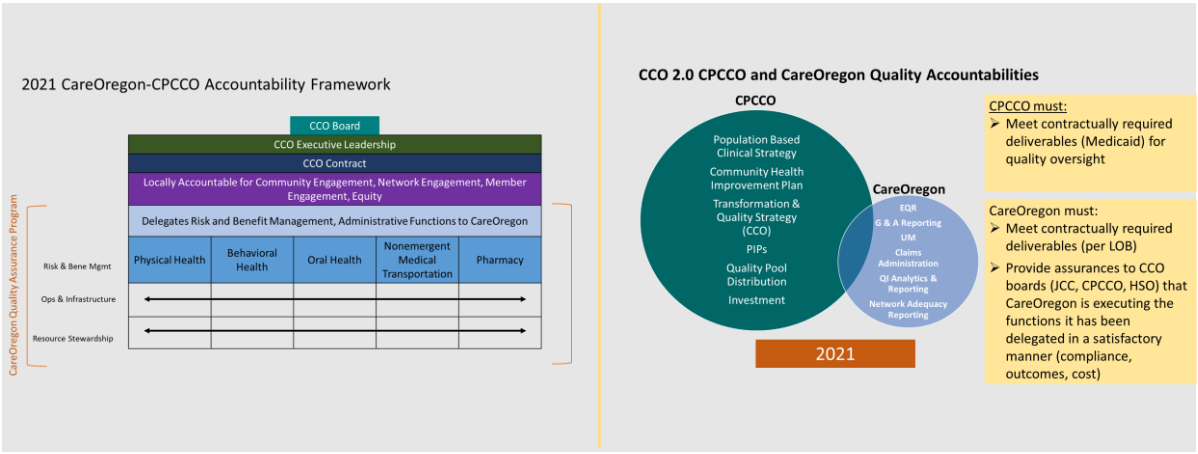
Columbia Pacific TQS Approach and Oversight:

Columbia Pacific CCO 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), Columbia Pacific 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 Columbia Pacific for physical and behavioral health 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 Columbia Pacific HIT infrastructure, assures and monitors network adequacy, and administers value-based payment models. CareOregon is responsible for ensuring that all CareOregon and Columbia Pacific delegates are provided appropriate oversight and are operating in full compliance with state and federal regulations. The Columbia Pacific 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 Columbia Pacific Medical Director leads the CareOregon Quality Health and Outcomes Steering Committee, and partners closely with CareOregon Quality Assurance committees to provide alignment between Columbia Pacific and CareOregon.

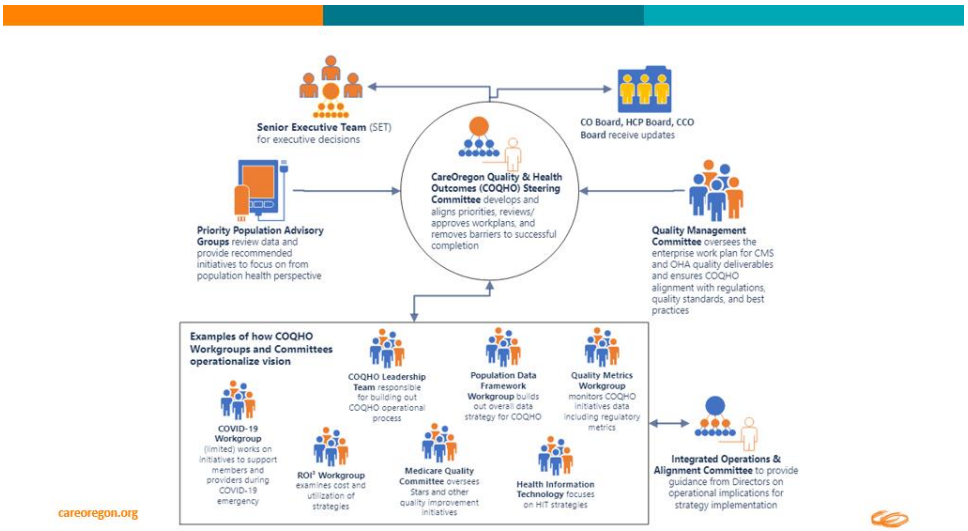
The annual Columbia Pacific TQS process leverages the CareOregon quality governance structure and staffing to ensure Columbia Pacific consistently meets its contractually required OHA deliverables (see #2).

