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 1: Increase Access to Assertive Community Treatment (ACT) or Alternative, Intensive, Community-based Services

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

If continued, insert unique project ID from OHA: 87

B. **Components addressed**

i. Component 1: Access: Quality and adequacy of services
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.

EOCCO initially planned to utilize the OHA -generated Special Health Care Needs reports to identify members with SPMI diagnosis who may be eligible and assessed for Assertive Community Treatment (ACT) or other alternative, intensive outpatient services to prevent utilizing a higher level of care by providing the appropriate services and supports in a community-based setting. The Data Analytics unit matched each member that occurred on the list to identify individuals with SPMI as a primary, secondary, or tertiary diagnosis. Once identified, key indicators were to inform the care coordination team if identified Members accessed community-based interventions before higher levels of care were necessary. Services evaluated for using this method included members with severe psychiatric, behavioral, or other comorbid conditions who are not currently receiving ACT services or alternative, intensive community-based treatment, or ICC, but were receiving:

- Pharmacotherapy
- Psychosocial therapy
- Supported Employment
- Social skills training
- Peer Delivered Services
- Case management

While EOCCO was continuing to collect the required data, the program changed during the year.

ACT		No ACT, no other claims		No ACT, Other Claims		Total Members	Total Percent of Total
Members	Percent of Total	Members	Percent of Total	Members	Percent of Total		
16	1.82%	637	72.63%	224	25.54%	877	100.00%

The table above demonstrates the number of individual members identified on the special health care needs report who had an SPMI diagnosis in calendar year 2020 utilizing the methodology described above. Of the 877 members on the list who met criteria, 16 were receiving ACT services and 224 were receiving less-intensive, community-based, alternative services.

The program no longer solely utilizes the special healthcare needs report to identify members who are potentially eligible for Assertive Community Treatment (ACT) or alternative, intensive, community-based services. Because all of the units managing the strategy lacked the resources to conduct the required outreach for this effort, the care coordination staff shifted their focus to focus on members that met the following criteria:

- Recurrent inpatient admissions (e.g. 2 or more inpatient psychiatric admissions in past 12 months)
- Inpatient lengths of stay greater than 30 days in past 12 months
- Excessive use (e.g., 2 or more visits in 30-day period) of crisis or emergency services

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

The program no longer solely utilizes the special healthcare needs report to identify members who are potentially eligible for Assertive Community Treatment (ACT) or alternative, intensive, community-based services. The program will begin to utilize the SHCN report to anticipate program capacity utilization.

- The care coordination team utilized the following strategy to monitor the targeted population:
- Utilize the special health care needs report as a starting point to anticipate likely eligible member eligibility
- Utilize Collective Medical emergency department (ED) reports to determine which EOCCO members with SPMI diagnosis and/or a history of SUD have visited the ED for behavioral health services.
- Conduct daily clinical liaison meetings to review EOCCO member visits to ED in EOCCO's geographic service region with CMHPs and EOCCO clinicians to plan the course of clinical and UM decision making required for EOCCO members seen in the ED the previous day/night for behavioral health services.
- Integrated Services Team (IST) program and service liaison will maintain links to external agency clinicians and teams that provide clinical services to identified high-needs EOCCO members.
- Engage in regularly scheduled and real time, case-by-case care coordination for identified high-needs EOCCO members that are likely eligible for ACT and other, alternative community-based services.
- Engage with both internal and external teams to identify gaps in knowledge of care coordination or system knowledge by conducting regular check-in meetings with crisis teams and exceptional needs care coordinators (ENCC) in geographic service region.
- Review reports from care management database to ensure ACT and other, alternative community-based services are offered to likely eligible members for continual improvement

E. **Brief narrative description**:

EOCCO will continue to use data pulls for analysis to help identify likely ACT-eligible members by monitoring data reports. In the ongoing phase of the project, EOCCO will only use the SHCN report to evaluate the program capacity. Key indicators in the Collective Medical and ACT outcome reports will inform how to offer individual members community-based interventions before higher levels of care are necessary. Immediate interventions will include, but will not be limited to, offering care coordination, and creating Individual Management Plans (IMP). Utilizing the Collective Medical and ACT outcome reports, EOCCO will pull monthly reports that monitor the following data:

- Members with severe psychiatric, behavioral, or other comorbid conditions. Recurrent inpatient admissions (e.g., 2 or more inpatient psychiatric admissions in past 12 months)
- Inpatient lengths of stay greater than 30 days in past 12 months

- Excessive use (e.g., 2 or more visits in 30-day period) of crisis or emergency services

In addition, EOCCO will pull reports to include utilization of the following services:

- Members with severe psychiatric, behavioral, or other comorbid conditions who are not currently receiving ACT services or alternative, intensive community-based treatment, or intensive care coordination (ICC), but are receiving:
  - Pharmacotherapy
  - Psychosocial therapy
  - Supported Employment Services
  - Social skills training
  - Peer Delivered Services
  - Case management
- Members with severe psychiatric, behavioral, or other comorbid conditions who are not currently receiving ACT services or alternative, intensive community-based treatment, or ICC, and:
  - Are having difficulty engaging in traditional, office-based outpatient treatment
  - Consistently no-show for traditional, office-based outpatient treatment appointments

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

Activity 1 description: Engage with both internal and external teams to identify gaps in knowledge of care coordination or system knowledge by conducting regular check-in meetings with crisis teams and exceptional needs care coordinators (ENCC) in geographic service region. Review reports from care management database to ensure ACT and other, alternative community-based services are offered to likely eligible members for continual improvement. Review findings annually for all TQS programs at EOCCO Quality Improvement Committee.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitor ACT caseload count, review care management database to review for ACT program screening.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2021 is baseline year	Follow-up for all Members screening as likely eligible for ACT services	1/1/2022	Reassess after Q1 2021	Achieve 90% follow-up of those identified as likely eligible for ACT services

A. **Project or program short title**: Project 2: Language Access Plan

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

If continued, insert unique project ID from OHA: 88

B. **Components addressed**

i. Component 1: Access: Cultural Considerations
ii. Component 2 (if applicable): CLAS Standards
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No

v. If this component addresses social determinants of health & equity, which domain(s) does it address? **N/A**

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

vi. If this project addresses CLAS standards, which standard does it primarily address? 6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing

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

The onset of COVID-19 unfortunately posed challenges to promoting the utilization of interpreters, especially for in-person interpreters due to many sites imposing visitor restrictions. However, EOCCO understands the importance of the delivery of culturally appropriate services, which involves providing linguistic assistance to individuals who need it. Recognizing that barriers to providing culturally responsive care include member engagement, health literacy, and language proficiency, EOCCO is in the process of strengthening its Language Access plan. This will include updating workflows, creating innovative strategies, and tracking and monitoring systems within and across our health service domains (physical, behavioral, dental). Written communications with members and utilization of interpreter services are both critical components of this set of activities that make-up our Language Access Plan.

In our previous TQS submission, EOCCO focused on improving the Language Access Plan by (a) improving our review of member materials by applying a language access lens testing with focus groups, and (b) tracking utilization of Spanish interpreter services. Regarding member materials, in 2020 we reviewed and updated a number of materials, especially those available to members on the EOCCO website. We also updated our workflow to review written materials as part of our Health Equity Plan. This has involved the development of goals to ensure consistent development of accessible and equitable member education, including establishing a comprehensive material development process with structured guidelines and steps for content testing, review, and obtaining necessary approvals. This process will be sustained by the development of a new policy and procedure, as well as a checklist comprised of the key elements such as the following: tracking the language(s) material has been translated to, identifying whether LCACs have evaluated the material, whether it meets readability and font size requirements, etc.

However, due to COVID-19 constraints, we were unable to test materials with focus groups, but have leveraged LCAC engagement. Since we foresee this constraint continuing through 2021, we will not be pursuing this activity in 2021, but will continue to engage EOCCO LCACs in evaluating materials.

EOCCO is focused on tracking and increasing utilization of Spanish interpreter visits provided through our language service provider, Passport to Languages. Of the 10,001 interpreter services that were delivered through Passport to Languages at medical appointments in 2020, 9,153 (91%) were to Spanish-speaking members. However, of the 6,586 (11% of EOCCO total membership) members who identified Spanish as their preferred language, only 1,181 (18%) of them utilized Passport to Languages for medical appointments in 2020. This gap reflects that there are still opportunities to increase interpreter utilization among our Spanish speaking members and provide external communications about the availability of interpreter services.

Considering the progress toward this goal, EOCCO will continue to focus on the second activity that was previously identified concerning Spanish speaking interpreter services. EOCCO has revised this activity to take into consideration ongoing state and local guidelines while remaining committed to improving language access.

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

Although EOCCO has a good foundation already in place, this project will continue to strengthen and improve our Language Access Plan. Specifically, we will focus on the utilization of interpreter services by EOCCO members and providers. In 2020 EOCCO had a significant increase in interpreter utilization through Passport to Languages for medical visits (10,001), compared to the 588 that were arranged in 2018 and the 569 in 2019. Although EOCCO was unable to test member materials with focus groups in 2020, we did track the percentage of materials that follow readability guidelines and/or have been translated to Spanish. This included documents that outlined COVID-19 information, NEMT services, our advance directive form, complaint form, resource information about food delivery services, domestic violence resources, information on changing PCPs, and important phone numbers. Of the 37 member documents that were published on the EOCCO website in 2020, 18 (49%) have been translated to Spanish.

We will continue to: (a) track the utilization of interpreter services through EOCCO's interpreter services, such as Passport to Languages, and (b) develop a provider and member outreach campaign to increase awareness and utilization of interpreter services. In 2020, the conflicting priorities during the pandemic impeded our progress toward the member outreach monitoring activities we had outlined. This submission includes adjustments to our monitoring activities.

E. Brief narrative description:

To improve access to our EOCCO services, this project takes into account the cultural and linguistic background of our members and specifically addresses the needs of individuals who have limited English proficiency (LEP). Our focus in 2021 will be to monitor our health care interpreter services as well as provide outreach to members to inform them of the availability of health care interpreters. In doing so, the project will primarily address CLAS Standard 6, in addition to 5 and 11:

- EOCCO will work with subcontractors to gather more detailed information on interpreter utilization rates for members whose primary language is not English. This information will be further analyzed to identify trends in geographic locations, age, or interpretation modality (i.e. telephonic, in-person, video). This will meet CLAS Standard 11.
- EOCCO will also develop a culturally specific Spanish member outreach campaign to inform and guide members in arranging interpreters for their visits. Additionally, EOCCO will leverage its provider newsletter to include instructions for providers to arrange interpreters. This will meet CLAS Standards 5 and 6.

F. Activities and monitoring for performance improvement:

Activity 1 description: EOCCO will implement a member outreach campaign targeted at Spanish-speaking members to increase awareness and utilization of interpreter services. To do so, EOCCO will compare the percentage of members whose primary language is Spanish to the percentage of members who utilized Spanish interpretation service. This will quantify gaps in Spanish interpreter utilization. Additionally, EOCCO will generate physical member outreach materials that will be mailed to members and include instructions on how to access interpreter services.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Track the percentage of Spanish interpreter services provided during member's medical appointments through Passport to Languages. Identify a baseline for interpreter service utilization for behavioral health visits.

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

18% of Spanish-speaking members utilized Passport to Languages in 2020 for medical appointments.	Increase utilization of Passport to Languages to 22% among Spanish-speaking members.	3/2022	Increase utilization of Passport to Languages to 30% among Spanish-speaking members.	3/2023
EOCCO currently does not have a baseline measure for interpreter service utilization for behavioral health services.	Recognizing this measurement gap, EOCCO will establish a process to identify current behavioral health interpreter utilization.	8/2021	Create a process to routinely track, measure, report, and improvement interpreter utilization for behavioral health visits.	6/2023

Activity 2 description: To further assist EOCCO's provider network in coordinating interpreter services for all members who are in need, we will create and distribute "I SPEAK" language identification cards to clinics. The cards will also have accompanying instructions for clinic staff to arrange interpreters for EOCCO members. EOCCO is also monitoring the use of interpreter services (including the use of qualified and certified interpreters) within each of our clinics to ensure equitable access among our members with limited English proficiency.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Distribute language identification cards with at least one outpatient medical clinic. Utilize monthly calls with clinics to understand utilization and experience with language cards and delivering quality health care interpretation through the use of certified and qualified interpreters.

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
EOCCO does not currently use or distribute these cards.	Partner with at least 1 outpatient medical clinic to use "I SPEAK" cards consistently.	6/2021	Engage outpatient clinics to understand their experience using the cards.	3/2022

A. **Project short title**: Project 3: Access to Initial Behavioral Health Assessment within Seven Days

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

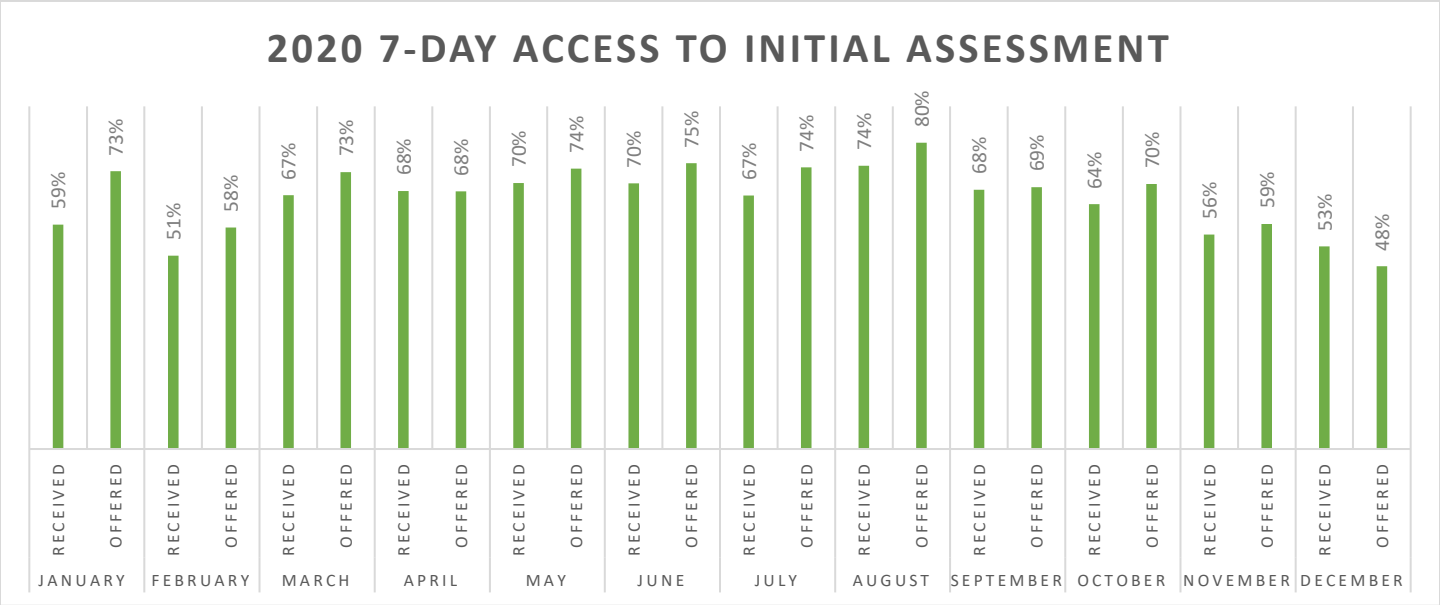
If continued, insert unique project ID from OHA: 89

B. Components addressed

i. Component 1: Access: Timely
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.

EOCCO collected monthly data reports that monitor the number of initial referrals and inquiries for behavioral health assessments for providers of comprehensive behavioral health services. Providers report all initial requests for behavioral health assessments including assessments offered and those received.



Based on the provider reports, EOCCO established that the average access to initial assessment rate across the network for calendar year 2020 is 64%; the offered rate was slightly better at a rate of 68%. Of the comprehensive behavioral health providers included in this reporting group, four are currently on access corrective action plans and two are working on performance improvement plans. If access remains insufficient, EOCCO will consider multiple options to ensure appropriate access to initial behavioral health assessments, including, but not limited to, recruitment of additional providers

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

In 2020, providers were required to submit access reports monthly, transitioning from quarterly reporting the year prior. Increasing the frequency that providers were required to submit reports, allowed EOCCO to identify trends in access more quickly. Additionally, increased frequency also identified the need to update the template to gather additional data for better analysis.

After reviewing 2020 data, EOCCO recognized that the access to behavioral health services program was inadequate to identify potential gaps in access for members seeking initial services. EOCCO has adapted the access provider template to include the following data points (for non-priority populations):

1. Initial appointment offered within seven days for:
    a) Adult mental health assessment
    b) Youth mental health assessment
    c) Adult substance use disorder assessment
    d) Youth substance use disorder assessment
2. Number of no shows for initial appointment offered within seven days for:
    a) Adult mental health assessment
    b) Youth mental health assessment
    c) Adult substance use disorder assessment
    d) Youth substance use disorder assessment
3. Initial appointment received within seven days for:
    a) Adult mental health assessment
    b) Youth mental health assessment
    c) Adult substance use disorder assessment
    d) Youth substance use disorder assessment
4. Number of no shows for initial appointment received within seven days for:
    a) Adult mental health assessment
    b) Youth mental health assessment
    c) Adult substance use disorder assessment
    d) Youth substance use disorder assessment
5. Total number of members who refused appointments when offered for:
    a) Adult mental health assessment
    b) Youth mental health assessment
    c) Adult substance use disorder assessment
    d) Youth substance use disorder assessment
6. Average number of days from request of appointment to receiving appointment for prescribing practitioner.

E. **Brief narrative description**:

EOCCO will assess current primary care clinics with integrated behavioral health services and determine best practices for integration (completed, Primary Care Behavioral Health Model and Collaborative Care Model contracts with EOCCO). Development of community-wide plan for behavioral health integration, including repapering of contractual agreements for Collaborative Care Model and Primary Care Behavioral Health Model within primary care. Provide assurances that primary care clinics have clinic capacity and adaptive reserve for integration, including a PCPCH tier status of Tier 4 or higher. Our goal is to integrate behavioral health services into primary care in 50% of all primary care health systems.

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

Activity 1 description: 7 Day Access Targets/Benchmarks for Initial Assessment

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

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

64% Received, 68% Offered	75% Received, 90% offered	January 1, 2021	3% increase network wide, by reporting quarter	3/31/2021 6/30/2021 9/30/2021 12/31/2021

Currently, access to initial behavioral health assessment is tracked by monthly provider reports. In 2021, all access reports will be validated at on-site reviews.

Additionally, in calendar year 2021, EOCCO will begin to evaluate provider appointment system reports to ensure access for priority populations will meet requirements in OAR 410-141-3525 at annual review and review out-of-network requests for services due to inadequate availability of initial appointments at least quarterly. EOCCO will also begin to collect access data from PCPCH's in the provider network.

A. **Project short title**: Project 4: Behavioral Health Integration within EOCCO Primary Care Clinics

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

If continued, insert unique project ID from OHA: 90

B. **Components addressed**

i. Component 1: Behavioral 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.
vii. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

The original assessment in 2020 was to review the contracts for current primary care clinics with integrated behavioral health services and determine best practices for integration (Primary Care Behavioral Health Model). However, due to staffing changes within the EOCCO Behavioral Health arm (GOBHI) and COVID-19 pandemic disruptions, development of community-wide plan for behavioral health integration, including repapering of contractual agreements for Primary Care Behavioral Health Model within primary care have been carried over into the 2021 TQS plan. As part of the roll-out in 2021, our BH Integration team will use a "pilot county" to ensure that the repapering of contract (including data tracking, workflow requirements, best practice recommendations) are amenable to the abilities of our rural and frontier clinics, i.e. clinic capacity and adaptive reserve for integration. Our continued goal is to integrate behavioral health services into primary care in 50% of all primary care health systems over the next 5 years (by 2024).

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

The GOBHI Behavioral Health Integration Team has developed a pilot program in Wallowa County, focusing on the collaboration of Wallowa Valley Center for Wellness (WVCW) and the recently contracted Wallowa Memorial Hospital, who oversees integrated behavioral health services for Wallowa Memorial Medical Clinics in Enterprise and Joseph. This process will incorporate evidence-based guidelines and recommendations from service industry experts. The Behavioral Health Integration Project Manager will host a series of meetings, with regular check-ins at three, six and nine months with the goals to understand the relationship between primary care and the Community Mental Health Practices

(CMHPs), revamp the current contract to be more equitable for all agencies AND the patient served. They will create a community care team that serves the patients in alignment with CCO 2.0 guidelines and other state and county requirements as well as create a systems-level integration strategy that is applicable and adaptable to other integrated programs in the EOCCO region.

The Vision for EOCCO Behavioral Health Integration should include:

i. Incorporation of a collaborative care team to meet the needs of each patient and situation with
    1. A suitable range of behavioral and physical health care expertise;
    2. Shared operations, workflows, and practice cultures; and
    3. Formal and on-the-job training

ii. A shared patient population and mission, and

iii. A systematic clinical approach:
    1. Employing methods to identify patients who have need or may benefit from care.
    2. Coordinating with local Community Health Programs.
    3. Engaging patients and their families in identifying their needs for care.
    4. Involving patients and clinicians in decision making.
    5. Utilizing an explicit, unified, and shared care plan; and
    6. Systematic follow-up and adjustment of care plan if needed

E. **Brief narrative description**:

In 2018, Greater Oregon Behavioral Health, Inc. (GOBHI), a majority owner of the EOCCO, developed a 'boilerplate' contract with primary care clinics in the EOCCO region that intended to provide behavioral health services integrated into their primary care clinic. The contract offered a [redacted] (PMPM) rate for each clinic to subsidize these services. In 2019, with the assistance of GOBHI psychologists and other internal expertise, GOBHI modified current contracts to include an increase from [redacted] on a case-by-case basis). The contracts also included evidence-based methodology through the Collaborative Care Model (also called the IMPACT model) to provide a more robust process for data gathering, process monitoring and patient outcomes. These contracts were revised for adult only populations. By mid-2020, with the recent restructuring of GOBHI, the new requirements under CCO 2.0, and the beginning of an international pandemic, these developments have propelled the need for a fresh, innovative approach to the Behavioral Health Integration work within the EOCCO. This includes a review of current efforts and contract language as well as establishing/maintaining a collaborative partnership between primary care and other local behavioral and mental health services including our CMHPs. This also includes adopting the Primary Care Behavioral Health (PCBH) model of care for all currently contracted primary care practices.

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

Activity 1 description (continue repeating until all activities included): Behavioral Health Integration Pilot in Wallowa County

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Assessment and changes to current contract and implications in real-world/real-time situations.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Launch BH Integration Pilot (Wallowa County)	• Review of current contract from GOBHI • Discussion of changes to contract language and overall impact on clinic practice	April 2021	• Re-vamping of current contract to include PCBH model to all nine PCPCH-integrated	December 2021

	• Overview of data tools to enhance communication/collaboration (Collective Medical Technology)
	• Present final recommendations to GOBHI/EOCCO of systematic approach to primary care integration
	  ○ Contract changes
	  ○ Data tracking
	  ○ Access to care
			practices currently under BH Integration contract
			• Provide training and TA on an ongoing basis to clinics (as needed)
			• Ongoing monitoring of data, including (but not limited to) access, penetration rates and crisis/acute care	

Activity 2 description: Internal EOCCO Behavioral Health Integration Meetings

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Internal assessment of Pilot Program and other TA needs for PCPCH Integrated Practices

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Bi-monthly EOCCO BH Integration Team Meetings	• Troubleshoot any concerns/issues to workflow or data tracking (OON authorization, CPT coding, etc.) • Assessment of TA needs, including training for new hires	Ongoing, with a launch date of December 2021	• Quarterly check-ins with contracted clinics to assess and troubleshoot concerns/issues- bring these back to BHI Team on a regular basis • At least once a year training for BHI clinics, as needed.	Ongoing; may be less frequent depending on need.

A. **Project short title**: Project 5: Health Equity Improvement and Stratification

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

If continued, insert unique project ID from OHA: 91

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.

This Quality Improvement project was designed to strengthen our capabilities to use REALD standards in our ongoing health service planning, evaluation, and monitoring. It utilizes our Health Information Exchange (HIE), Arcadia Analytics, that draws data from our health care provider's Electronic Health Records (EHR) and provides population health management functions that are inclusive of demographic data.

The past year we made progress on refining the quality of our data, though it fell short of what we were hoping to accomplish. Our data warehouse still uses member demographic information from the 834 enrollment files. We had hoped that in 2020 we would be able to supplement these enrollment files with updated information from Arcadia to reduce the number of members who had 'unknown' listed as part of their demographic profile. Unfortunately, this process proved to be more complex than we anticipated. We are currently determining the best way to store updated information in our internal data base, while ensuring our system does not overwrite pertinent member files.

Additionally, the impact of the COVID-19 pandemic can be felt throughout this project. The suspension of the redetermination of benefits process has inflated EOCCO membership rates by roughly 20%, putting a strain on our limited service area. Simultaneously, the pandemic has attributed to increased rates of alcohol, tobacco, and other substance use nationwide. While EOCCO had previously chosen to focus on cigarette smokers, our data has not yet been fully analyzed at a population health level to determine if health disparities exist between different groups as outlined in the 2020 TQS submission. Our data collection methods were reduced to using only Arcadia to detect members who identified as current smokers. Elective surgeries were postponed for a portion of last year, limiting the information we would normally receive from referrals. In addition, staff turnover and the increased workload brought on by COVID-19 led to the completion of fewer health risk assessments, which typically provided us with another source of data on members who smoke. While we were able to collect information from Arcadia, these barriers prevented us from collecting supplemental data from two of our three sources we had identified in our 2020 TQS submission.

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

Over the course of 2020, we have taken steps to improve the quality of our member data. Our analytics team has reformatted our monthly provider reports which includes REALD data on members who need outreach. These reports go out to all providers who participate in the incentive measure program. Based on feedback from clinics this has been a highly utilized resource that is helpful for care teams to identify when a member may need ancillary services to accompany their appointment, such as language assistance or transportation. In addition, we were able to use 2020 data from Arcadia to stratify these members by race as previously outlined in the 2020 TQS submission (see table below). This information will help us strategically target and develop educational resources to cigarette smokers among demographics experiencing a disparity.

Race	Number of Tobacco Smokers
White	513
Unknown	48
American Indian or Alaska Native	4
Asian	2
Black or African American	7
Native Hawaiian or Other Pacific Islander	2
Other	33
Grand Total	**609**

Count of EOCCO Members by Race who are Cigarette Smokers as of 3/10/21

E. **Brief narrative description**:

Accurate and reliable descriptions of the service population is an essential aspect to plan for and provide services that account for the diversity of the service population, and for example, include linguistic and culturally responsive components. Using our Health Information Exchange (HIE), Arcadia Analytics, we can draw data from our health care provider's Electronic Health Records (EHR) which provides timely data and gap lists that are inclusive of demographic data. This project will strengthen our ongoing procedures to store, retrieve, and use demographic data of our EOCCO members that meet the REALD standards. This information will complement data collected by our member health advocate team who reach out to members that have been identified as cigarette smokers through health-risk assessments. With improved demographic data collection, EOCCO will stratify members who identify as cigarette smokers by REALD standards to assess for health disparities/inequities and produce targeted educational materials to refer members to EOCCO's inhouse tobacco cessation program.

This project addresses CLAS standard # 11 ("Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes …"). It also addresses CLAS standard #. 12 ("conduct regular assessment of … health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area").

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

Activity 1 description EOCCO is evaluating demographic data including race, ethnicity, and language from Arcadia Analytics to improve our member records in our data analytics warehouse. Arcadia Analytics pulls EHR data from 13 of our largest EOCCO health providers, data from our internal claims system, and member demographic data from the 834 files. Arcadia will save the most updated demographic data from any of the data sources to store in the member's profile. Baseline data was pulled from 834 enrollment files on December 31, 2019, which indicated that 53.3% of our membership reported "unknown" when identifying their race. EOCCO plans to decrease the rate of members who report "unknown" for their race through this data collection and improvement activity.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Conduct a semi-annual review of our member population using EOCCO's internal data warehouse to determine if the number of members with 'unknown' listed as their race has been reduced.

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

53.3%	43.3%	03/2022	43.3%	03/2022

Activity 2 description: EOCCO will evaluate demographic data of members who are cigarette smokers identified through EHRs via Arcadia Analytics, health risk assessments, and prior authorization requests for elective surgeries to determine whether disparities exist. Strategically target educational materials to the impacted demographic(s) once disparities are identified.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Review demographics for members who have self-identified as cigarette smokers based on Arcadia data, health-risk assessments, or referrals by June 2021. Develop at least one population-specific resource by December 2021.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
We are not aware of disparities based on REALD demographics.	We have identified disparities based on REALD demographics.	06/2021	Strategically target educational resources to smokers in demographics experiencing a disparity.	12/2021

A. **Project or program short title**: Project 6: Culturally Responsive Services by Community Health Workers

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

If continued, insert unique project ID from OHA: 92

B. **Components addressed**

i. Component 1: **Health Equity: Cultural Responsiveness**
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 component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and built environment ☐ Social and community health

vi. If this project addresses CLAS standards, which standard does it primarily address? 3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

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

Expanding utilization and access to Community Health Workers (CHW) remains a high priority for EOCCO, especially as the pandemic has exacerbated community distrust in healthcare and health disparities. Community Health Workers are an essential bridge to appropriately communicate information and assist members with navigating healthcare systems.

Unfortunately, efforts to assess CHW capacity needs (activity 1) of this did not occur due to a shift towards pandemic response but remains a key focus area that EOCCO will continue and prioritize in 2021. However, EOCCO continued to

engage CHWs employed by community and healthcare organizations to address barriers that they face, engage them in re-shaping their work through collaborative groups and in exchanging learning opportunities, providing them a voice in policy making and assisting with provider enrollment, which address activity 2.

Recognizing that the previous project submission was ambitious, in 2021 EOCCO will focus on the two outlined activities that will strategically increase and improve accessibility to CHWs and will not continue the previously outlined third activity.

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

Culturally and linguistically responsive services promote health equity because they both impact health and are responsive to an individual's cultural health beliefs and practices, preferred language, health literacy level, and communication needs. CHWs are positioned to deliver culturally and linguistically appropriate services. CHW services are part of the broader set of Traditional Health Worker (THW) services that also include, for example, peer-based support, doulas, and patient navigation. This set of services are delivered by providers who have a high level of knowledge and or experience with the health conditions of the individuals they serve. Typically they are also familiar with (a) the barriers to accessing services experienced by individuals in the community, such as the challenges of navigating a complex array of services, as well as (b) the characteristics of the local social settings (e.g., neighborhoods, local communities) where the service populations live. As such, CHWs have first-hand knowledge of the cultural health beliefs and norms that impact health behaviors as well as health care utilization; in other words, they are equipped to provide culturally responsive services.

Thus, we have chosen our CHW program as a focus for this quality improvement project that addresses culturally responsive care. We will apply a health equity lens to our CHW program and address both: (a) our ongoing examination of the demographic profiles of the 12 counties that we serve in eastern Oregon and that are rural or frontier by REALD standards and (b) further support the existing CHW workforce by delivering target training and education opportunities.

The importance of CHW-based health care services is largely shared across eastern Oregon according to our community engagement initiatives. For example, CHW-based services appear among the three top-ranked priority areas in our most recent EOCCO CHP. Current data also demonstrates that the utilization of CHW services has increased annually since 2014. The Table below highlights the CHW-related claims that have been submitted. EOCCO anticipates that utilization of these services will only continue to increase.

Calendar Year	2014	2015	2016	2017	2018	2019	**Total**
Total Claims	18	69	423	1,163	1,693	1,855	**5,221**

Additional data on EOCCO's CHW workforce and services were collected via an electronic survey in July of 2020. This survey was sent to all EOCCO clinics and community partners; 26 partners completed the survey. Among the survey findings, these are particularly relevant to this quality improvement project:

- A majority of CHW services are provided in the organization's physical location or community events.
- Nearly 77% of respondents plan to employee CHWs within the next year.
- Respondents estimated that only 50% of their employer organizations were billing claims for CHW services to EOCCO for reimbursement. The most common reasons for this were that the billing process is confusing, cumbersome, and lengthy.

E. Brief narrative description:

To increase the capacity to provide culturally responsive care through Community Health Worker-delivered services, EOCCO will implement a plan that will ultimately result in increased levels of CHW-based care that will impact health equity. This quality improvement project will further align CHW-based services with local/regional health priority agendas across the EOCCO service area and continue to support training and education needs for the current CHW workforce.

EOCCO's "Culturally Responsive Services by Community Health Worker" project will address CLAS Standards 3 and 12, while ensuring members receive culturally responsive services:

- Assess CHW capacity for culturally responsive care by analyzing data from EOCCO's most recent CHA and Population Assessment and CHW roster. This will address CLAS Standard 12.
- Equip CHWs and their employer-organizations to implement CHW-based culturally responsive services by updating training for CHWs based on identified needs, updating the materials and resources used by the program, and training provider organizations in EOCCO's CHW program. This will address CLAS Standard 3.

F. Activities and monitoring for performance improvement:

Activity 1 description: Align CHW-based culturally responsive care to EOCCO-wide priority health agendas. Assess CHW capacity for culturally responsive care. The EOCCO Traditional Health Worker Liaison will work with the Community Health Team and the Analytics team to examine our counties': (a) demographic make-up based on REAL+D standards by using our latest CHA and Population Assessment, (b) stated health priority needs for each county based on our latest Community Health Plan as well as community engagement activities, CCO metrics performance tracking, and (c) latest roster of CHW workers.

Based on the analyses of this set of information, gaps in each county's service population and health priority area will be identified for CHW-based care that addresses health equity gaps in local communities. Because the population size varies substantially across the 12 EOCCO counties, we will distribute the activities across three groups (tiers) of counties stratified by population size in different timelines (see table below). The county size tiers are based on the county's portion of our EOCCO total estimated enrollees derived from enrollment information from February 2021: (1) Tier-1 consists of two counties (Umatilla and Malheur) that together approximately total 56% of our enrollees (each county accounts for 20% or more of total EOCCO members), (2) Tier-2 consists of three counties (Morrow, Union and Baker) that together approximately total 26% of our enrollees (each county accounts for 6% to 12% of total EOCCO), and (3) Tier-3 consists of seven counties (Sherman, Gilliam, Wheeler, Grant, Wallowa, Harney and Lake) that together approximately total 17% of our enrollees (each county accounts for a range of 1% to 4% of total EOCCO).

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: The EOCCO Traditional Health Worker Liaison will work with the Community Health Team and the Analytics team to evaluate the CHW capacity needs by county.

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

CHW capacity needs have not been examined for two Tier-1 counties that account for 55% of our members.	Capacity needs analyses examined for at least 1 of 2 *Tier-1* counties.	6/2021	Capacity needs analyses examined for ALL (2) *Tier-1* counties.	7/2022
CHW capacity needs have not been examined for three Tier-2 counties that account for 26% of our members	Capacity needs analyses examined for at least 1 of 3 *Tier-2* counties.	6/2021	Capacity needs analyses examined for ALL (3) *Tier-2* counties.	7/2022
CHW capacity needs have not been examined for seven Tier-3 counties that account for 17% of our members.	Capacity needs analyses examined for at least 2 of 7 *Tier-3* counties.	7/2021	Capacity needs analyses examined for ALL (3) *Tier-2* counties.	7/2022

Activity 2 description: Ensure implementation readiness of CHW-based culturally responsive care. EOCCO will equip CHWs and their employer-organizations to implement CHW-based culturally responsive services by updating training for CHWs based on identified needs, updating the materials and resources used by the program, and training provider organizations in EOCCO's CHW program.

We will assess the training needs of CHWs who will be working on culturally responsive care following the results of Activity 1. Training will include culturally responsive care, following OHA's Office of Equity and Inclusion (OHA-OEI) standards, updating certification as a THW per OHA-OEI standards, and or other content-specific training per assignment in their target county service sector. The CCO Traditional Health Worker Liaison will work with organizations that train CHWs in Eastern Oregon, organizations who employ CHWs, and LCACs for input and guidance. EOCCO will update materials and resources and complete production – including approval – of materials and resources needed to carry out CHW-based care to meet both best practice standards as well as culturally and linguistically appropriate standards for the identified priority sub-population. The CCO Traditional Health Worker Liaison will work with contracted trainers and with member services to update program materials to conduct services with CCO members. Health service providers in our provider network that are most critical to accomplish our local health agendas will be re-trained/updated on the utility of CHW program including the scope of their work, how they can impact health goals such as the CCO metrics program, as well as billing procedures that allow organizations to get reimbursed for those services.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor the percentage of CHWs who are trained/certified to work with identified health priority populations. Track completion and OHA approval of materials and resources that meet cultural and linguistic standards for identified priority populations. Monitor training on billing procedures for CHW-based culturally responsive services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Training needs for CHW-based culturally responsive care have not been determined nor completed.	20% of CHWs trained/certified to work with identified health priority population(s).	9/2021	100% of CHWs trained/certified to work with identified health priority population(s).	9/2022
Materials and resources (e.g., written brochures) that meet cultural and linguistic standards for identified priority populations have not been identified.	Produce materials and resources (e.g., written brochures) that meet cultural and linguistic standards for identified priority populations to inform of CHW services.	8/2021	Track the channels and methods in which materials and resources (e.g., written brochures) that meet cultural and linguistic standards to inform identified priority populations of CHW services are delivered and used. This will inform effectiveness and accessibility of materials.	9/2022
50% of CHW survey respondents answered that their employer organizations were billing claims for CHW services to EOCCO for reimbursement.	Develop targeted training material and education events that will be delivered to all necessary parties (e.g. CHWs, claims staff) who deliver CHW-based services. Increase CHW survey respondents	8/2021	Train/update all necessary parties involved in billing procedures (e.g., CHWs, claims staff) for CHW-based services. Increase CHW survey response to “yes” to the question about whether employers	12/2022

	answering "yes" to the question about their employers submitting claims to 55%.		submit claims for CHW-based services to 80%.	

A. **Project short title**: Project 7: Behavioral Health Screenings in Dental Offices

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

If continued, insert unique project ID from OHA: n/a

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.

Select clinics in EOCCO's service area have adopted integrated care with dental, physical, and behavioral health providers. These clinics have been providing standardized depression screening for several years. In 2019, EOCCO's Depression Screening and Follow-up rate was 65.9%; however, dental offices are not a source for depression screenings. Currently, 0% of EOCCO dental offices are screening for depression.

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

Depression is a severe medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning. Identifying and treating depression in its early stages is critical. Our goal is to provide depression screenings within dental offices to increase access to care for OHP members.

E. **Brief narrative description**:

Patients with behavioral health issues can access the behavioral health system in numerous ways. However, there remains an essential missing portal to mental health and addiction treatment, specifically through the oral health system. Dentists are an integral part of the health care system yet are lacking workflows to screen and refer EOCCO members to behavioral health services. This pilot project proposes implementing depression screening methods in five dental offices and connecting them with Care Managers who will follow-up with patients who screen positive. The Oregon Health Authorities' depression screening and follow-up measure specifications will be used as guidance to evaluate dental provider utilization of depression screenings: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2021-specs-(Depression-Screening)-12-18-20.pdf.

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

The utilization of office-based patient health screening methods by physical and behavioral health providers in EOCCO's service area does not need to be re-invented for oral health providers. The five dental offices will implement the Patient Health Questionnaire (PHQ)-9 and track the administration of the screening. Pilot dental offices will have direct access to the Greater Oregon Behavioral Health Inc. (GOBHI)'s Care Management (CM) staff. GOBHI's CM staff can immediately determine whether a member is already receiving behavioral health services or has in the past and collaborate with the dental office to plan the best way to initiate a behavioral health referral.

If a patient screens positive using the PHQ 9, then the dental office will make a phone call to a Care Manager with the member's identifying information and the behavioral health concern to initiate a referral. The Care Manager will contact the member and discuss the possibility of access to the behavioral health system. If successful, the Care Manager will make a referral to an EOCCO program, documenting in EOCCO's care management program, HMS Essette, along the way. A GOBHI CM staff person will maintain contact with a referred member by transitioning them to the behavioral health system intake and engage them in an ongoing treatment process if necessary. See *Attachment 3 Oral Health Depression Screening* Workflow for additional information.

Four dental offices have agreed to participate in the pilot project: Winding Waters Medical Clinic (FQHC), Medical Center Dental, Advantage Dental-- Milton Freewater, and Advantage Dental--Hermiston. EOCCO hopes to include one more dental office that serves ODS members, totaling five dental practices. The two Dental Care Organizations (DCOs) that serve EOCCO, Advantage Dental and ODS, are involved in this pilot project. Additionally, Winding Waters Medical Clinic will join the pilot because they have adopted an integrated care model, and EOCCO staff want to evaluate the difference between administering depression screenings in a dental office versus an integrated care practice.

ODS and Advantage staff will be the point-persons for their select dental offices and responsible for liaising between dental providers and EOCCO staff. Additionally, a GOBHI representative will be responsible for training the dental offices on depression screening protocols and establishing workflows between the Care Management team and dental providers. Lastly, EOCCO staff, with the help of the DCOs, will be responsible for evaluating the pilot project. All parties will meet every quarter to make sure project goals are moving forward and will communicate via email between meetings.

Overall, EOCCO hopes to see improved oral health and greater access to behavioral health services for OHP members.

Activity 1 description (continue repeating until all activities included): Identify five dental offices to participate in the pilot project. Schedule introductory meetings with them to develop depression screening workflow and training.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Pilot project

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Four dental offices identified to pilot depression screenings.	Identify five dental offices to pilot depression screenings. Begin trainings and create workflow outlines.	5/3/2021	Use PDSA quality improvement strategy to evaluate and modify workflows (as needed) and evaluate pilot project and recruit more dental offices to	6/30/2022

			adopt behavioral health screenings.	

Activity 2 description: Implement the Patient Health Questionnaire (PHQ) 2 and 9 at the five pilot sites with all EOCCO patients ages 12 and older, at least annually. Patients who screen positive on a PHQ-9 will be referred to GOBHI's Case Management team for follow-up.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: The number of EOCCO patients screened using a PHQ-2 and PHQ-9 as well as those who received follow-up. The data will follow the Depression screening & follow-up OHA 2021 incentive measure specifications: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2021-specs-(Depression-Screening)-12-18-20.pdf. This data will be provided via the DCO case management teams who will track the screenings for each pilot site.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0%	8%	12/31/2021	25%	12/31/2023

A. **Project short title**: Project 8: Technical Assistance for PCPCHs

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

If continued, insert unique project ID from OHA: 94

B. **Components addressed**

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

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

The COVID-19 pandemic resulted in a substantial increase in Medicaid enrollment across Oregon in 2020. EOCCO's membership grew from 52,288 in December 2019 to 59,607 in December 2020. By default, this has resulted in a larger number of members being assigned to PCPCH certified clinics. The CCO's primary care clinic auto-assignment process enrolls patients in the highest-tiered PCPCH clinic in their area by default, meaning that the growth in EOCCO membership over the past 12 months has led to an increase in member assignment to PCPCH clinics with higher tier designations.

Unfortunately, the COVID-19 pandemic also meant that the Primary Care Transformation Coordinator was not able to provide in-person Learning Collaboratives related to PCPCH applications and requirements. Many clinics were unable to gather the data required to apply for PCPCH re-enrollment or tier advancement due to an increased focus on the COVID-19 response. The PCPCH Standards and Advisory Committee also postponed planned July 2020 changes to the PCPCH Technical Specifications and measures until January 2021.