Figure 2



Senior CareOregon staff partner with the Columbia Pacific 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 Columbia Pacific 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, Columbia Pacific's local Community Advisory Councils (CACs). The report is ultimately reviewed and approved for submission by the Network and Quality Committee of the Columbia Pacific Board of Directors.***

<u>Quality and Population Health: Overview of Relationship between Columbia Pacific and CareOregon:</u>



Throughout 2021, CareOregon, Columbia Pacific's parent company, has developed an overarching Quality and Population Health infrastructure to help guide and support the strategic initiatives within Columbia Pacific. This new **CareOregon Quality Health and Outcomes (COQHO)** structure helps provide structural support and leverage resources needed to do robust quality work, such as data, shared prioritization, value-based payment, and care coordination. This quality program is led by the Senior Medical Director of Clinical Services for CareOregon, who is also Medical Director of Columbia Pacific CCO. COQHO is directly accountable to the CareOregon board of directors, and the regional specific work, led by Columbia Pacific leadership, is directly accountable to the CCO governance structure (described above, and shown below).

Grievances and Appeals, Member Rights, Compliance and UM:

Columbia Pacific's grievances and appeals are managed by CareOregon. CareOregon's Quality Assurance Manager for 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 Columbia Pacific CCO medical director.

The Quality Assurance Manager for 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 Columbia Pacific Network & Quality Committee receives a quarterly summary of complaints and appeals by Columbia Pacific 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 Columbia Pacific Executive Director and the Board's Network and 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 CareOregon Director of Quality Assurance sits on the Columbia Pacific Network & Quality Committee as a non-voting member to keep the committee informed of progress on corrective actions and escalate barriers when necessary.

Columbia Pacific CCO monitors over and under-utilization by regularly reviewing a cost and utilization dashboard and maintaining a cost and utilization portfolio which highlights programs, projects and initiatives we are doing to address over and under-utilization. In the past, CareOregon had a robust Cost and Utilization Steering Committee, made up of many senior leaders coming together to review data and decide on priority initiatives to address cost and utilization. We have now transitioned from this structure to an ROI^3 committee (focusing on return on investment for cost, quality and access), to identify opportunities to impact the triple (or quadruple aim). In this committee we will focus on things such as identifying opportunities to address low value care, identifying how best to utilize our value-based payments to impact quality, or discussing and planning for interventions related to MEPP. In addition to this macro level review of cost and utilization trends, the CCO medical directors convene regularly with CareOregon Medical Management medical directors to analyze utilization trends and monitor utilization against clinical guidelines and evidence-based best practices to assure benefits are synced with the most appropriate clinical guidance, and support the provider network through training and data review of clinical best practices and review of prior authorizations, appeals, and overturns.

Columbia Pacific continually uses our quality program and overall quality improvement process to identify opportunities for improvement within our strategic initiatives, requests or directives from the network/CAP/CAC, and/or in response to findings related to regulatory requirements. Our Clinical Advisory Panel and Network and Quality Committee 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 Columbia Pacific Medical Director leads and serves. If modifications are made, they are developed from scientific evidence or a consensus of health care professionals in a particular field. Columbia Pacific 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 Columbia Pacific CAP and are made available through the Columbia Pacific provider portal to all medical providers as needed.

2022 Quality Assurance and Performance Improvement Work Plan

Focus Area	Planned Activities	Cadence/Timing	Owner
Access & Availability	Review provider access and wait time	Quarterly	VP, NCS
	Review DSN Narrative/OHA Evaluation	July	VP, NCS
	TQS 1, 2, 3 Project Monitoring	March, Sept	Dir, QA
	Monitor 2021 CMR Findings & Improvement Plans	July	Dir, QA
Utilization Management (QAPI)	Monitor/analyze referrals, pre-auths, NOAs, appeals, hearings	Quarterly	Sr Med Dir, Ops
	Monitor 2020 Cov & Auth EQR Findings and Improvement Plan	Feb, Sept	Dir, QA
	TQS 15 Project Monitoring	March, Sept	Dir, QA
	Escalation Pathway for QBR	ad hoc	Dir, QA
Grievances & Appeals (QAPI)	Monitor, track, and trend grievances to develop action plans for reduction of grievances through education and support	Quarterly	VP, Ops
	TQS 6 Project Monitoring	March, Sept	Dir, QA
CCIP (CMS)	Monitor quarterly; annual attestation to CMS	Quarterly	Dir, QA
Model of Care and SHCN Monitoring (QAPI, CMS)	Quarterly MOC Report	Quarterly	VP, PHP
	Duals Integration Project	TBD	Dir, QA
	TQS 14 Project Monitoring	March, Sept	Dir, QA
	Submission Review; intervention if required for <70 score	February	VP, PHP
Language Access/Equity	Language Access Steering Committee Participation	Monthly	Dir, QA
Member Experience	Review CAHPS results, establish thresholds for performance and identify opportunities for improvement	needs discussion	VP, CX
	Member Satisfaction Analysis	Quarterly	VP, CX
	Escalation Pathway for QBR	ad hoc	
2022 Policy Approvals	Review and approve per policy approval process as reviewer group	ad hoc	Dir, QA