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

Despite the difficulties described above, the Primary Care Transformation Coordinator was able to continue offering virtual Technical Assistance (TA) to clinics as requested. TA consisted of support in updating practice workflows, assistance understanding the PCPCH measures, and reviewing the upcoming changes to the PCPCH Standards to be implemented in January 2021. This TA allowed EOCCO to continue providing insight and support for the PCPCH clinics in a remote format.

Although the Coordinator was not able to host in-person Learning Collaboratives as planned, EOCCO did see an increase in both the percentage of EOCCO members assigned to a Tier 4 or 5 clinic. In December 2019 73.2% of EOCCO members were assigned to Tier 4 or 5 clinics, while in December 2020 77.1% of members were assigned to a Tier 4 or 5 site. The total count of PCPCH clinics that were certified at a tier 4 or higher also increased. In December 2019, 29 EOCCO primary care clinics were certified a tier 4 or 5. In December 2020 37 clinics were certified a tier 4 or 5.

E. **Brief narrative description**:

EOCCO staff will continue to work with clinics to provide one-on-one TA as requested. TA can cover any topic related to the PCPCH process, including but not limited to becoming a newly certified clinic, maintaining, or increasing the PCPCH tier, understanding new Technical Specifications and PCPCH measures, and implementing projects to address the measures.

EOCCO does not anticipate offering in-person Learning Collaboratives during 2021 due to the ongoing COVID-19 pandemic. However, the Primary Care Transformation Coordinator will continue to provide one-on-one virtual support and facilitate a clinic collective of PCPCH best practices if enough requests are received for inter-clinic collaboration.

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

Activity 1 description: Increase the number of certified PCPCHs to achieve tier 4 or higher certification.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Measure the percent of EOCCO members assigned/attributed to a PCPCH clinic.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
As of December 2020: No certification: 7.9% Tier 1: <0.1% Tier 2: 0.0% Tier 3: 15.0% Tier 4: 47.5% Tier 5: 29.6% Total: 100%	No certification: 7.1% Tier 1: 0.0% Tier 2: 0.0% Tier 3: 15.8% Tier 4: 45.8% Tier 5: 31.3% Total: 100%	12/2021	No certification: 6.2% Tier 1: 0.0% Tier 2: 0.0% Tier 3: 15.5% Tier 4: 46.6% Tier 5: 31.6% Total: 100%	12/2022

Activity 2 description: Increase the number of certified PCPCHs to achieve tier 4 or higher certification.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Track the total number of PCPCH-certified clinics with EOCCO patients assigned for primary care by tier.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
As of December 2020: Tier 1: 1 Tier 2: 0 Tier 3: 13 Tier 4: 24 Tier 5: 13 Total: 51	Tier 1: 0 Tier 2: 0 Tier 3: 14 Tier 4: 24 Tier 5: 14 Total: 52	12/2021	Tier 1: 0 Tier 2: 0 Tier 3: 13 Tier 4: 25 Tier 5: 15 Total: 53	12/2022

A. **Project short title**: Project 9: 3-day Follow-up Post Emergency Department (ED) Visit

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

If continued, insert unique project ID from OHA: 95

B. **Components addressed**

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

A team of medical reviewers analyzed the daily ED census report to identify claims that were determined to be a result of a Serious and Persistent Mental Illness (SPMI) or Substance Use Disorder (SUD) condition. Between 03/17/2020 - 01/27/2021 EOCCO recorded a total of 432 ED visits for members with SPMI or SUD-related complaints. Of that sample 110 visits (25%) were documented as having received adequate follow up within three days of discharge from the ED.

	Case Count	Percentage
Met 3-Day follow Up	110	25%
Exceeded 3-day follow up	167	39%
Pending data	155	36%

3-day follow up post ED compliance, 3/17/20-1/27/21

The COVID-19 pandemic further exacerbated the barriers felt by members facing SPMI and other SUD. Many individuals were not accessing care at this time. ED visits dropped substantially during this time period, agencies were not as able to serve people in person, which is an important component when working with members who have SPMI or SUD. Community stakeholders and CMHPs have done their best to meet members where they are to try to engage them in services. This includes locating individuals without permanent homes and in active substance use.

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

Several initiatives were taken to advance this project in 2020. EOCCO has begun conducting daily meetings with community stakeholders, local CMHPs and clinical quality specialists to ensure members who presented in the ED for a SPMI and/or SUD-related condition were referred to appropriate community-based services. Community stakeholders were going to find people where they were when able once the COVID-19 pandemic allowed for safe interactions. Care Management Staff follows up with care coordination and intensive care coordination services to members with SPMI.

In addition, EOCCO began developing an automated report using the PreManage/Collective platform that uses ICD-10 codes to capture emergency department visits that suggest a SPMI or SUD-related visit. This report has strengthened collaboration between patients, providers, and EOCCO, by providing more in-depth patient information with real-time Emergency Department notifications. This report, referred to as the ED Rounds report, is reviewed every morning Monday through Friday with stakeholders. During rounds the medical professionals, review the Collective data and then identify what members need to have what kind of intervention. By doing this it has helped identify members that may be having additional complex needs.

While the hospital ED is the wrong place to treat SPMI and SUD issues, it is one of many right places to identify and follow up with members who, for whatever reason, may not have found their way to outpatient treatment. EOCCO views an ED visit as a "right door" to access its behavioral health and SUD treatment capacities. Ongoing monitoring of ED utilization for mental health (MH) or SUD services at the ED will be analyzed on a periodic basis to understand trends and identify gaps in services. While our performance fell short of our intended target and benchmark goal we set for the prior year, we have decided to continue working towards the performance rates that were previously defined in the 2020 TQS submission.

E. **Brief narrative description**:

EOCCO receives a daily report of all EOCCO members who were in an ED the previous day. This report includes diagnostic information along with other clinical data. Each day, the members who are determined by a medical reviewer to have presented to the ED as a result of SPMI and/or SUD conditions are entered into the medical management software system.

Daily calls are placed by EOCCO Care Management staff to the community-based providers who are responsible for doing the follow up, in turn generating at least one of the following OHA-approved Current Procedural Terminology (CPT) codes for follow up from acute care:

98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510, 90846, 90791, 90792, 90832-90834, 90836-90838

EOCCO will follow up with the outpatient provider regarding what appropriate connection to community-based services took place, and document in the medical management software system exactly what type (code) of follow up took place, who was the responsible person and when.

Care Management staff will monitor the software system to determine if, after the intervention with the provider, individual members are returning to the ED seeking services for mental MH or SUD. If an individual member continues to return to the ED for MH or SUD services, Care Management staff will complete an individualized management plan (IMP). Interventions may include but are not limited to referrals to care coordination, case management, medical services, ACT, peer delivered services, and supported employment services.

The Care Management staff provides care coordination and intensive care coordination services to members with SPMI. The medical management software does not identify which members receive home and community-based services under the State's 1915(i) State Plan Amendment.

EOCCO ensures that Supported Employment Services are available for all adult members that are eligible for this service. EOCCO ensures that participating network providers that operate certified ACT programs screen and engage EOCCO members with an SPMI diagnosis who may be eligible for the ACT program to encourage participation. EOCCO is addressing this activity in Project 1.

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

Activity 1 description: Develop procedure to identify (SPMI/SUD) members to access behavioral health services through identification via the Collective platform and daily ED Rounds utilization reports. Work to establish better rates of 3-day follow up by enhancing collaboration between CMHPs, medical providers, and other community stakeholders

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitor compliance for 3-day follow-up post ED visit.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
25% compliance for 3-day follow up post ED visit	60% compliance for 3-day follow-up post ED visit.	03/2022	70% compliance for 3-day follow-up post ED visit, and a 10% increase the following year.	03/2023

Activity 2 description: EOCCO provides care coordination and/or case management services to members with SPMI receiving home and community-based services under the State's 1915(i) State Plan Amendment. We will establish a baseline and set goals for improvement.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Identify 1915(i) Members and special health care needs members within medical management software.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No 1915(i) or special health care needs members identified in medical management software.	1915(i) or special health care needs members identified in medical management software.	09/2021	1915(i) or special health care needs members identified in medical management software.	03/2022

A. **Project short title**: Project 10: Improving the Utilization and Impact of Frontier Veggie Rx

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

If continued, insert unique project ID from OHA: 96

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 built 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.

COVID-19 did create barriers to participants being able to access the program due to office closures and staff reductions. Participants would not have had access to vouchers as they had to be picked up in person. This barrier was addressed through a work-around by having prescribers contact participating households on a monthly basis and mailing booklets to them. Utilization has increased due to this process and has been shown by the reimbursement of used vouchers to the vendors.

A barrier and gap analysis of the Frontier Veggie Rx program was completed on an ongoing basis throughout the last year. The largest barrier/gap was that there are not enough funds to serve the number of people in need with this program. All prescribers in the four counties felt that there were many more eligible for the program than what the program could serve. In Sherman County, one of the main barriers and gaps was the lack of markets where participants could shop. Work has been done to reach out to unconventional vendors to carry fresh and frozen produce specifically to fill this need. It has been rewarding to see the connections made and new avenues being made available for participants to access produce. In Wheeler County, one of the main barriers or gaps is that there is only one prescriber serving that area. We will seek other qualified prescribers in Wheeler County to assist with this program.

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

A full and modified pre- and post-survey (see attached) has been developed utilizing information gathered from the State-wide Veggie Rx Network, Nutrition Oregon Campaign, and Share Our Strength (Eastern Oregon Healthy Living Alliance, Valley Family Health Care, and Greater Oregon Behavioral Health, Inc.). It will be implemented in its full state in Harney, Lake and Malheur Counties with the implementation of the Frontier Veggie Rx Innovation grant as it is longer than the “5 or fewer questions” previously stated. However, it will be pared down for usage in Sherman, Gilliam, and Wheeler Counties (see attached). We feel that we may be able to incentivize approximately 10 households in these three counties to complete the full pre- and post-survey.

An education component will also be included for Harney, Malheur, and Lake Counties with ongoing nutrition education for participants in the FVRx Innovation grant. This education component has three options: 1) receive educational materials in PDF format, 2) complete online nutrition education as provided, and finally 3) 1:1 counseling with a Registered Dietician. There are four units that compose the printed and online materials. Households will have to complete the unit and corresponding quiz in order to receive their next prescription (booklets). Program Manager and Prescribers seek to have approximately 10 households in each county (Gilliam, Sherman, and Wheeler) complete two of the four nutrition education components. There may be incentive options for these households.

E. **Brief narrative description**:

Project Unchanged: EOCCO's long-term goal is to improve the utilization and health impact of the FVRx program. In this Quality Improvement project, we will address barriers to successful utilization of FVRx, align performance measures with targeted health impact goals, and pilot test performance targets and benchmarks. Activities to improve the utilization and impact of FVRx will be driven by formative evaluation techniques, such as focused and targeted data collection on gaps and barriers to utilization from multiple stakeholders who currently implement and use this program. The FVRx Program Manager, FVRx Steering Committee, Quality Improvement, and Analytics teams will in turn formulate feasible problem-solving approaches to the barriers and disseminate them; the teams will also revise the performance measures, and pilot test improvement targets and benchmarks for FVRx. The set of activities are feasible because (a) they will be part of our ongoing activities to coordinate FVRx through a steering committee, (b) the focused data collection approach, and (c) our experienced Analytics and Quality Improvement teams who carry out these functions routinely.

Because our FVRx addresses food insecurity in rural settings that have high poverty rates, we will be addressing the economic stability domain of SDOH. Moreover, FVRx is an intervention to increase access to healthy foods and environmental conditions such as fresh food deserts in rural counties; therefore, we will be addressing the neighborhood and built environment domain of SDOH. Lastly, our set of activities relies on LCACs, Local community program implementers, and users; thus, it involves social and community health components of SDOH as well.

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

Activity 1 description (continue repeating until all activities included): To increase the consumption of fruits and vegetables by participating households as well as to measure whether households are becoming more food secure. The Program Manager will work with existing Prescribers to implement a pre- and post-survey to be captured at the time of enrollment and prior to the final disbursement of booklets in March 2022.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Implement a pre- and post- survey for all Harney County participating households and for 10 participating households in each of the following Counties: Gilliam, Sherman, and Wheeler.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Currently, no metric in place for measuring whether participating households have increased their produce consumption as a result of participating in the FVRx program.	75% of new program participants report that they have increased their produce consumption by at least one serving per day as a result of participating in the FVRx program.	12/2021	Complete 65% of pre-surveys by June 2021. Complete 75% of post-surveys by March 2022.	03/2022
Currently, no metric in place for measuring whether	50% of new program participants report being more food	12/2021	Complete 65% of pre-surveys by June 2021.	03/2022

participating households have become more food secure as a result of participating in the FVRx program.	secure after being enrolled and participating in the FVRx program for 12months.		Complete 75% of post-surveys by March 2022.	

Activity 2 description: To reduce Social Determinants of Health barriers to food security by participating households. The Program Manager will work with Community Health Workers and other prescribers to ensure that households are being referred and connecting to appropriate community programs and resources.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Include in the Enrollment Form a question about SDOH needs and make the appropriate referral.

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently, no method is in place to track whether participating households are being referred to other programs	Community Health Workers and prescribers will assess social determinants of health barriers and identify and refer 85% of participating households to the appropriate community programs and resources. Goal is to have 33% of referred households self-report that they have made a connection to a new/renewed program or resources.	12/2021	Community Health Workers and prescribers will work with the Program Manager to develop and implement a tracking system for capturing SDOH needs and referrals. This will be accomplished by June 2021. Connections to new/renew programs or resources will be self-reported in the post-survey. Complete 75% of post-surveys by March 2022.	03/2022

A. **Project short title**: Project 11: Additional Support and Care Coordination for Members with Special Healthcare Needs

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

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

B. **Components addressed**

i. Component 1: Special health care needs
ii. Component 2 (if applicable): Serious and persistent mental illness
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.

A significant barrier to the progression of the 2020 project was the reprioritization of resources and shift in focus from targeted projects to operationalizing the necessary structures in response to the COVID-19 outbreak across the state. EOCCO was required to reallocate staffing resources to assist in development of protocol and workflows to ensure adequate access to care, disease prevention and provider support in navigating the new and quickly changing pandemic environment. The outbreak environment did not support allocation of case management time needed to do specialized outreach to a minor subset of members with SHCN. While the specific project for 2020 to address needs among members with SHCN was not carried out, EOCCO made strides in implementing internal workflows and policies that would build a foundation for a project in 2021. EOCCO carried out additional provider education regarding members with SHCN, implemented internal referral processing changes as well as system configuration updates as soon as the staffing and resources became available to prepare for the upcoming years projects. The impact of the year-long pandemic on the mental and behavioral health has been significant, as such, EOCCO has opted to change the direction of this project to that which may be of greater benefit to a larger sub-set of SHCN members who may not otherwise seek help and resources that they need. Therefore, increasing collaboration and coordination of care between physical and behavioral health with an emphasis on culturally and linguistically appropriate materials.

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

EOCCO has implemented tracking mechanisms to identify members with special health care needs (SHCN). EOCCO has also developed and implemented a process for members with SHCN to directly access specialists, even without a funded diagnosis and service code whether they seek service in or out of network, which completed one of the activities in the 2019 TQS. While all SHCN members have access to specialists without a referral, EOCCO has identified the need to increase engagement with members with behavioral health needs. This includes members with substance use disorders (SUD), severe and persistent mental illness (SPMI) and intellectual and developmental disabilities (IDD). Members with either a primary, secondary, or tertiary diagnosis of SUD, SMPI and/or IDD will be identified for specialized outreach. Behavioral health case managers will screen members for referral to intensive case management or other services and resources that they may need to improve outcomes and prevent disparities driven by such diagnoses.

Subsequently, EOCCO has identified opportunities for improving condition-specific outreach to members with SHCN who have limited English proficiency. While all EOCCO materials are translated to Spanish, it is important to recognize among members with SHCN there may be other diagnoses or commonly spoken languages for which condition-specific materials are not developed as they are a minority of the overall EOCCO membership. EOCCO intends to identify common languages and diagnoses among the SHCN membership to ensure that these members are notified of their access to interpreters for appointments with providers, case management and to linguistically and culturally appropriate materials through EOCCO customer service.

E. **Brief narrative description**:

EOCCO regularly reviews and analyzes special healthcare needs (SHCN) membership data to identify trends, assess utilization and share information with primary care providers whose members are flagged as SHCNs. For the purposes of this TQS project, EOCCO intends on focusing specifically on higher risk subgroups such as members with substance use disorders (SUD), severe and persistent mental illness (SPMI) or intellectual and developmental disabilities (I/DD) in order to ensure they are properly screened and referred to intensive case management or other available resources within their county. The selection of new project criteria with specialized coordination of services for behavioral health needs comes as a result of the increased need for support and outreach to the identified subpopulation of members with SHCN during the prolonged declaration of a state of emergency and pandemic.

In addition to the above, EOCCO understands that members may have and may continue to delay care in light of the pandemic. Culturally and linguistically appropriate condition-specific educational material will be developed in order to do targeted outreach to members with limited English proficiency regarding top three identified diagnosis codes. Educational materials will also reiterate access to interpreters for appointments and when contacting EOCCO customer service with questions or concerns. Material will be translated, posted to the EOCCO website, available for primary care provider offices, specialist offices and developed for mail distribution. This supports CLAS standard 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 services.

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

Activity 1 description: Analyze claims query for members on SHCN plan with SUD, SPMI and/or I/DD diagnoses. Members on a SHCN plan with at least one of the listed SUD, SPMI or I/DD diagnoses as primary, secondary, or tertiary will be identified for targeted screening for referral to intensive case management. EOCCO will continuously track this target population to ensure adequate access to care, resources, and increased coordination.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Identification and screening of qualified members for referrals to intensive case management.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No coordination or referral of members with SHCN and SUD, SPMI or IDD diagnoses to intensive case management.	Evaluate current data and establish baseline.	5/2021	Implement focused intervention by screening of identified target population and making ICM referrals as needed.	10/2021

Activity 2 description: Develop culturally and linguistically appropriate educational materials for members with SHCNs based on assessment of members with limited English proficiency. Newly developed material will be focused on the top two most common primary, secondary, or tertiary diagnoses codes among this sub-population. Materials will be distributed via EOCCO website, provider offices and mail. At a high level, EOCCO will collect and analyze data regarding utilization of interpretive services and inquiries from members with SHCN before and after the development and dissemination of targeted educational materials.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor the development of educational materials for members with special healthcare needs and limited English proficiency to increase access and equity.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No baseline data regarding primary diagnoses among SHCN members with limited English proficiency.	Evaluate current data and determine primary diagnoses among members with limited English proficiency baseline.	5/2021	Develop print educational outreach materials for members with SHCNs and limited English proficiency regarding available resources.	10/2021

A. **Project short title**: Project 12: Impacting Acute Incidents Resulting from Negative Member Outcomes through Care Coordination

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

If continued, insert unique project ID from OHA: 98

B. **Components addressed**

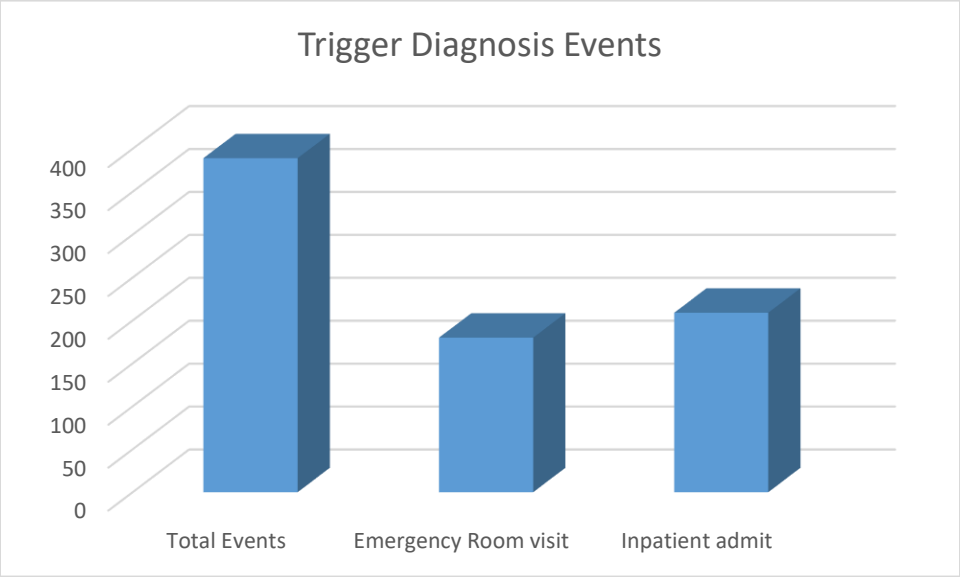
i. Component 1: Utilization review
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it 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.

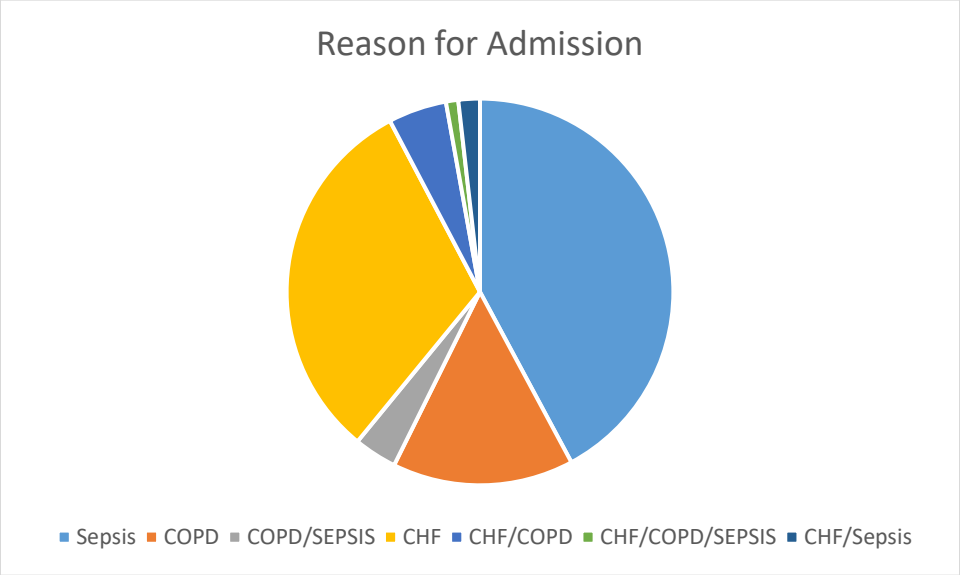
In our previous TQS we worked to identify interventions we could implement to support members and providers in accessing the most effective and economic care. We focused on reviewing members who have been hospitalized with a primary diagnosis of sepsis, chronic obstructive pulmonary disease (COPD), or heart failure. Our goal was to improve health outcomes through care coordination and case management interventions.

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

Reports for the period 8/1/20-1/31/2021 showed the following data:



Further analysis of the data shows the following:



The data showed that 218 members admitted during this time frame. Of the 218 individual member admissions 112 members (51%) had more than one event (inpatient stay and/or emergency room visit).

33% of members had 3 or more events (inpatient stay or emergency room visit) during this time frame.

EOCCO provided case management to 41 members who had a trigger diagnosis admission.

Due to the prevalence of COVID-19 we anticipate the number of admissions is lower than normal. This is related to hospital capacity that was near and over capacity. In addition, we suspect that sepsis related admissions may have been COVID-19 related.

E. **Brief narrative description**:

This project will inform care coordination activities through the review of utilization data. We have developed and generate a report to identify the target population.

We need to continue to: (a) analyze the report to set a baseline, target, and benchmark for measurement; (b) analyze the monthly data to identify care coordination interventions; (c) implement care coordination interventions to improve member outcomes; and (d) re-evaluate the data and interventions.

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

Activity 1 description: Revise current report frequency

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: We currently run a daily report for all admissions on trigger diagnosis list. We need to revise the current report to a weekly and monthly cadence as well as trend data for the frequency of multiple events.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Daily reports	Develop weekly and monthly report	5/2021	Report will be running weekly and monthly	5/2021

Activity 2 description: Analyze the report to determine baseline readmission rate for this population.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Initial data analysis

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
For the time period 8/1/2020-1/31/2021, 51% of members had more than 1 event. We will continue to establish baseline data due to the likeliness that COVID-19 impacted admissions in 2020.	Improve event rate (inpatient stays and emergency room visits for members with multiple readmissions)	9/2021	Event rate (inpatient stays and emergency room visits) are lower	12/2021

Activity 3 description: Drive development of care coordination interventions using the data and reports mentioned above.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Initial data analysis

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Collective notifications of emergency department visits and inpatient admissions are reviewed by a nurse and members are referred to case management as appropriate	Goal is to provide care coordination for members with 2 or more admissions with trigger diagnosis	5/2021	Implement care coordination interventions	9/2021

Activity 4 description: Reevaluate the quantitative result to develop new care coordination interventions to reduce readmissions and improve member outcomes.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Initial data analysis

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
We provide interventions through case management	Identify additional care coordination interventions	9/2021	Implement care coordination interventions	12/2021.

A. **Project short title**: Project 13: Improving the Accessibility of Hepatitis C Care

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

If continued, insert unique project ID from OHA: 99

B. **Components addressed**

i. Component 1: Utilization review
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Grievance and appeal system
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.

EOCCO conducted outreach to 90 members in 2019 and 60 members in 2020 who received an authorization for Hepatitis C Direct-Acting Antiviral (DAA) medications. This outreach begins prior to the member beginning treatment and concludes 12 weeks post completion of medication. EOCCO issued 6 denials for requests for Hepatitis C Direct-

Acting Antiviral (DAA) medications. 4 of these denials were due to the member not meeting criteria; 2 were overturned and approved upon reconsideration and 2 denials were due to the member having other primary coverage.

EOCCO also monitors appeals and complaints related to access to care for hepatitis C treatment. In 2020, EOCCO did not receive appeals or complaints related to access issues. We suspect that covid-19 had an impact on the number of members who obtaining screening and treatment for HCV. We need to continue to develop a list of providers who are screening and treating members for HCV.

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

For our initial project EOCCO focused on identifying the prevalence of HCV in our service area relative to the members accessing care for HCV. In addition, we attempted to measure the availability of testing and treatment through area providers and public health departments to identify gaps. Our goal was to work with community partners to increase access to HCV screening and treatment in the EOCCO service area. We also made improvements to our internal process for monitoring appeals and grievances data to redirect members seeking care and eliminate barriers to HCV services. In the 2020 calendar year EOCCO updated their grievance and appeals software to allow for better tracking of open claims. This helped standardize the workflow by providing a clear, easily recognizable status of a member complaint, appeal, or grievance, instead of requiring staff to manually track the status of a claim. The collection of this data was to help identify gaps in HCV services. For 2021 we are going to remove the activity related to identifying the prevalence of HCV in our service area and focus on the members who are actively being prescribed DAA medications. We are also going to survey providers to determine if barriers exist for screening members for Hep C or referring members for treatment.

E. **Brief narrative description**:

In the coming year we will continue to measure the availability of testing and treatment for members with HCV through area providers and public health departments to identify gaps. We will work with community partners to increase access to screening and treatment in the EOCCO service area. We will continue to monitor appeals and grievances data to redirect members seeking care and eliminate barriers to HCV services.

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

Activity 1 description: Identify barriers to screening and referring for treatment

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Survey provider community to determine barriers to screening members for HCV and referring for treatment

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
We have not identified barriers provider have to screening members for HCV and referring for treatment	The barriers identified by the providers will help guide EOCCO to better assist providers and members	8/1/2021	We identify barriers that impact providers from screening for HCV and referring members for treatment	8/1/2021

Activity 2 description: Identify providers screening for and/or treating HCV

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: A list of providers screening for and/or treating HCV is generated

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
We do not have a comprehensive list of providers to whom to refer member	We have identified providers screening for and/or treating HCV by county	9/2021	We have generated a list of providers to support care coordination	9/2021

Activity 3 description: Identify areas to target for increasing provider availability for HCV screening and treatment by comparing the provider availability to the needs of our members

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Data is organized by county to assess gaps in provider availability

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Areas to target for intervention have not been identified	Areas to target for intervention are identified	12/2021	Areas to target for intervention are identified	12/2021

Activity 4 description: Partner with communities to expand HCV screening and treatment. Set baseline once provider availability has been identified and set goals for increasing capacity throughout 2021 based on the needs identified

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Data is organized by county to assess gaps in provider availability

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Areas to target for intervention have not been identified	Areas to target for intervention are identified	12/2021	Areas to target for intervention are identified	12/2021

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: Assessment of Oral Health Integration within EOCCO

B. Project unique ID (as provided by OHA): 93

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): The EOCCO Second Opinion Analysis project will discontinue because it has achieved the intended outcome. There were zero member complaints related to lack of access to or denial of a second opinion in 2016, 2017, and 2018. Additionally, physical health second opinion requests dropped from 8 in 2017 to zero in 2018, and Advantage Dental also had zero second opinion requests in 2018. Lastly, GOBHI and ODS both had very few second opinion requests in 2018. This data leads EOCCO to believe that increased evaluation and process improvement has decreased member complaints and the need for second opinions.

A. Project short title: Project 11: Maternal and Baby Linkage to Support
B. Project unique ID (as provided by OHA): 97
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): EOCCO was required to shift priorities and timelines due to the impact of the COVID-19 pandemic on the Medicaid industry in Oregon. Resources had to be shifted to focus on communications, strategies and efforts pertaining to the prevention of COVID-19 spread and testing efforts.

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).

Quality Improvement Committee Documentation Attachments include:

- EOCCO Quality Improvement Committee Charter
- EOCCO Administration and Management of Policies and Procedures Policy
- EOCCO Clinical Practice Guidelines Policy
- EOCCO Medicaid Member Grievances and Appeals Policy
- EOCCO Transformation and Quality Strategy Policy
- EOCCO Diversity, Equity, and Inclusion Charter
- EOCCO Health Information Technology Charter
- EOCCO Incentive Measure Committee Charter
- EOCCO Member Engagement Subcommittee Charter
- EOCCO Network Management Subcommittee Charter
- EOCCO QIC Policy Subcommittee Charter
- EOCCCO Regulatory Compliance Committee Charter
- February 2020 QIC Agenda
- February 2020 Minutes
- April 2020 QIC Agenda
- April 2020 QIC Minutes
- June 2020 QIC Agenda
- June 2020 QIC Minutes
- August 2020 QIC Agenda
- August 2020 QIC Minutes
- October 2020 QIC Agenda
- October 2020 QIC Minutes

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Eastern Oregon Coordinated Care Organization Quality Improvement Committee Charter

Eastern Oregon Coordinated Care Organization (EOCCO) Quality Improvement Committee (QIC)

The EOCCO board of directors is the authority of and has the responsibility for determining the EOCCO transformation and quality program strategy (TQS). The board has delegated the EOCCO QIC with the responsibility for the operations of the EOCCO transformation and quality assurance and performance improvement program to ensure that EOCCO members receive high quality physical, behavioral and dental care and services. The committee and subcommittees are decision-making entities with the authority and representation to develop and implement integrated transformational and quality improvement activities it deems appropriate and necessary to improve the patient experience of care and health of the EOCCO populations, and to reduce the cost of healthcare.

Membership

The members of the EOCCO QIC are comprised of decision-making representatives and operational leaders. The Quality Improvement Coordinator and Chief Medical Director will be the chairpersons of the committee.

The committee will also include the co-chairs of the 5 subcommittees and the following positions:

- EOCCO Chief Compliance Officer

Subcommittees

Subcommittees are chaired by members of the EOCCO QIC or designee.

- Network Management Committee
- Policy Review Committee
- Diversity, Equity, and Inclusion Committee
- CCO Metrics Committee
- Member Engagement Committee

Each subcommittee will create and approve their own charter and submit it to the QIC Committee for final review and approval.

Meetings

The EOCCO QIC and subcommittees meet at least every other month and establish the locations of future meetings at the conclusion of each meeting. An agenda directs the meetings. Documented and dated minutes provide a record of the committee and subcommittee's activities, recommendations, and actions.

Quality improvement methodology

EOCCO uses continuous quality improvement methodologies to assess, plan and improve the quality of care and service we provide to EOCCO members. The most used is the Plan-Do-Study-Act (PDSA) methodology. This tool is the basis for P) assessing the current situation and completing root cause analysis, determining interventions, identifying the required resources and timeline, and the tracking/monitoring/reporting methods; D) implementing the intervention to the targeted population segments; S) measuring and evaluating the results of the intervention and A) decide next steps: adapt, adopt, abandon.

Responsibilities

a. Evaluation of QAPI program (TQS requirements outlined in Contract).
    i. Creation and monitoring of corrective action plans when deficiencies identified.
b. Evaluation of Member care (per EOCCO policies on member care - examples below);
    i. Clinical practice guidelines;
    ii. Medical Management Program & clinical decisions;
    iii. Member handbook; iv. Member services & outreach communication;
    v. Language access & effective communication;
    vi. Member R & R;
    vii. Advance directives and DMHT;
    viii. Non-discrimination;
    ix. Member access to care; plus others.
c. Evaluation components for (a-b) –
    i. Annual activities conducted to assess CQI;
    ii. Rationale for activities selected;
    iii. Ongoing improvement activities to address gaps;
d. Conduct quarterly review and analysis of all complaints and appeals;
e. Review of written P & P, Protocol and Criteria for member care every two years or PRN.

The EOCCO QIC addresses quality of clinical care, services, and health and safety needs of EOCCO members as well as the coordination and collaboration of activities to provide high quality physical, behavioral and dental care and service to our members, including members with complex healthcare and/or cultural and linguistic needs and or severe and persistent mental illness.

Designated EOCCO representatives and/or subcommittees are responsible to complete and report TQS and other OHA-contractual assignments and outcomes to the EOCCO QIC. These include the development and implementation of integrated policies and procedures and performance improvement projects, progress toward incentive measures improvement targets and preparedness for OHA-mandated external quality reviews.

Ongoing responsibilities include the prioritization of initiatives, monitoring, assessment and analysis of the quality and effectiveness of initiatives for reducing barriers to receiving care, access to services, integration of care, culturally and linguistically appropriate services, provider network adequacy, diversity, equity and inclusion, Patient-Centered Primary Care Home, utilization review, the care management system (including severe and persistent mental illness and special healthcare needs), grievances and appeals system, health information technology, use of data and reporting, health complexity, social determinants of health and value-based payment models.

Reporting to the Board of Directors

EOCCO QIC is responsible to advise the EOCCO board of directors about transformational and quality improvement opportunities to assure the quality of services and operations in the EOCCO service area. The President, EOCCO, as the executive sponsor of the EOCCO QIC, reports TQS activities to the EOCCO board of directors at least once each year.

EOCOO Administration and Management of Policies and Procedures Policy

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		EOCCO Quality Improvement Committee	
Subject:	EOCCO Administration and Management of Policies and Procedures Policy				
P & P Original Effective Date:	7/21/2020	**P & P Origination Date:**	7/10/2020	**P & P Published Date:**	7/21/2020
P & P Revision Effective Date:	7/21/2020	**P & P Revision Published Date:**		7/21/2020	
Reference Number:	CCO-GOV-5-07212020	**Next Annual Review Date:**		7/2021	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

Policy Statement and Purpose

This policy and procedure addresses the oversight, administrative process, and management of all EOCCO policies and procedures. The purpose of this policy and procedure is to ensure that EOCCO policies and procedures provide guidance, direction, and expectations for the operational functions of the organization. EOCCO policies and procedures help ensure compliance with applicable laws, regulations, and contractual requirements. EOCCO policies and procedures also provide accountability and document how EOCCO conducts business.

Definitions

A. **EOCCO**: Eastern Oregon Coordinated Care Organization

B. **OAR:** Oregon Administrative Rule

C. **OHA:** Oregon Health Authority

D. **Original Effective Date**: The start date of when a policy and procedure takes effect.

E. **Origination Date**: The date a policy and procedure is created.

F. **Policy Statement**: A brief description that explains the purpose and core provisions of the policy and procedure.

G. **Procedure**: Established methods and requirements for the implementation of a policy and procedure.

H. **Published Date**: The date a policy and procedure is accessible to all affected and interested parties

I. **Quality Improvement Committee (QIC):** An EOCCO committee delegated by the EOCCO board of directors for determining the EOCCO transformation and quality program strategy (TQS). The EOCCO QIC is responsible for the operations of the EOCCO transformation and quality assurance and performance improvement program to ensure that EOCCO members receive high-quality care and services for physical, behavioral, and dental health. The committee and subcommittees are decision-making entities with the authority and representation to develop and implement integrated transformational and quality improvement activities it deems appropriate and necessary to improve the patient experience of care and health of the EOCCO populations and to reduce the cost of healthcare.

J. **QIC Policy Subcommittee:** An subcommittee of the EOCCO QIC that is responsible for the oversight, administrative process, and management of all EOCCO policies and procedures.

K. **Revision Effective Date**: The date a policy and procedure is changed.

Procedure

A. Oversight of Policies and Procedures
   1. The QIC Policy Subcommittee is responsible for directing the oversight, administrative process, and management of all EOCCO policies and procedures. This includes: a. Approving or denying all new policies and revisions to policies
      b. Assigning ownership of policies and procedures to a designated subject matter expert
      c. Overseeing the review process of policies and procedures
      d. Guiding policy and procedure staff access
      e. Ensuring policies and procedures align with the guiding principles and mission of EOCCO
      f. Archiving policies and procedures that are no longer relevant or needed.
      g. Maintaining a current list of all EOCCO policies and procedures
   2. Structure of the QIC Policy Subcommittee
      a. The QIC Policy Subcommittee is comprised of decision-making representatives and operational leaders from physical, behavioral, and dental health including: i. EOCCO Compliance Officer ii. Physical Health Medicaid Services Manager iii. Manager, Dental Medicaid Services iv. Physical Health Quality & Compliance Project Manager v. Physical Health Medicaid Services Supervisor vi. Dental Health Director of Medicaid Services vii. Behavioral Health Policy Analyst

b. The QIC Policy Subcommittee is lead by a chair or co-chair(s), who:
   i. Plan and facilitate meetings ii. Determine meeting content and agenda iii. Provide oversight of meeting minutes

3. QIC Policy Subcommittee Meetings
   a. The QIC Policy Subcommittee meets every quarter with additional meetings scheduled on an as needed basis. The QIC Policy Subcommittee meets as needed to update policies as required through the OHA contract, Administrative Rulebooks, or OAR's.
   b. Meetings are attended by QIC Policy Subcommittee members, appointed by the QIC Policy Subcommittee chair or co-chair(s) and subject matter experts as needed.
   c. The Quality Improvement Committee delegates policy approval authority to the EOCCO QIC Policy Subcommittee.
      1. Policies and procedures reviewed are subject to a majority vote for approval.
      2. If the QIC Policy Subcommittee is unable to obtain a majority vote, the policy approval will proceed to the QIC for a final vote.

B. Administrative Process
   1. New Policies
      a. EOCCO staff identify a policy and procedure that needs to be created through Medicaid requirements or a gap identified in addressing current Medicaid requirements. These events drive the development of the policy and procedure proposal.
      b. The policy submitter will use policy software or the EOCCO Policy and Procedure Template Form to develop a policy and procedure proposal.
      c. The policy submitter will complete the EOCCO Policy Request Form with information including:
         i. The rationale and need for creating a new policy and procedure
         ii. Relevant EOCCO policies and procedures, OARs, OHA contract requirements, federal guidelines, references, and forms.
         iii. Verification of consultation with other affected departments iv. Time sensitivity
      d. The policy submittor submits the policy and procedure proposal and EOCCO Policy Request Form to the EOCCO QIC Policy Subcommittee for a decision.
      e. Proposed policies are reviewed at the next scheduled QIC Policy Subcommittee meeting, or earlier if identified by the submitter.
         i. Upon approval, policy and procedure ownership is identified by the EOCCO QIC Policy Subcommittee
      f. Denied policy and procedure proposals are returned to the policy submitter with the reason for denial.
   2. Policy and Procedures Revisions
      a. Non-substantive changes, including updates to contact names, links, or grammatical and formatting errors, do not require the committee approval process and may be submitted directly to a QIC Policy Subcommittee chair for correction.
      b. For policy and procedure revisions that require substantive change, the policy owner(s) submit a policy request form to the QIC Policy Subcommittee with the proposed policy and procedure revisions.
         i. Policy revisions are reviewed at the next scheduled QIC Policy Subcommittee meeting, or earlier if identified by the submitter.

ii. The QIC Policy Subcommittee reviews proposed policy and procedure revisions and the policy request form, then decides whether to approve or deny the request.
iii. Approved policy and procedure revisions are returned to the policy owner(s), published, and shared with affected and interested parties.
iv. Denied policy and procedure revisions are returned to the policy owner(s) with the reason for denial, which may include recommendations for re-submission.

3. Archiving Policies and Procedures
   a. The QIC Policy Subcommittee may archive and withdraw an EOCCO policy and procedure from use when a policy and procedure is no longer relevant, outdated, or is superseded by a new policy.

C. Management of Policy and Procedures

1. Access to policies and procedures

   a. EOCCO policies and procedures will be centrally located and accessible to affected and interested parties.
   b. EOCCO will implement the use of policy software to store and manage all EOCCO policies and procedures.
   c. Access level to EOCCO policies and procedures will be determined by the QIC Policy Subcommittee and policy owner(s).

2. Staff review of policies and procedures
   a. All EOCCO policy and procedures are reviewed and updated by the identified policy owner(s) and QIC Policy Subcommittee on an annual basis and as needed to ensure that policies and procedures stay relevant, accurate, and current.
   b. Affected staff will review assigned policies and procedures at least annually and as determined necessary by the policy owner(s) and the QIC Policy Subcommittee.
   c. Policies and procedures may be reviewed by affected staff via print copies, emailed copies, network posting, and through the use of policy software.
   d. Staff review of policy and procedures will be documented through the use of policy software.

3. Policy and Procedure Format
   a. EOCCO will use the same template for all policies and procedures.
   b. The organizational structure of policies and procedures will include the following sections: i. Policy Statement and Purpose

ii. Definitions iii. Procedures iv. Related Policies & Procedures, Forms and References v. Revision Activity vi. Affected Departments

4. Policy and Procedure Organization
   a. Policy and procedures will be organized by a categorization and numbering system developed and maintained by the QIC Policy Subcommittee.

Related Policies & Procedures, Forms and References

EOCCO Policy Categories/Numbering Document

EOCCO Policy and Procedure Template Form

EOCCO Policy Request Form

Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
7/10/2020	EOCCO Quality Improvement Committee	7/21/2020	7/21/2020

VI. Affected Departments:

EOCCO Clinical Practice Guidelines Policy

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		EOCCO Quality Improvement Committee	
Subject:	EOCCO Clinical Practice Guidelines Policy				
P & P Original Effective Date:	9/2012	**P & P Origination Date:**	9/2012	**P & P Published Date:**	9/2012
P & P Revision Effective Date:	04/28/17, 04/27/18, 10/01/2019,1/21/2021	**P & P Revision Published Date:**		04/28/17, 04/27/18, 10/01/2019, 1/21/2021	
Reference Number:	CCO-OPER-2-01212021	**Next Annual Review Date:**		01/2022	
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☐ Pharmacy ☒ Behavioral Health					

Policy Statement and Purpose

Eastern Oregon Coordinated Care Organization (EOCCO) staff use clinical support tools based on evidence-based guidelines and written policies. Criteria are applied based on the individual circumstances and conditions of EOCCO members. EOCCO staff complete an assessment of the local delivery systems to support clinical interventions and access to current healthcare resources for assistance in providing services to EOCCO members.