Focus Area	Planned Activities	Cadence/Timing	Owner
Enterprise Quality Management	Evaluate the effectiveness of the Quality Program to include monitoring activities and clinical, operational, and satisfaction initiatives.	Quarterly, then by March 15 of subsequent year	Dir, QA
	Completion of 2022 Work Plan for enterprise	Jan-Feb	Dir, QA
	TQS 1,2,3, 6, 14, 15	March and October	Dir, QA
Quality of Care Reviews	Track and trend issues; medical director group to determine how feedback/clinical support shall be provided	Peer Review Minutes to BoD, annual review Q4	Sr Med Dir, Ops
Clinical Practice Guidelines	Update and approve annually or every two years	COQHO	Med Dir, Quality
Clinical Quality Indicators (CCO Metrics & Star Measures)	Identify areas at risk for enterprise; allocate resources as necessary; provide supprt	Quarterly	Med Dir, Quality

Columbia Pacific CCO
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Network & Quality Committee Calendar – 2022 (updated 1/10/2022)

Month	Date	Topic
January	1/11/2022 9:00 – 10:00am	QA Topics: -Annual Calendar
February		
March	3/8/2022 9:00 – 10:00am	QA Topics: • TQS (Transformation Quality Strategy) Submission to OHA (be sure to highlight SHCN, UM) • Status Report on Improvement Plans for 2021 CMR Findings -EQR (External Quality Review) and Upcoming CMR Informational Item • -DSN Report and Network Optimization Discussion (to include 2021 CMR Findings)
April		
May	5/10/2022 9:00 – 10:00am	QA Topics: • Grievances & Appeals • Utilization Management
June		
July	7/12/2022 9:00 – 10:00am	QA Topics: • Network Optimization/Access & Availability/DSN • Status Report on Improvement Plans for 2021 CMR Findings, 2022 CMR Update, Areas of Risk
August		
September	9/13/2022 9:00 – 10:00am	QA Topics: • Selected TQS Components (align with enterprise-TBD)
October		
November	11/8/2022 9:00 – 10:00am	QA Topics: • Grievances & Appeals • Utilization Management

		• CMR Findings (if available but unlikely)
December		

Columbia Pacific CCO
Clinical Advisory Panel Charter

Aim:

The Columbia Pacific CCO Clinical Advisory Panel (CAP) provides strategic leadership and direction for clinical transformation work that will help Columbia Pacific CCO achieve the Quadruple Aim.

Overarching goal:

The CAP will ensure CPCCO's clinical transformation efforts and priorities are strategically aligned with those of its constituent organizations, the CPCCO community advisory council 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 is a separate committee of the Columbia Pacific CCO Governance structure, accountable to the CCO Board of Directors.

Responsibilities:

- Establish priorities for care transformation based on data, best practice, and provider and user experience and knowledge
- Review, evaluate and/or recommend specific initiatives to meet short and long-term Quadruple Aim goals
- Set clinical targets for transformational efforts and oversee progress toward goals
- Promote sharing of best practices, development of community clinical best practice standards, and a practice culture of collaborative learning and continuous improvement
- Assure achievement of priority clinical metrics, including Core Performance and Quality Incentive Measures, and participate in the development of a monitoring system for CCO performance
- Review and recommend care models, and new incentive and payment methodologies that increasingly reward accountability for improved outcomes
- Participate in identifying opportunities to improve population health in the CCO service area (Clatsop, Columbia, and Tillamook Counties)
- Review and recommend to the CCO Board priority programs for funding by the CCO
- Understand and define integration, and identify opportunities to integrate
- Identify clinical gaps in care and access based on data in local communities
- Identify areas for clinician and staff upskilling
- Identify innovative strategies for workforce recruitment and retention
- Identify equity gaps and work on opportunities to address them

CAP Membership:

The Columbia Pacific CAP should be comprised of individuals across the clinical spectrum, with between 15-17 total members, representing the full 3-county service area of Columbia Pacific

CCO. The following are recommended disciplines for CAP membership:

- Physical Medicine Physicians (more than 1)
- Behavioral Health Professionals (more than 1)
- Social services professional (more than 1)
- At least one clinical nurse
- At least one pharmacist
- At least one dentist
- At least one Public Health professional
- At least one Emergency Department/Inpatient Leadership representative
- At least one Quality Improvement professional
- If possible: One addictions specialist

Ideally one member of the CAP is also a member of the CCO Board of Directors. Members will be selected based on direct involvement with the transformation efforts of the Columbia Pacific CCO, upon application. Applications may be submitted at any time, and will be acted upon with openings in the CAP membership. Non-members may attend open meetings of the CAP at any time, as specified below.