Definitions

A. **EOCCO**: A coordinated care organization that provides services to enrollees in the Oregon Health Plan (OHP) in accordance with the laws, rules, regulations and contractual requirements that apply to the Oregon Health Plan.

Procedures

EOCCO makes available tools and resource information to enable EOCCO staff to provide appropriate clinical review services. Resources used include, but are not limited to the following:

A. Behavioral Health
   1. American Society of Addiction Medicine Patient Placement Criteria, 2nd edition, Revised
   2. Oregon Administrative Rules
   3. Prioritized List of Health Services
   4. Milliman Care Guidelines Health Behavioral Health Care Guidelines

B. Oral Health
   1. American Dental Association (ADA) Practice Parameters
   2. California Dental Association Quality Evaluation for Dental Care
   3. Various dental specialty protocols, i.e., pediatric, oral surgery, periodontal, endodontic)
   4. ADA Center for Evidence-Based Dentistry
   5. Oregon Administrative Rules
   6. OHP Prioritized List
   7. Pediatric Dentistry Reference Manual

   8. FDA Guidelines for Prescribing Dental Radiographs
   9. DCO-specific internal policies and procedures

C. Physical Health
   1. Oregon Administrative Rules
   2. Prioritized List of Health Services
   3. EOCCO Medical Necessity Criteria
   4. Milliman Care Guidelines
   5. DMEPOS (CMS) Local Coverage Determinations

D. Guideline development and approval
   EOCCO's quality improvement committees develop, review and approve guidelines in consultation with appropriate healthcare professionals.

E. Review and revision
   Guidelines are reviewed at least biennially to ensure that the most recent version is incorporated into practice.

F. Dissemination process
   EOCCO posts its clinical guidelines information at www.eocco.com/providers/manuals-guidelines for provider and member education and access. Clinical guideline information is also published in the EOCCO provider manual. The Member Handbook includes information about how members can access the clinical guidelines.

Related Policies & Procedures, Forms and References

42 CFR 438.236

OAR 410-141-3525 (7) and (11) (d)

Coordinated Care Organization contract, Exhibit B Part 4 (11)

Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
Annual review	EOCCO Quality Improvement Committee	03/13/15	03/13/15
Annual review	EOCCO Quality Improvement Committee	04/08/16	04/08/16
Annual review concluded week of 4/24 via email communications; updated behavioral health guidelines; changed order of physical health guidelines; updated dissemination process	EOCCO Quality Improvement Committee	04/28/17	04/28/17
Annual review; changed terms (MAP to OHP prioritized list); added DMEPOS (CMS) Local Coverage Determinations to physical health procedure	EOCCO Quality Improvement Committee	04/27/18 via email vote	04/27/18

Annual Review: clarification of language	EOCCO Quality Improvement Committee	7/29/19	7/29/19
Annual Review	EOCCO Quality Improvement Committee	1/21/2021	1/21/2021

VI. Affected Departments:

EOCCO Medicaid Member Grievance and Appeals Policy

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		Quality Programs	
Subject:	EOCCO Medicaid Member Grievances and Appeals Policy				
P & P Original Effective Date:	2012	**P & P Origination Date:**	**2012**	**P & P Published Date:**	**2012**
P & P Revision Effective Date:	5/12, 8/13, 11/13, 05/14; 12/15; 12/16; 12/18; 7/20, 1/21	**P & P Revision Published Date:**		5/12, 8/13, 11/13, 05/14; 12/15; 12/16; 12/18; 7/20, 1/21/	
Reference Number:	CCO-GA-1-07072020	**Next Annual Review Date:**		01/2022	
Product (check all boxes applicable to this policy) ☒ Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health ☒ NEMT					

I. Policy Statement and Purpose

Eastern Oregon Coordinated Care Organization (EOCCO) provides an internal procedure for members or their representatives to voice or submit and obtain timely resolution of their grievances and appeals. EOCCO processes physical health, behavioral health, oral health and non-emergent transportation grievances and appeals. EOCCO is the final adjudicator of all appeals. EOCCO does not discourage grievances and appeals, encourage withdrawal, or retaliate or take punitive actions against any member or provider that uses any aspect of the grievance system, including the expedited appeal process. EOCCO does not preclude Members from making complaints or grievances that have been made previously, or from filing or submitting, the same complaint or grievance to both the subcontractor and CCO. This policy applies to EOCCO, EOCCO's subcontractors and participating providers. All member communications are written in a format and language that may be easily understood by the member.

II. Definitions

A. **Adverse benefit determination:** A denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole, or in part, of a payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure to act within the timeframes regarding the standard resolution of grievances and appeals (42 CFR §438.408(b)(1) and (2)); the denial of a request by a member residing in a rural area to exercise his or her right to obtain services outside the network (42 CFR §438.52(b)(2)(ii)); or the denial of a request by a member to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

B. **Contested Case Hearing:** A hearing requested by a Medicaid member or representative (including provider) with the member's written consent regarding an appeal decision by EOCCO that has denied benefits for requested services, payment of a claim or terminated, discontinued or reduced a course of treatment or any other adverse benefit determination. The hearing request must be filed with EOCCO or the Oregon Health Authority (OHA) hearings unit no later than 120 days following the date of the EOCCO written appeal decision. A member may initiate a contested case hearing if EOCCO fails to adhere to notice and timing requirements. The member and representative, EOCCO, and the legal representative of a deceased member's estate are all parties to the contested case hearing. Contested case hearings (expedited or standard) are filed using Hearing request form (MSC 443) or the Denial of Medical Services Appeal and Hearing Request form (OHP 3302).

C. **Appeal:** A request by a Medicaid member or the member's representative for review of an EOCCO adverse benefit determination. An appeal must be filed no later than 60 days following the date of the EOCCO notice of adverse benefit determination.

D. **Grievance:** An expression of dissatisfaction to the state, EOCCO or a provider from a member and/or about any matter not involving an adverse benefit determination, appeal, or contested case hearing. A grievance can be filed at any time with EOCCO or OHA. Grievances may involve but are not limited to: denial in service in full or in part, driver or vehicle safety, the quality of care and services provided, appropriateness of services access to services, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension of time proposed by EOCCO to make an authorization decision. Grievances are sometimes referred to as complaints.

E. **Expedited Appeal**: An expedited review is when EOCCO determines upon request from the member that taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. An expedited appeal request is automatically accepted when the provider makes the request on behalf of the member or supports the member's request.

F. **Notice of Adverse Benefit Determination:** A written notice to the member of a denial or limitation by EOCCO of a requested covered service; a reduction, discontinuation or termination of previously authorized services; or a denial of claims payment or other adverse benefit or claims determination, in whole or in part in which the member is liable. The notice of adverse benefit determination includes the member's right to file an appeal and information on how to file an appeal.

G. **Oregon Health Authority (OHA) Health Systems Division:** The Oregon Health Authority Health Systems Division administers the Oregon Health Plan, the state's Medicaid and Children's Health Insurance Program, and contracts with coordinated care organizations (CCOs), mental health programs and others to support community-based health services. OHA enrolls Medicaid providers and offers services and support to Medicaid members.

H. **Representative:** A representative is an individual who can make Medicaid-related decisions for a member who is not able to make such decisions themselves. In this policy a representative also includes the member's provider. A provider, with the member's consent, has the authority to file an appeal, grievance, or contested case hearing with EOCCO. EOCCO considers the member, the member's representative, or the legal representative of a deceased member's estate as parties to an appeal.

III. Procedure

A. Timely Filing of Grievances and Appeals

Members must file an appeal no later than 60 calendar days from the date on the notice of adverse benefit determination. EOCCO will not consider appeals received beyond the time limit. There is no timeline for filing a grievance.

B. Receiving Grievances/Appeals

1. Grievances/appeals can be received in the following methods:
   a. Written/US Postal Service: Grievances/appeals received through the US Postal Service are processed daily and routed, upon receipt, to the appeal unit.
   b. In person at all EOCCO offices. All offices have the following forms available: OHP Complaint Form (OHP 3001), Hearing request form (MSC 443), and Notice of Hearing Rights (OHP 3030); or the Denial of Medical Services Appeal and Hearing Request form (OHP 3302).
   c. Facsimiles: Delivered to the appeal unit as received.
   d. Email: Grievances/appeals received at OHA and/or a CCO are forwarded to EOCCO for handling via secure email. Grievances/appeals received in any business area are forwarded, upon receipt, to the appeal unit.
   e. Telephone:
      i. When a member calls with an expression of dissatisfaction, the EOCCO representative, attempts to resolve the issue at the initial contact.
      ii. Whether or not the EOCCO representative is able to resolve the member's grievance at the initial contact, the EOCCO representative documents the member's grievance/appeal and sends to the appeal unit for handling.
2. The EOCCO representative gives the member the option to write the grievance/appeal or file the grievance/appeal orally. If the member chooses to write the grievance/appeal and they did not receive a form, the EOCCO representative mails the member the EOCCO complaint form if requested. EOCCO also accepts grievances/appeals written on the OHP Complaint Form 3001.
3. The EOCCO representative gives the member reasonable assistance in completing the forms and taking other procedural steps related to filing the grievance/appeal. This includes providing interpreter services and toll-free numbers with TTY for the hearing impaired at no charge to the member. EOCCO will reimburse for Community Health Workers (CHW) services to provide non-clinical support and help patients navigate the healthcare system. Please refer to the EOCCO Language Access and Effective Communication Policy.
4. If the member is filing an oral appeal (not an expedited appeal):
   a. The member is informed that the information will be taken over the phone, but the member is required by OHA to follow the oral filing with a written, signed appeal and that the written appeal must be received within 60 days of the initial Notice of Adverse Benefit Determination. Expedited appeals are accepted orally. The oral inquiry seeking to appeal an adverse benefit determination is used as the received date of the appeal (to establish the earliest possible filing date for the appeal).
   b. The EOCCO representative records the grievance/appeal in the member's own words on the EOCCO grievance form, and communicates the following to the member:
      i. Repeats back to the member the grievance/appeal as recorded to confirm accuracy.
      ii. The grievance/appeal is investigated through the EOCCO appeal process.
      iii. Reinforces the need to follow the oral filing of an appeal with a written and signed appeal within 60 days of the initial Notice of Adverse Benefit Determination.
5. The EOCCO representative documents the grievance/appeal information and sends the grievance or appeal form to the appropriate appeal unit upon completion of the call.

6. If the appeal or grievance is filed by any representative besides the member, written consent is needed to respond to the representative. Written consent will be stored with the file. See sections L and M.
7. Sufficiently in advance of the resolution timeframe, the EOCCO representative informs the member of the limited time to submit evidence and testimony, in person and in writing, to support their case and make legal and factual arguments in the case of an expedited appeal resolution.
8. If the member requests an appeal or hearing with OHA prior to the completion of the appeal, OHA transfers the request to EOCCO for processing. EOCCO reviews the request immediately and processes it according to the appeal process outlined in this document.

C. Logging Grievances/Appeals

1. The representative of the appropriate appeal unit enters the appeal in the appropriate database. If the grievance/appeal is not yet resolved, the resolution date, resolution time and resolution will be added when the information becomes available. The grievance/appeal Access database identifies:
   a. Access ID#
   b. Recorder
   c. Group Number
   d. Grievance service type
   e. Review Level
   f. MD/DD reviewer
   g. File preparation
   h. Date filed
   i. Time filed
   j. Decision date
   k. Date acknowledgement letter sent
   l. Oral resolve date
   m. Oral resolve time
   n. Oral time lapse
   o. Date resolved/NOAR
   p. Time resolved/NOAR
   q. Time lapse
   r. Date claim or pre-service requested
   s. Notice of adverse benefit determination date
   t. Member's last name
   u. Member's first name
   v. Member's ID#
   w. Cover All Kids
   x. Special needs
   y. Mental health
   z. Member's county aa. Written or oral
   aa. Dental
   bb. Provider first & last name
   cc. Clinic name
   dd. Practitioner number
   ee. Nature of complaint/appeal narrative
   ff. Resolution Narrative
   gg. Letter translated (language)
   hh. Complaint category
   ii. Appeal category
   jj. Appeal sub category

kk. Appeal service type
ll. Expedited requested?
mm. Denied service upheld
nn. Overturned at appeal
oo. Partial denial
pp. Member withdrew appeal
qq. Date Member withdrew appeal
rr. Dismissed late filing
ss. Invalid waiver
tt. Continued benefits requested
uu. Continued benefits provided
vv. Hearing filed?
ww. Hearing received date
xx. Date of hearing
yy. Continued benefits requested (hearing)
zz. Continued benefits provided (hearing)
aaa. No show
bbb. Not hearable
ccc. Member withdrew hearing
ddd. Plan overturned prior to hearing date
eee. ALJ affirmed decision
fff. ALJ overturned decision

2. Appeals are categorized into the following areas:
   a. Denial or limited authorization of a requested service
   b. Single PHP service area, denial to obtain services outside the PHP panel
   c. Reduction, suspension, or termination of previously authorized services
   d. Failure to act within the timeframes provided in § 438.408(b)
   e. Failure to provide services in a timely manner, as defined by the State
   f. Denial in whole or in part, of payment of services
   g. Denial of a member's request to dispute a financial liability
3. Appeal subcategories include:
   a. Treatment is not a covered service
   b. Requires PA and was not preauthorized (include non-panel provider requirement for PA)
   c. The service is not medically/dentally appropriate
   d. The service or item was received in an emergency care setting and does not qualify as an emergency service.
   e. The provider is not on EOCCO's panel and prior approval was not obtained (if such prior authorization would be required under Medicaid rule).
4. Grievances are categorized into the following areas:
   a. Access
   b. Interaction with provider, plan or staff
   c. Consumer rights
   d. Quality of care
   e. Quality of service
   f. Client billing issues
   g. Denial of services in full or in part
   h. Driver or vehicle safety

i. Quality of services
j. Appropriateness of services
k. Access to services

D. Notification of Receipt of Grievance/Appeal
1. If a decision on a grievance is not reached within five business days of receipt, the appropriate appeal unit sends the member an acknowledgment letter within five business days of receipt of the grievance. The letter communicates the following:
   a. The grievance has been received and is being investigated.
   b. A delay is necessary to resolve the grievance and that the member will receive a written decision within 30 calendar days from the date of receipt of the grievance. The letter specifies the reason(s) for the delay.
   c. The complainant is asked to complete the enclosed form(s), if it is needed to investigate the grievance.
2. For appeals, the appropriate appeal unit sends the member an acknowledgement letter within five business days of receipt.
   a. The letter informs the complainant that the appeal will be resolved within 16 calendar days of receipt. The receipt date for oral filings of appeals is the date the oral appeal is received.
   b. The member is informed that the timeframe for resolution may be extended up to 14 days if the member requests the extension or if EOCCO cannot resolve the written appeal within 16 calendar days of receipt, and satisfactorily shows (if requested by OHA) the need for additional information and how the delay is in the member's interest. The appropriate appeal unit sends the member another letter explaining the delay and that EOCCO reaches a decision and informs the member in writing within 30 days of receipt of the written appeal.
   c. The member or the member's representative is provided the opportunity to present evidence and allegations of fact or law related to the issues in dispute in person or in writing, if he or she chooses.
   d. The member is provided the opportunity to examine the member's file, including medical records and any other documents or records to be considered during the appeals process.

E. Request for Standard Appeal
1. EOCCO will resolve each appeal as expeditiously as the member's health condition requires.
2. EOCCO will resolve standard appeal within 16 days of receiving the member's written appeal.
3. If EOCCO needs to extend the timeline for the appeal, not at the request of the member, the following will take place:
   a. EOCCO will make reasonable efforts to give the member prompt oral notice of the delay.
   b. Within 2 days of oral notice, EOCCO sends a written notice with the reason for the decision to extend the timeframe and informs the member of the right to file a grievance.
   c. Resolve the appeal no later than the date of the expiration of the extension.

F. Request for Expedited Appeal
1. In the case of clinical urgency, the member may request an expedited appeal. EOCCO resolves expedited appeals and provides notice as expeditiously as the member's health condition requires, not to exceed 72 hours after EOCCO receives the expedited appeal request or applicable extension.
2. The member is given reasonable opportunity to present evidence and allegations of fact or law in person or in writing. The member is informed of the limited time available for this case.

3. For member requests, the medical or dental director will review the request and determine whether it qualifies as an expedited appeal. If the provider requests the expedited appeal, the request to expedite is automatically accepted.
4. If EOCCO denies the request for an expedited appeal:
   a. The appeal is transferred to the standard timeframe of no longer than 16 days from the day EOCCO receives the appeal with possible 14-day extension.
   b. Makes a reasonable effort to give the member verbal notice of the denial and follows up with a written confirmation within two days.
   c. Informs the member of the right to file a grievance if the member disagrees with the decision.
5. If EOCCO grants an expedited appeal, the appropriate appeal unit:
   a. Coordinates the resolution of the appeal and makes reasonable effort to provide the member oral notice no later than 72 hours after EOCCO receives the expedited appeal.
   b. If the decision is not wholly in favor of the member, the written notice adheres to the notification requirements set forth in section I(9) of this policy and procedure.
   c. Resolution of the expedited appeal may be extended up to 14 days if the member requests the extension or if EOCCO cannot resolve the appeal within 72 hours of receipt, and satisfactorily shows the need for additional information and how the delay is in the member's interest. EOCCO makes reasonable effort to give the member verbal notice of the delay and the reason for the delay and follows

      up with a letter explaining the delay within 2 days and that EOCCO will reach a decision and inform the member in writing within 72 hours plus 14 days of receipt of the expedited appeal. The letter will also inform the member of their right to file a grievance about this decision. If the decision is not wholly in favor of the member, the written notice adheres to the notification requirements set forth in section III(I)(9) of this policy and procedure.
6. EOCCO makes reasonable efforts to call the member and provider to tell them of the resolution within 72 hours of receiving the request and mails written confirmation of the resolution to the member within three days.

G. Investigation
   1. EOCCO coordinates the review and requests all records and documentation regarding the grievance/appeal, including, but not limited to, practitioner office records, ambulatory records, inpatient medical records, and any relevant information regardless of whether the information was submitted during the initial adverse benefit determination. All information is used to make the final determination. Each action taken on the case file is documented in the case notes and stored with the final file.
   2. If written consent is required, but not returned, EOCCO follows up with the member or the member's representative.
   3. For oral appeals, the written appeal must be received within 60 days of the notice of adverse benefit determination. EOCCO makes and documents reasonable effort to secure the written appeal from the member. If no written appeal is received within 16 days of the oral appeal, the appeal is closed. If the written appeal is later received (within 60 days of the notice of adverse benefit determination) the appeal is reopened and completed within the required timeframe.
   4. The appropriate appeal unit gathers additional information, as needed, from the complainant as well as from the Medicaid plan wording, claims, user's procedure manual (UPM), medical necessity criteria, utilization management notes from the operating system, and Oregon Administrative Rules.
   5. If the appropriate appeal unit has a question regarding the appropriate Oregon Administrative Rules to cite in the appeal resolution letter, the Appeal Coordinator (AC) will consult with the appropriate leadership for the business area.

6. The person(s) making the decision on a grievance/appeal may not have been involved in any previous level of review or decision making, must not be a subordinate of any individual involved with making the determination of the prior review and must not be receiving incentivized compensation to deny, limit, or discontinue services. Please refer to the EOCCO Conflict of Interest policy. If the appeal of a denial is based on lack of medical appropriateness or if an appeal involves clinical issues, healthcare professionals with the appropriate level of training and expertise to evaluate the services or issues in dispute make the decision on the appeal. For example, if the initial decision was made by a registered nurse, the case is directed to the medical director. The reviewer takes into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination to make their determination.
7. Clinical review is required for all medical necessity appeals, grievances regarding the denial of expedited resolution of an appeal and grievances that involve clinical issues such as quality of care concerns.
8. When necessary, the medical consultant reviews the grievance/appeal and any additional information against established criteria and makes a decision about each element of the grievance/appeal. The medical consultant determines the following:
    a. Whether appropriate clinical protocols and guidelines were followed.
    b. For quality of care concerns, whether there was no effect on the complainant's health status; there was an adverse effect upon the complainant's health status, but this was remedied; or the complainant's health status was seriously affected.
9. If at the member's request EOCCO continues or reinstates the member's benefits while the appeal is pending the benefits must be continued until one of the following occurs: a. The member withdraws the appeal; or
    b. The member does not request a contested case hearing within 10 days from when EOCCO mails an adverse decision; or
    c. A contested case hearing decision adverse to the member is made; or
    d. Until OHA issues an appeal decision adverse to the member or
    e. The authorization expires or authorization service limits are met.

H. Effectuation

If EOCCO or OHA overturn the original decision to deny, terminate, or suspend a service, and if the service(s) have not been furnished, EOCCO will authorize the service:

1. As expeditiously as the member's health condition requires but no later than the applicable turnaround time for the standard or expedited request; or
2. As expeditiously as the member's health condition requires but no later than 72 hours from the date the notice is received from OHA if a contested case hearing request is filed with OHA and EOCCO's decision is overturned.

I. Notification Requirements

All appeals and written grievances are resolved with a written resolution letter to the member or the member's representative. The resolution is written in language that is sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution. All written communication is sent in the member's preferred language. The AC works to accommodate the communication to account for a member with a disability or with limited English proficiency. Written notification requirements that are included with the written resolution to

complainants are as follows: 1. Appeals and grievances are responded to as expeditiously as the member's health condition requires.

2. EOCCO translates required written material into the prevalent non-English languages identified in its CCO enrollment or upon request. See the EOCCO Language Access and Effective Communication policy for details.
3. EOCCO resolves a grievance within 30 days of receipt if a decision was not possible within five business days of receipt.
4. EOCCO resolves an appeal within 16 days of receipt. If a delay is necessary due to the need for additional information, EOCCO sends the member a letter explaining the reason for the delay, that a decision will be reached within 30 days of receipt of the appeal, and the member's right to file a grievance about this decision.
5. The decision on each element of the member's grievance/appeal and the reasons for EOCCO' decision(s). The letter includes the results of the resolution process and the date it was completed.
6. In decisions made by EOCCO staff, an explanation of who made the appeal decision (i.e., nurse, medical director).
7. Grievance responses include the right to file a grievance with the Department of Human Services ombudsman's office by writing to 500 Summer Street NE, Salem, OR 97310 or by calling 503-947-2346 or toll free at 877-642-0450. They may also contact the OHP Client Services Unit (CSU) toll free at 800-2730557.
8. EOCCO will cooperate with the investigation and resolution of the grievance by the EOCCO representative or the OHA Ombudsman, including providing all requested records.
9. For appeal decisions not wholly in favor of the member:
    a. The particular Oregon state statutes and rules relied upon to reach the decision(s) to deny the appeal;
    b. The right to request a contested case hearing with OHA (expedited hearing if the appeal decision is expedited) and how to do so. EOCCO encloses forms OHP 3030 (Notice of Hearing Rights) and OHP 3302
    (Denial of Medical Services Appeal and Hearing Request) with the written resolution;
    c. The right to request to receive benefits while the hearing is pending and how to make the request;
    d. That the member may be held liable for the cost of those benefits if the hearing decision upholds EOCCO's decision.
    e. The member's right to continuation of benefits pending the appeal. EOCCO continues the member's benefits when requested if the member or member's representative files the appeal timely, within 10 calendar days after EOCCO mails the notice of adverse benefit determination or the intended effective date of EOCCO' proposed adverse benefit determination. In addition, the request must:
    i. Involve the termination, suspension, or reduction of a previously authorized course of treatment; ii. Involve services that were ordered by an authorized provider; iii. Pertain to the original period covered by the original authorization that has not expired.

    f. If at the member's request EOCCO continues or reinstates the member's benefits while the appeal is pending the benefits must be continued until one of the following occurs: i. The member withdraws the appeal; ii. EOCCO issues an appeal resolution; or iii. The authorization expires or authorization service limits are met.
    g. The member's right to the continuation of benefits pending an administrative hearing:
        i. If the member or their representative requests that EOCCO continue or reinstates their benefits while the appeal is pending and

ii. The notice of appeal resolution is adverse to the member, the benefits continue pending the administrative hearing.

h. If EOCCO overturns a decision to deny, limit or delay a benefit:

i. EOCCO corrects the adverse benefit determination taken up to the limit of the original request or authorization, retroactive to the date the adverse benefit determination was taken, even if the member has lost eligibility or the benefit package has changed after the date the adverse benefit determination was taken.

ii. If the service has not been furnished, EOCCO will authorize the services as expeditiously as the member's health condition requires but no later than 72 hours from the date of the decision.

i. If the member received the disputed services while the appeal was pending, EOCCO pays for the services per the plan provisions.

J. Monitoring/Reporting and Evaluation

1. Monitoring

The appropriate appeal unit leadership monitors the following:

a. Decisions about all elements of each grievance/appeal as necessary.
b. Timeliness of letters acknowledging receipt of grievances/appeals.
c. Timeliness of resolution within the mandated timeframes.
d. Timeliness of 14-day extension letter, when applicable.

2. Reporting and Evaluation

The following grievances are forwarded to the credentialing coordinator for placement in practitioner's credentialing files:

a. Quality of care
b. Professional relations/communications
c. Physical access
d. Physical appearance
e. Adequacy of waiting- and examining-room
f. Safety

3. EOCCO presents quarterly and annually grievance/appeal reports to EOCCO Quality Improvement Committee (QIC) Regulatory Compliance Committee on the following: a. Number of grievances/appeals obtained from Access database

b. Completeness and accuracy
c. Persistent or significant grievances/appeals
d. Timeliness of receipt, disposition, and resolution
e. Trends

4. The EOCCO QIC reviews the reports and analyzes issues raised by members in grievances and appeals and their resolution and makes recommendations for improvements, as necessary.
5. Annually, the EOCCO QIC reviews the grievance/appeal process and recommends process improvement, as appropriate.
6. At least annually, the grievance and appeal reports are presented to the EOCCO Governance Board.
7. Quarterly, EOCCO reports grievances and appeals to OHA using the OHA-prescribed reporting form.

a. This includes grievances that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.

K. Integration of dental care organizations (DCOs) with coordinated care organizations (CCOs), EOCCO integrates with two DCOs: Advantage Dental Services and ODS Community Health. The handling of appeals and grievances follows our standard processing guidelines as listed above. This section outlines the steps taken to coordinate the review with the appropriate DCO.

1. Dental grievances related to Advantage Dental Services members are reviewed and processed by Advantage Dental Services. The EOCCO appeal team will notify Advantage Dental Services of a new grievance within 24 hours of it being received. The grievances are sent to one of the above contacts via secure email (see section B).
2. Advantage Dental Services will complete the grievance review and provide the recommended resolution for grievances to EOCCO (the review will include a copy of all related documents and the proposed resolution letter). EOCCO will review and approve Advantage Dental Services to mail the resolution.
3. EOCCO requires a minimum of four calendar days to review and mail the resolution letter. Advantage Dental Services will send the completed grievance to EOCCO within 26 calendar days of receipt if a decision was not possible within five business days of receipt.
4. EOCCO will forward administrative hearing documentations to Advantage Dental Services as necessary. EOCCO and a representative from the Advantage Dental Services will participate in cases reviewed by the Administrative Law Judge.
5. Advantage Dental Services will submit all the grievance and appeal logs on the CCO approved logs from the OHA. The logs are due to EOCCO within 21 days after the quarter ends.
   a. For information on delegate oversight please see the EOCCO Subcontractor Monitoring and Oversight policy. EOCCO ensures the subcontractor meets the requirements consistent with this rule and OAR 410-141-3715 through 410-141-3915; (b) Monitor the subcontractor's performance on an ongoing basis; (c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and (d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
6. Dental grievances related to ODS members are reviewed and processed by EOCCO.
7. All dental appeals are handled by EOCCO.

L. Statement of Confidentiality

All information and documentation received or created by the appeal unit that includes protected health information (PHI) shall be maintained in a confidential manner in accordance with state and federal privacy laws. If PHI is to be used for purposes other than as required for treatment, payment and/or operations, or as required by federal or state law, an authorization will be obtained from the individual.

M. Storage

1. Following resolution, the supporting documentation of grievances/appeals are stored for a minimum of 7 years in the appropriate appeal units' document storing system. This includes all information found in section C.
2. Appeal and grievance case files are maintained in a manner accessible to the state and CMS.

3. Case files are recorded into the Access database for internal and external reporting and are saved indefinitely. This includes all information found in section C.

N. Release of information

1. Information can be shared between providers and EOCCO for the purpose of authorizations, treatments, services, items, quality of care, or requests for payment related to the grievance, appeal, or contested case hearing without the member's signed consent.
2. If EOCCO needs to communicate with other individuals or entities not listed above, EOCCO shall obtain the member's signed consent and maintain it in the file record.
3. EOCCO will provide the member (or the member's representative with appropriate documentation) a copy of their appeal file when requested free of charge. The case file provided may include medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by EOCCO (or at the direction of EOCCO) in connection with the appeal of the adverse benefit determination. This information is provided sufficiently in advance of the resolution time frame for appeals.

O. Contracts and handbooks

1. EOCCO informs providers and subcontractors, at the time they enter into a contract, about the member's right to request continuation of benefits that the CCO seeks to reduce or terminate during an appeal or contested case hearing filing, if filed within the allowable time frames, although the member may be liable for the cost of any continued benefits while the appeal or contested case hearing is pending if the final decision is adverse to the member.
2. EOCCO informs providers and subcontractors, at the time they enter into a contract, about:
   a. Member grievance, Notice of Adverse Benefit Determination, appeal, and contested case hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424.
   b. The member's right to file grievances and appeals and the requirements and timeframes for filing.
   c. The availability of assistance to the member with filing grievances and appeals.
3. EOCCO makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages in its particular service area.
4. EOCCO provides information to members regarding the following:
   a. An explanation of how EOCCO accepts, processes, and responds to grievances, appeals, and contested case hearing requests;
   b. Member rights and responsibilities; and
   c. How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.
5. EOCCO utilizes a member handbook approved by the state that:
   a. Includes the member's right to file grievances and appeals.
   b. Includes the requirements and timeframes for filing a grievance or appeal.
   c. Includes information on the availability of assistance in the filing process for grievances.
   d. Includes information on the availability of assistance in the filing process for appeals.
   e. Includes the member's right to request a contested case hearing after EOCCO has made a determination on a member's appeal which is adverse to the member.
   f. Specifies that, when requested by the member, benefits that the CCO seeks to reduce or terminate will continue if the member files an appeal or a request for state fair hearing within the timeframes

specified for filing, and that the member may, consistent with state policy, be required to pay the cost of services furnished while the appeal or contested case hearing is pending if the final decision is adverse to the member.

P. Staff Training

1. All EOCCO representatives and subcontractors who receive and respond to Medicaid grievances/appeals receive periodic in-services on the EOCCO grievance/appeal process. Training is designed to ensure staff respond appropriately to members, collect adequate information, document information appropriately and understand grievance/appeal and appeal procedures. Representatives who receive and respond to grievances/appeals are monitored on an ongoing basis by their supervisors as part of the review process.

III. Related Policies & Procedures, Forms and References

42 CFR §438.400 through §438.424

OAR 410-120-1860

OAR 410-141-3715 through 410-141-3915

Denial of Medical Services Appeal and Hearing Request Form (OHP 3302)

Hearing Request Form (MSC 443)

Notice of Hearing Rights (OHA 3030)

OHP Complaint Form (OHA 3001)

EOCCO Conflict of Interest Policy

EOCCO Language Access and Effective Communication Policy

EOCCO Notice of Adverse Benefit Determination policy

EOCCO Oregon Health Authority Contested Case Hearings Policy

EOCCO Service Authorization/Referral Request Policy

III. Revision Activity

Modification Date	Change or Revision and Rationale	Effective Date of Policy Change
08/07	Annual Review	08/07
06/08	Annual Review and OAR rule changes	07/08
07/09	Annual Review	08/09
10/10	Annual Review	10/10
05/11	Annual Review	05/11
1/12	Added clarification to expedited appeal process	1/12
06/12	Annual Review – updates to section C, H, I to match current process and OAR requirements.	06/12

08/13	Annual review – updates to match OAR terminology and new reporting categories	06/13
11/13	Update policy – split ODS dental and EOCCO into two separate policies	11/13
11/14	Annual review – added dental process	11/14

New P & P /Change / Revision and Rationale	**Final Review/Approval**	**Approval Date**	**Effective Date of Policy/Change**
Updated policy on new P&P template.	EOCCO QIC	12/11/15	12/1/15
Updated to reflect EOCCO external quality review audit	EOCCO QIC	12/8/16	12/8/16
Policy re-written per OHA recommendations.	EOCCO QIC	12/18	12/18
Annual updates	EOCCO QIC	7/19	7/19
Annual review and update	EOCCO QIC	7/7/2020	7/7/2020
Review and update for OHA Submission	EOCCO QIC	1/21/2021	01/21/2021

IV. Affected Departments:

Medical and Dental Customer Service

EOCCO Transformation and Quality Strategy

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION		**Policy & Procedure**			
Company:	EOCCO	**Department Name:**		EOCCO Quality Improvement Committee	
Subject:	EOCCO Transformation and Quality Strategy				
P & P Original Effective Date:	09/2012	**P & P Origination Date:**	**3/2015**	**P & P Published Date:**	**3/2015**
P & P Revision Effective Date:	04/08/16, 02/10/17, 4/2018, 1/2019, 1/2020	**P & P Revision Published Date:**		04/08/16; 04/14/17, 4/2018, 2/2019, 7/2019	
Reference Number:	CCO-OPER-4	**Next Annual Review Date:**		01/2021	
Division:					
Product (check all boxes applicable to this policy) ☒Dental ☒ Medical ☒ Pharmacy ☒ Behavioral Health					

Healthcare Services

Medicaid Services

Quality Programs

I. Policy Statement and Purpose

The Eastern Oregon Coordinated Care Organization (EOCCO) Transformation and Quality Strategy (TQS) provides for a systematic structure for decision making, allocation of resources and implementation of integrated quality improvement, health innovation and transformation activities with the goals of advancing the Triple Aim for EOCCO members and meeting our objectives in the delivery and evaluation of the quality and safety of the care and services provided to EOCCO members. EOCCO conducts its TQS annually and updates it as needed**.** A.

The program encompasses culturally competent health innovation and transformation activities and quality assurance and performance improvement activities pursuant to 42 CFR 438.330. This includes monitoring and evaluating the quality and safety of care and services provided in ambulatory settings, hospitals, residential treatment and skilled nursing facilities; through home healthcare services, free- standing surgical centers and ancillary services; and by the CCO through physical health, behavioral health and dental health services, as well as member services.

II. Definitions

A. **EOCCO:** A coordinated care organization that provides services to enrollees in the Oregon Health Plan in accordance with the laws, rules, regulations and contractual requirements that apply to the Oregon Health Plan. EOCCO is responsible for performing all administrative duties under the coordinated care organization contract with the state of Oregon.

III. Procedure B. Goals

1. Provide high quality, accessible, medically necessary and safe physical health, behavioral health and dental health services in the most appropriate setting.
2. Achieve the targeted outcomes of our performance metrics.
3. Ensure the access of culturally competent care and services to all members.
4. Continuously monitor the quality and safety of the care and service delivered to:
   a. Identify improvement opportunities
   b. Improve the health status of the EOCCO population and their communities
   c. Ensure high member satisfaction with care and service experience
5. Support EOCCO practitioners and providers to improve the quality and safety of care and service delivered in their respective settings
6. Collaborate with the Oregon Health Authority (OHA), and local and regional partners to continue the work on health transformation and integration.

B. Authority and Responsibility

The EOCCO Board of Directors is the authority of and has the responsibility for the EOCCO TQS. The board of directors has delegated the EOCCO Quality Improvement Committee (QIC), with the responsibility for the operations of the EOCCO transformation and quality strategy.

C. Program Structure

The EOCCO TQS structure includes the following:

1. EOCCO Quality Improvement Committee
   a. The EOCCO QIC provides oversight to transformation and quality assurance and performance improvement activities to ensure that EOCCO members receive high quality physical, behavioral and dental care and services. The committee is a decision-making body that has the authority and representation to develop and implement integrated quality improvement activities it deems appropriate and necessary to improve the patient experience of care and health of the EOCCO populations, and to reduce the cost of healthcare. The committee monitors EOCCO's annual TQS and work plan.
   b. The members of the EOCCO QIC are comprised of decision-making and operational representatives in physical health, behavioral health, dental health and pharmacy services representing the following service areas:
      i. Administrative services
      ii. Appeals & grievances
      iii. Care coordination
      iv. Case management
      v. Compliance
      vi. Medical director
      vii. Member services
      viii. Provider credentialing

ix. Provider relations
x. Quality and performance improvement
xi. Utilization management
xii. Senior management

c. An EOCCO QIC member, elected by the group every two years, chairs the committee.
d. EOCCO QIC meets at least quarterly. An agenda directs the meetings. Documented minutes, dated and signed, provide a record of the committee's activities and recommendations.
e. The President, EOCCO, is the executive sponsor of the EOCCO QIC.

2. Utilization review oversight committee
   a. The EOCCO utilization review oversight committee (UROC) assures the availability of evidence-based tools and resource information to enable EOCCO staff to provide appropriate clinical review services.
   b. The committee researches, develops and implements clinical necessity criteria, guidelines and treatment protocols for the review of service authorization requests and retrospective claims review. As needed, external community-based practitioners are consulted in the development and review of clinical criteria, guidelines and treatment protocols.
   c. The committee is comprised of physical health, behavioral health, oral health and pharmacy services clinical and non-clinical utilization management, compliance and quality representatives.
   d. The committee includes EOCCO senior level physical health, behavioral health, and dental health directors and/or chief officers.
   e. The committee monitors utilization against respective physical health, behavioral health and oral health evidence-based criteria and practice guidelines, treatment protocols and policies. Criteria, guidelines and treatment protocols are reviewed at least biennially.
3. EOCCO clinical advisory panel
   a. The EOCCO clinical advisory panel (CAP) serves as a clinical matters focus group for the EOCCO medical director and to help evaluate new clinical strategies that will achieve the Triple Aim.
   b. Responsibilities are to provide stewardship of the EOCCO delivery system transformation, monitor implementation of EOCCO risk contracts, serve as a delivery system focus group (review EOCCO physical, behavioral and dental care integration progress, EOCCO claims and clinical policies and EOCCO clinical decision tool utilization), provide stewardship of EOCCO's health information technology regional solution implementation and steward the EOCCO provider newsletter. The EOCCO medical director determines other responsibilities from time to time.
   c. The EOCCO medical director is responsible for CAP member nominations. CAP membership is comprised of no more than seven or less than five clinical providers from the EOCCO service area. d. Membership includes at least one public health provider, at least one behavioral health provider, at least two primary care physicians, at least one physical health mid-level provider and at least one oral health provider. The EOCCO clinical consultant is an ex-officio member of the CAP.
   d. The CAP meets quarterly. Contemporaneous minutes provide a record of the CAP's decision and actions. CAP activities are reported to the EOCCO board of directors.
4. EOCCO incentive measures workgroup
   a. The EOCCO incentive measures workgroup is a multidisciplinary body that develops quality improvement initiatives to improve the rates of the CCO incentive measures required by the OHA and address racial, ethnic and linguistic disparities in access, quality of care and outcomes. The workgroup provides feedback on educational materials in various media intended for EOCCO members and providers, and EOCCO communities at large.
   b. Membership includes EOCCO staff in quality improvement, population health administrative services, provider relations, behavioral health services, dental services, pharmacy services, liaisons

to EOCCO local advisory community councils (LCAC), CCO innovator agent, EOCCO clinical consultant and data analytics.

c. The health promotion and quality improvement specialists facilitate workgroup meetings.
d. The workgroup appoints dedicated committees to research, design and implement specific quality improvement projects.
e. The workgroup meets every other month to monitor incentive metrics rates, complete root cause analysis of low rates and develop and implement interventions to improve rates.
f. Contemporaneous minutes provide a record of the workgroup activities. Incentive measures workgroup activities are reported to the EOCCO QIC and board of directors.
g. Annually, EOCCO reports the performance of our incentive measures to the OHA and includes the data required to enable the OHA to calculate and verify EOCCO's performance.

5. Physician Leadership

   Senior-level medical, behavioral health and dental directors are actively involved in implementing EOCCO's utilization management programs and are instrumental in the design and implementation of activities that involve or affect clinical care and patient safety of EOCCO members. They make utilization review, member appeal and provider credentialing decisions and are substantially involved in the development of utilization management policy, clinical review criteria and clinical practice guidelines.

6. Credentialing Program

   A dedicated credentialing team performs initial credentialing, recredentialing and ongoing monitoring of EOCCO practitioners and organizational providers (facilities). It performs credentialing delegation oversight of qualified delegations, such as of our dental networks.

7. Quality assurance and performance improvement initiatives

   EOCCO staff develop, monitor and manage the quality assurance, performance improvement, health innovation and transformation activities.

   a. EOCCO team members facilitate, coordinate and/or participate in the research, design, implementation, monitoring and reporting of EOCCO quality improvement projects. These staff represent a variety of clinical and non-clinical roles and levels of responsibility and accountability in physical, behavioral health and dental services. Their work include, but are not limited to, performance improvement projects in patient safety, member access to care, member experience and satisfaction, member engagement and use of services, and eliminating racial, ethnic and linguistic healthcare disparities.
   b. Team members engage with the provider community and represent EOCCO in community, state, and local community advisory council collaborative projects designed to improve health outcomes and experience of care for EOCCO members.

8. Grievance system

   EOCCO provides a dedicated team to respond to complaints and appeals in accordance with applicable state and federal regulatory standards. An EOCCO QIC subcommittee of physical medicine, behavioral health, dental health and pharmacy services leaders review quarterly grievance reports to identify and implement interventions to remedy, sustain or improve an outcome and to reduce the highest rates of complaints.

9. Member Care

   a. Behavioral Health Services

      EOCCO provides for these services via its contracts with CMHPs, PCPCHs, OHA-certified organizations and independent practitioners. The range of services provided include mental health and substance use disorders education, support services and treatment and prevention; residential

care and coordination with higher levels of care. EOCCO performs retrospective chart reviews of the timeliness and appropriateness of services and care provided by CMHPs at least annually and a comprehensive onsite review at least once every three years. EOCCO administers a complex care management for severe or complex mental illness or condition that requires an intensive level of management and extensive resources to obtain optimal health or improved functioning. The program also provides services for intermediate and lower levels of care coordination.

b. Medical and Disease Management Services

Dedicated EOCCO staff provide intensive care coordination (ICC) to help EOCCO members achieve optimum level of health and functional capability through collaboration with the member and providers. The collaborative process is one of advocacy, communication, and identification of individual needs, facilitation of services and promotion of cost effective, quality outcomes. The program addresses members with complex needs which include, but are not limited to: physical and developmental disabilities, multiple chronic conditions, severe behavioral health illness, organ transplants, HIV/AIDS, progressive degenerative disorders and metastatic cancers. The objective is to help members achieve optimal level of health and functional capability by applying evidence based medicine and best practice in collaboration with these members and their providers. Other programs to meet the healthcare needs of EOCCO members include:

i. Health coaches who work with members with chronic health conditions ii. Care coordination for members who receive multiple services

iii. Intensive Case Management for members identified with high health complexity

c. Collaborations

EOCCO care coordination and complex care management teams meet regularly with APD/CPS representatives, and district managers to coordinate the care of members with special healthcare needs and who are high utilizers of healthcare services. The goal is to ensure right care at the right level at the right time through communication and collaboration

d. Dental Case Management

EOCCO dental case management teams coordinate the dental services for EOCCO members who have complex medical needs, are aged, blind, disabled, have multiple chronic conditions, mental illness or substance abuse disorders and either 1) have functional disabilities or 2) live with health or social conditions that place them at risk, for developing functional disabilities (i.e., serious chronic illness or environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.) Targeted member outreach by dental case managers is based on findings from dental assessments, as well as on physical, behavioral health or dental provider, and family/caregiver referrals.