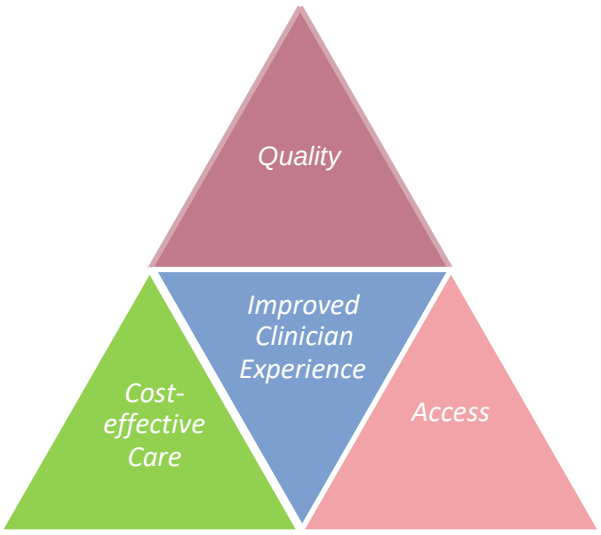
Every attempt will be made to have at least one CAP member who is also a member of the PC3 committee (whose role is to operationalize CAP directed strategy).

Meeting frequency and standards:

The CAP is staffed by both the Transformation Specialist and Medical Director.

- The CAP will have the following standards:
  - Meet every other month for 2.5 hours, with additional strategic subcommittees in between as needed.
  - The joint CAP-finance committee will continue to meet 2-3 times yearly
- Authorized to convene additional meetings
- Meetings will be open to staff from partner organizations and others by invitation
- CAP members who cannot attend a meeting should delegate their position to another person from their organization
- CPCCO staff will send updates in between CAP meetings so meetings can be largely focused on strategy and discussion

Quadruple Aim:



The CAP will use CPCCO clinical strategic buckets to help guide clinical strategy work within the CCO, specifically in the following areas:

- Quality (Metrics, Opioid work etc.)
- Access (Primary care and specialty),
- Cost-effective care (High utilizer and high-risk patients; hospital costs; utilization/referral patterns etc.)
- Integration (Within clinics with behavioral health and dental, and within the community)
- Clinic infrastructure and medical home
- Information Technology
- Recruitment and retention (provider upskilling and support, overall recruitment strategy, workforce wellness)
- Equity

Columbia Pacific CCO (CPCCO)
Network and Quality Committee Charter
October 2019

Purpose

The primary function of the Network and Quality Committee ("Committee") is to provide oversight of and assure compliance with the CCO's quality program, transformational quality strategies, network adequacy and external quality review audits. The Committee will also provide consultation to and assure adequacy of clinical quality improvement activities under the purview of CPCCO's Clinical Advisory Panel as needed.

Membership

The Committee is a Committee of the Board, in accordance with the CPCCO Operating Agreement and is comprised of three or more directors, one of whom will also serve as Chair of the Committee. Committee members serve a one-year term beginning January 1st and ending December 31st of the same year. Committee members may be re-appointed to successive terms subject to Board approval. The Executive Director will be primary staff of this Committee, with content expertise sought as necessary. The Executive Director may designate additional staff support as s/he deems appropriate to assure the Committee may discharge its functions appropriately.

Duties and Responsibilities

The Committee's specific responsibilities include:

- Review and recommend for Board approval CPCCO's annual quality plan, quality evaluation, Total Quality Strategy (TQS), QAPI, appeals and grievances and over/under utilization reports
- Review and approve the External Quality Review audit findings and corrective action plans
- Review and recommend strategies to address any deficiencies in the CPCCO provider network, including primary care, specialty, behavioral health and oral health and transportation providers, as reported in the Delivery System Network (DSN) submissions to OHA
- Update and recommend for Board approval any proposed distributions of Quality Pool funds to CPCCO clinics based on contribution to CPCCO incentive metrics performance
- Review utilization trends and variances to ensure CPCCO performs within the annual global budget
- Review and approve proposed changes in prior authorization requirements recommended by staff, to reduce or eliminate low-value services, to comply with HERC/Guidenotes, or other benefit changes mandated by the legislature or OHA
- Oversee other special projects affecting quality or network adequacy, as requested by the Board
- Review overarching CPCCO clinical quality strategies and approve investments in CAP-approved clinical strategies as applicable.

Meetings

The Committee may meet as often as may be deemed necessary or appropriate in its judgment, but at least quarterly each year, and may conduct Committee meetings by digital and telephonic means. A majority of the members of the Committee constitutes a quorum.