D. Quality Improvement Process

1. EOCCO uses continuous quality improvement methodologies to assess, plan and improve the quality of care and service we provide to EOCCO members. The most used is the Plan-Do-Study-Act (PDSA) methodology. This tool is the basis for determining and implementing improvements and testing changes in our quality processes or operations. The steps in the PDSA cycle are: a. Plan

   What is the current situation needing improvement? Complete root cause analysis or quality improvement process to determine the intervention. Determine the plan, including how to collect data. What resources are needed to implement (including cultural and linguistic appropriateness of

the intervention and how will it improve the study indicator? What is the tracking and monitoring plan to determine if we improved?

b. Do

Describe interventions for targeted segments, i.e., member, provider, provider office team, community partners (school based health centers, county health departments), implementation dates and tracking and monitoring of intervention results, observations and outcomes. c. Study

Measure and study the intervention results. Discuss data collection, data quality, time frames with interventions, barriers identified during intervention and how they were addressed d. Act

What are next steps? What is the plan for continual improvement? Is the intervention ongoing? Will it be expanded or will there be a change in approach? How will the intervention be adapted, adopted or abandoned?

2. Work Plan

The EOCCO QIC oversees work plans for quality assurance, performance improvement and health innovation and transformation projects and activities for the ensuing year. The work plan includes performance improvement activities regarding:

a. System activities used to implement and ensure quality coordinated health care, including behavioral health and oral health care
b. Mechanisms to detect both under-utilization and over-utilization of services, document the findings, report aggregate date, and describe follow-up action for both findings
c. Assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access, and cultural considerations
d. Assessment of the quality and appropriateness of care to members with special health care needs and methods used to evaluate the need for direct access to specialists
e. A demonstration of improvement in an area of poor performance in care coordination for members with serious and persistent mental illness (SPMI)
f. Grievance system information, including complaints, notice of actions, appeals, and hearings
g. Monitoring and enforcement of consumer rights and protections with the Oregon Integrated and Coordinated Health Care Delivery System that ensures consistent response to complaints of violations of consumer rights and protections
h. EOCCO QIC monitoring of the TQS.
i. Committee minutes on utilization review guidelines, treatment protocols and policies.
j. Participation as a member of the OHA Quality and Health Outcomes Committee.

Periodic progress and outcomes resulting from the work plan activities are reported to the EOCCO QIC.

3. Determining Aspects of Care

The EOCCO QIC, with input from the EOCCO incentive measures workgroup, data analytics team, medical directors, clinical advisory panel, or regional or local community advisory councils, determines the aspects of care and service that will yield important information regarding the quality of, or access to, care for EOCCO members. Aspects of care include but are not limited to patient safety, effectiveness of care, access and availability of care, experience and satisfaction with care, use of services and cost of care.

4. Data Sources

EOCCO quality initiatives utilize various data sources to monitor aspects of care and service, and identify improvement opportunities and implement improvement activities. These include, but are not limited to; claims data (physical, behavioral and dental health); pharmacy data; lab data; enrollment data; encounter data; social determinants of health data; cost and utilization dashboard (inpatient,

outpatient, professional, mental health, dental, and pharmacy cost and utilization); medical record documentation reviews; service authorizations and referrals; medical management data; out-of-network utilization; emergency department use; credentialing and recredentialing information; member complaints and appeals; patient satisfaction surveys; member satisfaction and experience surveys; member activation measures; potential adverse outcomes; state reported rates for CCO incentive measures; practitioner office site reviews; health risk assurances; information and feedback from regulatory (OHA, Centers for Medicare & Medicaid Services (CMS) entities; disenrollment data; focused studies; focus groups. For each aspect of care and service, the most representative data are collected and meaning derived from statistical and/or qualitative analysis.

5. Performance Improvement Projects
   a. The measurement of progress is an important aspect of EOCCO transformation and quality strategy. Based on the CCO contractual requirements, analysis of data related to EOCCO aspects of care and services, and improvement targets of CCO incentive measures, EOCCO implements CCO-level or statewide performance improvement projects.
   b. Our projects are in seven focus areas: improve behavioral health/physical health coordination, improve perinatal and maternity care, reduce preventable re-hospitalizations, ensure care is delivered in appropriate settings, improve primary care, deploy care teams to reduce unnecessary and costly utilization by super-utilizers, and address population health issues.
   c. EOCCO prioritizes projects based on evidence of the greatest need, regulatory requirements and available resources. Projects pertain to either aspects of clinical care or non-clinical service and are designed to achieve significant improvement, sustained over time, in health outcomes, member satisfaction and experience, and costs.
   d. Quality improvement and health promotion specialists lead integrated teams to plan and implement timely interventions to improve access to and quality of care. We assess these opportunities for improvement through practice standards, consultation with experts in the field, analysis of processes and identification of root causes. We use scientific literature and national and regional benchmarks to establish quality indicators.
   e. EOCCO uses the most appropriate data sources to measure outcomes of our performance. On an ongoing basis, we monitor progress of our projects with the applicable quality indicators and assess for effectiveness and on whether we need to explore further improvement opportunities and/or maintain the gain(s).
   f. Quarterly or as requested by the OHA, we report the status and results of our projects.

6. Documentation of projects

We document performance improvement projects on internal EOCCO forms or forms prescribed by CMS or the OHA. The form generally outlines the following project attributes.

   a. Identification and rationale for the aspect of clinical care or non-clinical services being studied, including gap and root cause analyses
   b. Specific quality indicators to measure performance
   c. Collection of baseline data
   d. Identification and implementation of appropriate system interventions to improve performance
   e. Repeated data collection to assess the immediate and continuing effect of the interventions and determine the need for further action
   f. Demonstrated improvement in the organization's performance sustained over time.

7. Annual evaluation

a. Annually, EOCCO evaluates its QAPI and transformation programs, projects and activities to assess the impact and effectiveness of its systems interventions. At a minimum, the report includes: i. Performance improvement projects ii. Collection and submission of performance measurement data
   iii. Mechanisms to detect both underutilization and overutilization of services
   iv. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs pursuant to 42 C.F.R. §438.340
b. See section VI.B for performance improvement components that are assessed.

The annual evaluation is submitted to the OHA. The President, EOCCO, reports the annual evaluation to the EOCCO Board of Directors.

E. Delegation

EOCCO ensures that any delegated quality assurance and/or quality improvement function meet EOCCO quality assurance and performance improvement standards and/or the rules and regulations of the OHA or CMS. EOCCO does not delegate quality responsibilities.

F. Statement of Confidentiality

All information and documentation received or created by the TQS program that includes protected health information (PHI) shall be communicated and maintained in a confidential manner in accordance with state and federal privacy laws. If PHI is to be used for purposes other than as required for treatment, payment and/or operations, or as required by federal or state law, an authorization is obtained from the individual.

G. Statement of Conflict of Interest

No staff representing EOCCO shall engage in the review and/or approval of care when he/she has participated in the provision of care. The compensation plans for professionals who make medical management decisions will not be based on the quantity or types of decisions rendered.

IV. Related Policies & Procedures, Forms and References

42 CFR 438.330; Health Plan Services Contract, CCO, Exhibit B-Part 10

V. Revision Activity

New P & P /Change / Revision and Rationale	Final Review/Approval	Approval date	Effective Date of Policy/Change
Annual review	EOCCO Quality Improvement Committee	03/13/15	03/13/15
Annual review	EOCCO Quality Improvement Committee	04/8/16	04/08/16
Annual review; added DCOs; updated membership	EOCCO Quality Improvement Committee	04/14/17	
Annual review; updated to reflect TQS; updated incentive measures workgroup membership	EOCCO Quality Improvement Committee	04/27/18 by email	04/27/18

Annual review	EOCCO Quality Improvement Committee	02/08/19	02/08/19

VI. Affected Departments:

- EOCCO Physical Health
- EOCCO Behavioral Health
- EOCCO Dental Health Services
- EOCCO Pharmacy Services
- Compliance
- Quality team

EOCCO Diversity, Equity, and Inclusion Charter

Eastern Oregon Coordinated Care Organization (EOCCO)
EOCCO Diversity Equity and Inclusion Charter

The Eastern Oregon Coordinated Care Organization will appoint a Diversity Equity and Inclusion (DEI)

Committee, as a subcommittee of the Quality Improvement Committee (QIC). The purpose of the DEI Committee is to strategize and implement a health equity plan that addresses health care disparities in the EOCCO service region. EOCCO adopts and supports Oregon's Health Equity definition that was put forth by the Office of Equity and Inclusion:

"Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- *The equitable distribution or redistributing of resources and power; and*
- *Recognizing, reconciling and rectifying historical and contemporary injustices."*

Membership

The members of the EOCCO DEI Committee are comprised of equal decision-making representatives from Moda, GOBHI, Advantage Dental, and ODS Community Dental. Committee members may serve on the committee for as long as they hold the position that qualifies them for the appointment. The cochairs will report to the QIC. The committee will be comprised of the following members:

<u>Physical Health Representatives:</u>

- Quality Improvement Specialist III (Health Equity) – Co-Chair
- Supervisor, Quality Improvement
- Senior Manager, Quality Improvement and Operations
- Supervisor, Medicaid Operations
- Quality Improvement Specialist III
- Health Equity Administrator
- VP, DEI and Community Initiatives
- Membership Accounting Specialist

<u>Behavioral Health Representatives:</u>

- Senior Consultant – Co-Chair
- Director of Community Engagement
- Manager of Human Resources

- Tribal Liaison
- Primary Care Transformation Specialist
- Communications Coordinator
- Care Specialist
- Traditional Health Worker (THW) Liaison
- Trauma Informed Care (TIC) Coordinator

Oral Health Representatives:

- ODS Community Dental: Dental Medicaid Latino Specialist – Co-Chair
- Advantage Dental: Network Development Manager

Meetings

The EOCCO DEI Committee meets on the fourth Tuesday of every other month at 1:30pm starting in January. The meeting locations will alternate between the Moda and GOBHI offices. The agenda and attachments are sent a week prior to the meeting for review. Meeting minutes will provide a record of the DEI Committee's activities, recommendations, and actions. If a specific topic needs to be discussed in more detail, then a workgroup may be formed with subject matter experts. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote of members present. Members will be polled to demonstrate that a decision has been reached by a majority. Each member has one vote and a simple majority (being 51%) carries a decision. Decisions will be brought to the QIC Committee by the co-chairs for final approval.

Responsibilities

The EOCCO DEI Committee is responsible for:

- Producing an annual Health Equity Plan and an annual health equity assessment report each year after that as required by OHA that includes the following:
  - A narrative section
  - Goals, objectives, activities, and metrics
  - Cultural responsiveness and implicit bias training and continuing education plan both within the organization and for the EOCCO provider network
- Reviewing the Health Equity Plan implementation and providing recommendations to responsible parties for its ongoing progress.
- Reporting to the QIC the status of the Health Equity Plan implementation progress, each annual assessment development, and each annual assessment report.
- Identifying and implementing health equity strategies as part of the Transformation and Quality Strategy (TQS) deliverable requirements.

ROSTER

Member	Title	Email
Courtney Whidden-Rivera	Supervisor, Quality Improvement	Courtney.whidden@modahealth.com

Jorge Ramirez Garcia	Senior Consultant	jramirez@gobhi.org
Summer Prantl Nudelman	Senior Manager, Quality and Operations	Summer.prantl@modahealth.com
Mina Zarnegin	Supervisor, Medicaid Operations	Mina.zarnegin@modahealth.com
Audrey Egan	Quality Improvement Specialist III	Audrey.egan@modahealth.com
Courtney Valenzuela	Quality Improvement Specialist III (Health Equity)	Courtney.Valenzuela@modahealth.com
Astrid Sosa	Health Equity Administrator	Astrid.Sosa@modahealth.com
Troy Soenen	Director of Community Engagement	Tsoenen@gobhi.org
Jill Boyd	Primary Care Transformation Specialist	jill.boyd@gobhi.org
Patrick Mulvihill	Communications Coordinator	patrick.mulvihill@gobhi.org
Lyndsey Ketchum-Harkless	Care Specialist	lharkless@gobhi.org
Sherrie Grief	THW Liaison	sgrief@gobhi.org
Michelle Brandsma	TIC Coordinator	mbrandsma@gobhi.org
Karen Wheeler	Tribal Liaison	kwheeler@gobhi.org
Janet Westphal	Advantage Dental: Network Development Manager	jwestphal@advantagedental.com
Ana Ovalle Barry	ODS: Dental Medicaid Latino Specialist	ana.ovallebarry@odscommunitydental.com
Karis Stoudamire-Phillips	VP, DEI and Community Initiatives	karis.stoudamirephillips@modahealth.com
Julian Pullings	Membership Accounting Specialist	julian.pullings@benefithelpsolutions.com

EOCCO Health Information Technology Charter

Eastern Oregon Coordinated Care Organization (EOCCO)
EOCCO Health Information Technology Charter

The Eastern Oregon Coordinated Care Organization will appoint a Health Information Technology (HIT)

Committee, as a subcommittee of the Quality Improvement Committee (QIC). The purpose of the Health Information Technology Committee is to align HIT efforts enterprise wide as well as collect data on EHR and HIE use and set targets for increased utilization by contracted physical, behavioral, and oral health facilities.

To ensure the security of Moda's information, networks, and information systems the Information Security Department will monitor project progress, primary and tangential activities, and integrations to assess for security and compliance issues or considerations.

Membership

The members of the EOCCO HIT Committee are comprised of equal decision-making representatives from Moda, GOBHI, Advantage Dental, and ODS Community Dental. Committee members may serve on the committee for as long as they hold the position that qualifies them for the appointment. The cochairs will report to the QIC. The committee will be comprised of the following members:

Physical Health Representatives:

- Supervisor, Quality Improvement – Co-chair
- Director, Analytics
- Senior Manager, Quality and Informatics
- Vice President, Medicaid Programs & EOCCO CEO
- Director, Information Security, Internal Audit
- Senior Manager, Data Science

Behavioral Health Representatives:

- Network & Computer Manager – Co-chair
- Analytics Manager

Oral Health Representatives:

- Advantage: Principal Software Engineer – Co-chair
- ODS: Manager, Dental Services

Meetings

The EOCCO HIT Committee meets on the first Monday of every other month from 10-11am starting in August. The meetings will be held remotely and at the Moda Health office. The agenda and attachments are sent a week prior to the meeting for review. Meeting minutes will provide a record of the HIT Committee's activities, recommendations, and

actions. If a specific topic needs to be discussed in more detail, then a workgroup may be formed with subject matter experts. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote of members present. Members will be polled to demonstrate that a decision has been reached by a majority. Each member has one vote and a simple majority (being 51%) carries a decision. Decisions will be brought to the QIC Committee by the co-chairs for final approval.

Responsibilities

The EOCCO HIT Committee is responsible for:

- Oversee the annual HIT data reporting for all contracted facilities as outlined in CCO contract, Exhibit J, Section 2. This includes rates of EHR adoption, HIE use, access to and use of hospital event notifications, and EHR product/HIT tools in use by each contracted physical behavioral and oral health facility.
- Utilize the above rates to inform strategies to support EHR and HIE adoption and use, as well as set targets for increasing that use.
- Report strategies, progress, and targets to OHA in EOCCO's updated HIT Roadmap on an annual basis.
- Review and prepare for the annual Information Systems Capabilities Assessment (ISCA) as part of the Oregon Health Authority's External Quality Review (EQR).
- HIT adoption and its associated Moda operational and technological integrations and work may include initial and ongoing exchange of sensitive, confidential, or covered information in addition to changes to Moda's technological infrastructure, applications, and business processes. Information exchanges, development projects, system integrations, and in-scope applications, websites, and web applications will be assessed for security concerns and compliance issues.

ROSTER

Member	**Title**	**Email**
Courtney Whidden-Rivera	Supervisor, Quality Improvement	Courtney.whidden@modahealth.com
Fred Lively	Network & Computer Manager	fred.lively@gobhi.org
Bill Dwyer	Director, Analytics	Bill.dwyer@modahealth.com
Nathan Trenholme	Senior Manager, Quality and Informatics	Nathan.trenholme@modahealth.com
Sean Jessup	Vice President, Medicaid Programs & EOCCO CEO	Sean.jessup@modahealth.com
Dayle James	Director, Information Security, Internal Audit	Dayle.james@modahealth.com
John Clouse	Senior Manager, Data Science	John.Clouse@modahealth.com
Matthew Byrne	Analytics Manager	mbyrne@gobhi.org
John Fullman	Advantage: Principal Software Engineer	johnf@advantagedental.com
Nancy Avery	ODS: Manager, Dental Services	nancy.avery@odscommunitydental.com

Reviewed & updated: 05/2020

EOCCO Incentive Measure Committee Charter

Eastern Oregon Coordinated Care Organization (EOCCO)
EOCCO Incentive Measure Committee Charter

The Eastern Oregon Coordinated Care Organization will appoint an Incentive Measure (IM) Committee, as a subcommittee of the Quality Improvement Committee (QIC). The purpose of the EOCCO Incentive Measure Committee is to unify efforts towards reaching the incentive measure targets and improving the health of the Eastern Oregon communities.

Membership

The members of the EOCCO IM Committee are comprised of equal decision-making representatives from physical, behavioral, and oral health as well as OHA and other partners of the CCO. Committee members may serve on the committee for as long as they hold the position that qualifies them for the appointment. The co-chairs will report to the Quality Improvement Committee (QIC). The committee will be comprised of the following members:

Physical Health Representatives:

- Senior Manager, Operations and Quality Improvement – Co-Chair
- Health Promotion and Quality Improvement Specialist III – Co-Chair
- Supervisor, Quality Improvement
- Medicaid Services Coordinator
- Data Analyst
- Clinical Pharmacist

Behavioral Health Representatives:

- Community Health Development Director – Co-Chair
- Primary Care Transformation Coordinator
- Children's Health and Community Supervisor
- Project Coordinator
- Business Development Project Manager
- Early Childhood Coordinator
- Data Analyst

Oral Health Representatives

- Advantage: Director, Medicaid Services – Co-Chair

- ODS: Manager, Dental Services
- ODS: Manager, OHP Contract and Quality

OHA: Innovator Agent

Meetings

The EOCCO IM Committee meets on the third Tuesday of every other month at 10am starting in January. The agenda and attachments are sent a week prior to the meeting for review. Meeting minutes will provide a record of the IM Committee's activities and interventions. If a specific topic needs to be discussed in more detail, then a workgroup may be formed with subject matter experts. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote of members present. Members will be polled to demonstrate that a decision has been reached by a majority. Each member has one vote and a simple majority (being 51%) carries a decision. Decisions will be brought to the QIC Committee by the co-chairs for final approval.

Responsibilities

The EOCCO IM Committee is responsible for:

- Ensure open communication between physical, behavioral, and oral health entities to promote collaborative planning.
- Evaluate and monitor the performance of current incentive measures.
- Provide strategic planning for future incentive measure interventions.
- Provide summary to Quality Improvement Committee (QIC) every other month.
- Submit performance data to OHA for inclusion in the incentive measure calculation by the end of the last business day of March of the Distribution Year.
- Create a written distribution plan for Quality Pool and Challenge Pool earnings. The plan should be provided to OHA each year within 60 days of the EOCCO's receipt of its final Quality Pool distribution.

ROSTER

Member	Title	Email
Courtney Whidden-Rivera	Supervisor, Quality Improvement	Courtney.whidden@modahealth.com
Summer Prantl Nudelman	Senior Manager, Operations and Quality Improvement	Summer.prantl@modahealth.com
Kali Paine	Health Promotion and Quality Improvement Specialist III	Kali.paine@modahealth.com
Audrey Egan	Medicaid Services Coordinator	Audrey.egan@modahealth.com
Lindsey Dew	Data Analyst	Lindsey.dew@modahealth.com
Troy Soenen	Community Health Development Director	tsoenen@gobhi.org
Jill Boyd	Primary Care Transformation Coordinator	jboyd@gobhi.org

Linda Watson	Children's Health and Community Supervisor	lwatson@gobhi.org
Tracy Blood	Project Coordinator	tblood@gobhi.org
Marci McMurphy	Business Development Project Manager	mmcmurphy@gobhi.org
Molly Johnson	Advantage Dental: Director, Medicaid Services	mollyp@advantagedental.com
Nancy Avery	ODS: Manager, Dental Services	nancy.avery@odscommunitydental.com
Yuberca Pena	ODS: Manager, OHP Contract and Quality	yuberca.pena@odscommunitydental.com
Estela Gomez	OHA: Innovator Agent	Estela.GOMEZ@dhsoha.state.or.us

EOCCO Member Engagement Subcommittee Charter

Eastern Oregon Coordinated Care Organization
(EOCCO) Member Engagement subcommittee Charter
The purpose of the EOCCO Member Engagement subcommittee is to unify efforts towards Member engagement for Eastern Oregon communities by collaboration with Behavioral Health, Dental and Physical Health.

Membership

The members of the EOCCO Member engagement subcommittee are comprised of equal decision-making representatives from key areas in physical health, behavioral health, ODS and other partners of the CCO. Committee members may serve on the committee for as long as they hold the position that qualifies them for the appointment. The committee will be comprised of the following members:

- Co-Chairs
- Medicaid Services
- Quality Improvement
- Marketing
- Dental
- Customer Service

Meetings

The EOCCO Member Engagement subcommittee will meet bi-monthly (day and time selection TBD). An agenda directs the meetings. Documented minutes provide a record of the committee activities, recommendations and actions.

Responsibilities

The EOCCO Member Engagement subcommittee is responsible for:

- Ensure that the requirements set forth by OHA, related to member communication and other engagement efforts, are met;
- Establish key performance indicators;
- Participation in Member Engagement and Outreach Committee (MEOC) and implement initiatives;
- Provide strategic planning for future member engagement initiatives; o Create and lead member engagement initiatives
- Draft and ensure that policies reflect the most up-to-date requirements of the CCO contract, Oregon Administrative Rule (OAR), and Code of Federal Regulations (CFR);
- Align member engagement initiatives and campaigns with integrated behavioral health, physical health and dental care;
- Assist other EOCCO sub-committees, providing support as identified;
- Develop the framework and scope for member engagement across EOCCO for physical, behavioral health and dental care;

Roles & Responsibilities		
Representative	**Role**	**Responsibilities**

Member Engagement Subcommittee Co-chairs	Facilitation and leadership	Monitoring rule and regulation and communicating changes in EOCCO policy Ensure deliverables are submitted to EOCCO Compliance, TQS coordinator, or QIC coordinator on time and as appropriate
Medicaid Services	Collaboration and Integration	Expert on member communication Liaison to OHA and assisting with the operationalization of the identified initiatives Communicate OHA guidance and requirements
Quality Improvement	Collaboration and Integration	Integrate QI opportunities and streamline quality efforts with behavioral health and dental
Marketing	Strategy regarding contextual communications for the Medicaid population	Support Medicaid services with planning and implementing communication materials to members and providers
Dental	Collaboration and Integration	Communicate ideas and efforts put forth that occur on a statewide level and identify how to target specific counties Communicate and align benefits between other DCO's in the EO region when a transition occurs
Customer Service	Voice and advocate of the member	Analyze and communicate member/provider feedback Inform content and communication planning
Ad hoc representation	Voice and advocate of the member	Care Coordination and Case Management Local Community Advisory Panel member

Permanent Committee Roster		
Role	**Member**	**Email**

Member Engagement Subcommittee Co-chair	Kayla Jones	kayla.jones@modahealth.com
Member Engagement Subcommittee Co-chair	Karen Keomuangtai	kkeomuangtai@gobhi.org
Medicaid Services	Mina Zarnegin	mina.zarnegin@modahealth.com
Quality Improvement	Kali Paine	Kali.Paine@modahealth.com
Marketing	Patrick Mulvihill Darci Weber	pmulvihill@gobhi.org darci.weber@modahealth.com
Dental	Corinne Thayer	corinne.thayer@odscommunitydental.com
Customer Service	Colleen Duncan	colleen.duncan@modahealth.com

EOCCO Network Management Committee Charter

Eastern Oregon Coordinated Care Organization (EOCCO)
Network Management Committee Charter

The Eastern Oregon Coordinated Care Organization will convene Network Management Committee meetings on a quarterly basis beginning in January 2020. The Network Management Committee will be responsible for maintaining and monitoring a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services to both current members and those that EOCCO can anticipate will become enrolled as members.

EOCCO shall ensure all members can access providers within acceptable travel time or distance to patient-centered primary care homes or PCPs; primary care, adult and pediatric; OB/GYN; behavioral health (mental health and substance use disorder), adult and pediatric; specialists, adult and pediatric; hospital; pharmacy; oral care, adult and pediatric; and additional provider types as required to meet he need of its Membership.

Membership

The members of the EOCCO Network Management Committee are comprised of equal decision-making representatives, including, but not limited to:

- Network Management Subcommittee Co-chairs; Moda Network Strategy Staff;
- GOBHI Contract Administration;
- GOBHI Geospatial Analyst;
- GOBHI DSN SME;
- Dental (ODS and Advantage)
- Local Community Advisory Council SME;
- Utilization Management & Care Coordination Staff; and Ad hoc representation, as required, by subject matter.

The committee will be comprised of nine (9) members.

Committee members will serve permanently, as required.

Meetings

The EOCCO Network Management Committee will meet quarterly and establish the locations of future meetings at the conclusion of each meeting. An agenda directs the meetings. Documented minutes provide a record of the committee activities, recommendations and actions. Ad hoc meetings will be scheduled as required.

Responsibilities

The EOCCO QIC Network Management Subcommittee will oversee the operationalization of the ECOO access plan that establishes:

- The protocol for monitoring and ensuring access;
- Outlining how provider capacity is determined; and
- Establishing procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity.

Reporting Network Adequacy to the EOCCO Quality Improvement Committee (QIC)

Network Adequacy dashboards will be created to and presented to the QIC at least annually for their review. Network Management Committee co-chairs will be responsible present the data to QIC.

Roles & Responsibilities		
Representative	**Role**	**Responsibilities**
Network Management Subcommittee Co-chairs	Facilitation and leadership	Monitoring rule and regulation and communicating changes in EOCCO policy Ensure deliverables are submitted to EOCCO Compliance, TQS coordinator, or QIC coordinator on time and as appropriate
Moda Network Strategy Staff	Network adequacy reporting	Running reports in Quest
GOBHI Geospatial Analyst	BH network advisor	Advise Moda Network Strategy Staff as appropriate
GOBHI Contract Provider Administrator	GOBHI BH Contract Subject Matter Expert	Provide updated BH contract provider information
GOBHI DSN SME	Advises on Roster	Owning the DSN for GOBHI
Utilization and Medical Management Staff/ Care Coordination Staff		PAs for BH Reporting for BH priority care coordination and access to those services

LCAC Staff	Community liaison	Provides consumer input via meeting minutes from LCAC meetings
Ad hoc representation	Subject Matter Expertise as required	Operational advice and insight

Permanent Committee Roster:

Role	Member	Email
Network Management Subcommittee Co-chair	Kayla Jones	kayla.jones@modahealth.com
Network Management Subcommittee Co-chair	Wendy Chavez	Wendy.chavez@EOCCO.com
Moda Network Strategy	Melisa Strong	melisa.strong@modahealth.com
GOBHI Contract Administration	Colleen Wells	CWells@GOBHI.org
GOBHI DSN SME	Beatriz Olivan	BOlivan@GOBHI.org
GOBHI Geospatial Analyst	Andy Davis	ADavis@GOBHI.org
Utilization Management Staff	Mary Elsethagen	mary.elsethagen@eocco.com
Local Community Advisory Council SME	Jill Boyd	Jill.boyd@EOCCO.com
Dental		
Care Coordination	Mary Elsethagen	mary.elsethagen@eocco.com

EOCCO QIC Policy Subcommittee Charter

Eastern Oregon Coordinated Care Organization (EOCCO)
QIC Policy Subcommittee Charter

The Eastern Oregon Coordinated Care Organization will convene QIC Policy Subcommittee meetings at least quarterly beginning in winter 2020. The EOCCO QIC Policy Subcommittee will be responsible for maintaining and coordinating all policy activities. The EOCCO QIC Policy Subcommittee will be empowered to approve all EOCCO policies upon achieving consensus on the validity and necessity of each policy.

Membership

The members of the EOCCO QIC Policy Subcommittee are comprised of equal decision-making representatives, including, but not limited to:

- QIC Policy Subcommittee Co-chairs;
- Compliance Officer(s);
- Corporate Privacy & Security Officer;
- Medicaid Services Supervisor; and
- Ad hoc representation, as required, by subject matter.

The permanent committee will be comprised of five (5) members.

Meetings

The EOCCO Policy Subcommittee will meet at least quarterly and establish the locations of future meetings at the conclusion of each meeting. An agenda directs the meetings. Documented minutes provide a record of the committee activities, recommendations and actions.

Responsibilities

The EOCCO will oversee all EOCCO policies and procedures by engaging in the following activities:

- Ensure that policies reflect the most up-to-date requirements of the CCO contract, Oregon Administrative Rule (OAR), and Code of Federal Regulations (CFR) by monitoring OHA public hearing notices, the Federal Register, and guidance issued by oversight entities;
- Ensure EOCCO policies are relevant and necessary to CCO operations and rescind any unnecessary and irrelevant policies;
- Oversee and maintain the EOCCO policy library;
- Ensure content owners and subject matter experts are notified of changes to policies and that the policies are reviewed by the appropriate staff as required in contract and OAR;
- Actively participate in readiness review and EQR's;
- Develop the framework of each policy and work with content owners and/or subject matter experts to elicit accurate portrayal of operational procedure; and
- Create and monitor schedules for policy reviews as required by contract, rule, or regulation, and ensure policy reviews are spaced appropriately to have minimal impact on day-to-day EOCCO operations.

Promulgating Policies for Approval to the EOCCO Quality Improvement Committee

If the EOCCO QIC Policy Subcommittee cannot achieve consensus approval for any EOCCO policy, the policy will be promulgated to the EOCCO QIC Committee for review and approval at the next available bi-monthly meeting.

EOCCO Regulatory Compliance Committee Charter

Eastern Oregon Coordinated Care Organization (EOCCO)

Regulatory Compliance Committee Charter

The Eastern Oregon Coordinated Care Organization Regulatory Compliance Committee shall facilitate the Board of Directors' effective oversight of the organization's compliance program, engagement in compliance issues impacting the organization's Medicaid business, and provision of support and resources for the organization's Compliance Officer. The EOCCO Compliance Officer will serve as chair of the committee.

Membership

EOCCO Compliance Officer

EOCCO Compliance Staff

Not fewer than (2) EOCCO Board Members

EOCCO CEO

EOCCO Operations Manager

EOCCO Quality Programs Manager

EOCCO Appeals and Grievance Supervisor

EOCCO Quality and Compliance Program Manager

Meetings

Not less frequently than once a quarter.

Responsibilities

- Verify, approve and facilitate, as warranted, the organizations adoption and periodic review of a compliance plan that encompasses all required elements for the organization's Medicaid business, including overseeing the EOCCO's fraud, waste, and abuse prevention program;
- Review EOCCO's quarterly appeals and grievance log and grievance system analysis;
- Ensure that the organization's compliance activities are supported by adequate staff and other resources;
- Conduct periodic reviews of operational compliance metrics; Receive and direct the organization's response(s) to regular and ad hoc reports from the Compliance and Quality Committees and the Compliance Officer; and
- Take other such actions as are consistent with its purpose.

Quorum

A majority of the members of the Committee shall constitute a quorum and the Committee shall act only on the affirmative vote of a majority or more of the members present at the meeting and entitled to vote.

Authority

The Board has delegated to the Committee the power and authority necessary to accomplish its purpose and discharge its responsibilities. In accordance with its purpose, the Committee shall have authority to meet with and seek any information it requires from employees, officers, directors, or external parties. The Board's delegation of authority to the Committee shall be construed broadly, in accordance with the Committee's purpose.

Reporting to the EOCCO Board of Directors

The Committee shall provide, at intervals as determined by the Board, a report on its proceedings and activities to the Board, including the occurrence of and actions taken in response to any compliance issues coming before the EOCCO Regulatory Compliance Committee. Meeting minutes will be taken for each EOCCO Regulatory Compliance Committee meeting and will be provided within the subsequent EOCCO Board of Directors' meeting material packet.

Approved December 2019

Approved December 2019

February 2020 QIC Agenda

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday February 24, 2020
Moda Tower 24E, 10am to 12:00pm
Phone conference: 800-508-7891, then 2644774#
AGENDA

• Introductions & additions to agenda	5’	
• Review QIC Roster	5’	
• Approve EOCCO QIC Charter	5’	Attachment 1
• Subcommittee Charter Review o Incentive Measure o DEI o Policy o Network Management ○ Member Engagement	30’	Attachment 2 Attachment 3 Attachment 4 Attachment 5 Attachment 6
• Compliance & Quality Report – Nick Gross ○ TQS	15’	
• Other business – All		
• Future agenda items		
• Next meeting: April 27th 2020 10 am – 12 pm Moda Health		

Membership roster:	
Jessica Baurer	Moda Health
Wendy Chavez	GOBHI
Renee Doan, RN	Moda Health

Colleen Duncan	Moda Health
Mariah Emerich	Moda Health
Nick Gross	Moda Health
Jennifer Howell	Moda Health
Todd Jacobson, LCSW	GOBHI
Molly Johnson	Advantage Dental
Karen Keomuangtai	GOBHI
Scott Lenhardt	Moda Health
Hillary Parks	Moda Health
Melinda West	Advantage Dental
Courtney Whidden	Moda Health
Jim Rickards, MD	Moda Health
Corinne Thayer	ODS Community

February 2020 QIC Minutes

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday February 24, 2020
Moda Tower 24E, 10am to 12:00pm
Phone conference: 800-508-7891, then 2644774#

AGENDA

Introductions & additions to agenda

Review QIC Roster

- Did not include dental in this meeting since they are not chairing any of the subcommittees. Kayla to ask Corinne Thayer (ODS) if she would like to serve as a "tri-chair" on the Member Engagement subcommittees so we have dental representation on main QIC. Should also include Advantage DCO representative since they manage ~70% of EOCCO member population.
- Courtney and Summer nominated Mary Ann (Advantage) for both Member Engagement and Incentive Measure subcommittees.
    - Tentatively ask her to tri-chair Incentive Measure subcommittee.
- Discussion on whether the committee should include both ODS and Advantage for dental representation
- Reviewed OAR 141-3525 contract and determined that we will need dental representation as well as Medical Director at future meetings

Approve EOCCO QIC Charter

- Karen presented draft QIC charter, which covered QIC membership, subcommittees, meeting frequency (every two months in even-numbered months), and QIC responsibilities
- Wendy inquired as to whether there is an EOCCO Member Safety committee and/or policy. Summer will research this and report back to the group. ○ Summer suggested changing the wording of the MCE section.
- Troy requested adding a section regarding committee decision-making processes. Committee decided on using majority rule to make decisions, and in the case of a stalemate the decision would be referred to the EOCCO Board since QIC reports directly to the Board.
- QIC will also provide meeting minutes to the EOCCO Governing Board annually, or as requested. The QIC also updated the language in the charter regarding reporting to the Board to reflect current changes in EOCCO's President and CEO positions.
- Summer motioned to approve QIC charter with these updates, Troy seconded.

The QIC voted to approve the charter.

Approve EOCCO QIC Charter ○ Karen presented draft QIC charter, which covered QIC membership, subcommittees, meeting frequency (every two months in even-numbered months), and QIC responsibilities

- Wendy inquired as to whether there is an EOCCO Member Safety committee and/or policy. Summer will research this and report back to the group. ○ Summer suggested changing the wording of the MCE section.
- Troy requested adding a section regarding committee decision-making processes. Committee decided on using majority rule to make decisions, and in the case of a stalemate the decision would be referred to the EOCCO Board since QIC reports directly to the Board.
- QIC will also provide meeting minutes to the EOCCO Governing Board annually, or as requested. The QIC also updated the language in the charter regarding reporting to the Board to reflect current changes in EOCCO's President and CEO positions.
- Summer motioned to approve QIC charter with these updates, Troy seconded.
  The QIC voted to approve the charter.

Compliance & Quality Report – Nick Gross

- TQS team had their collaboration meeting last Wednesday. They hope to have all sections drafted and sent to Nick by Monday 3/2 before starting compilation and review. Final TQS is due to OHA on Monday 3/16. ○ Jenn and Karen volunteered to be on TQS Review Committee for final review.
- TQS team will also send document to full QIC to review prior to OHA submission.

Membership roster:	
Wendy Chavez	GOBHI
Nick Gross	Moda Health
Jennifer Howell	Moda Health
Todd Jacobson, LCSW	GOBHI
Karen Keomuangtai	GOBHI
Courtney Whidden-Rivera	Moda Health
Troy Soenen	GOBHI
Jorge Ramirez-Garcia	GOBHI
Kayla Jones	Moda Health

Janet Holland*	GOBHI
Mina Zarnegin	Moda Health

*Attended by phone

April 2020 QIC Agenda

EASTERN OREGON COORDINATED CARE ORGANIZATION

Quality Improvement Committee

Monday, April 27, 2020

Moda Tower 12A, 10am to 12:00pm

Phone conference: 1-866-691-2764, Meeting: 9593472#

AGENDA

<table>
<tr><td>● Introductions & additions to agenda</td><td>5’</td><td>All</td></tr>
<tr><td>● Review QIC Charter:
o Addition of Oral Health.
o At least one health professional representative of the scope of services delivered.
o Committee Decision Making: Last meeting - “Majority rule to make decisions, and in the case of a stalemate the decision would be referred to the EOCCO governance board for final adjudication.”
▪ This practice would be standard on all Sub-committees with the exception the adjudication would fall to the QIC.</td><td>10’</td><td>Todd Jacobson
Attachment 1</td></tr>
<tr><td>● Sub-committees and co-chairs Report

Quality Improvement Committees
<table><tr><td>QI Committees</td><td>~~GOBHI~~ BH Chair</td><td>~~Moda~~ PH Chair</td><td>Oral Chair</td></tr><tr><td>Member Engagement</td><td>~~Karen K.~~</td><td>Kayla J & Mina Z</td><td>Molly Johnson</td></tr><tr><td>Policy</td><td>~~Wendy C~~</td><td>Jennifer H</td><td></td></tr></table></td><td>60’</td><td>As Listed</td></tr>
</table>

Network Management	~~Wendy C~~	Kayla J			
Incentive Measures	Troy S	Courtney WR	Molly Johnson		
Diversity Equity and Inclusion	Jorge R	Courtney WR			
● Assignment of New GOBHI Chair for subcommittees - If deemed necessary.					

● Assign new Titles for Chairs - including Add Oral Health. ● QAPI program - 410-141-3525 (5) (a-f) - Consensus on if these are subcommittee functions. ● Annual Report - (See QIC requirements below) - Each committee represents a unique reporting requirement which aggregates into an annual evaluation? 410-141-3525(11) (b).		
● EQR process and Update.	30’	Kayla & Mina
● Overall QIC requirements and framework: 410-141-3525(11) (a-d) o Record & produce dated minutes: corrective actions with progression and outcomes. o Annual written evaluation of QI program (TQS/QAPI report as outlined in contract) and of member care as measured against EOCCO P & P related to member care. o Quarterly analysis of complaints and grievances as required by 410-141-3915. o Review written procedures, protocols and criteria for member care no less than every two years, or more frequency as needed to maintain currency with clinical guidelines and administrative principles.	15’	Summer & Todd
● Adjourn		

Roster	Attendance
Courtney Whidden-Rivera	
Todd Jacobson	
Jorge Ramirez	
Troy Soenen	
Kayla Jones	
Jennifer Howell	
Nick Gross	
Summer Prantl	
Molly Johnson	
Dr. Jim Rickards	

April 2020 QIC Minutes

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday, April 27, 2020
Moda Tower 12A, 10am to 12:00pm
Phone conference: 1-866-691-2764, Meeting: 9593472#

AGENDA

● Introductions & additions to agenda ○ Reviewed February minutes. Summer motioned to approve minutes, Kayla seconded. Minutes are approved.	All
● Review QIC Charter: ○ Addition of Oral Health – Nancy Avery has been added to committee ○ At least one health professional representative of the scope :es of servi delivered. ○ Committee Decision Making: Last meeting - "Majority rule to make decisions, and in the case of a stalemate the decision would be referred to the EOCCO governance board for final adjudication." ▪ This practice would be standard on all Sub-committees with the exception the adjudication would fall to the QIC.	Todd Jacobson Attachment 1

● Sub-committees and co-chairs Report ○ Added an oral health co-chair to several subcommittees – Member Engagement & Incentive Measures

As Listed

Quality Improvement Committees

QI Committees	**~~GOBHI~~ BH Chair**	**~~Moda~~ PH Chair**	**Oral Chair**
Member Engagement - Mina has been added as subcommittee co-chair. - Now have both Advantage & ODS representation on committee - Advantage may send different representatives to meetings depending on subject matter being discussed, i.e. may send Marketing staff member rather than Molly on occasion.	~~Karen K.~~ QIC agreed that committee add BH co-chair in the future	Kayla J & Mina Z	Molly Johnson

Policy - Jenn Howell will serve as additional committee chair - Kayla reached out to Becky Miller to serve on committee as tri-chair with Jenn & Kayla - Nick expressed concern that sub-committee does not have oral health co-chair. Molly and Nancy are both willing to serve as members of committee - Previous meeting update: Have met 3 times and have signed off on multiple policies. Also plan on reviewing and signing off on remaining new policies from	~~Wendy C~~ Becky Miller [recommended]	Jennifer H	n/a

Readiness Review. Will likely meet more than once per month in the future due to EQR and other concerns.			
Network Management - Todd recommended that Beatrice serve as GOBHI co-chair. Kayla has reached out to her, do not have a response yet - Have added Missy Mitchell from Advantage & Nancy Avery from ODS for oral health representation - Previous meeting update: Held kickoff meeting in February, added oral health representation. Plan to meet again in next few weeks. Will have physical, oral, and beh. representatives give overview of their networks and main network issues.	~~Wendy C~~ Beatriz Olivan [recommended]	Kayla J	n/a

OHA Transformation and Quality Strategy (TQS) **CCO:** Eastern Oregon CCO

Incentive Measures - Summer will serve as co-chair on this subcommittee so that she can be an official member of QIC - Previous meeting update: Met on 3/17 and reviewed 2019 metric performance. Anticipate meeting either 14 or 15 out of 19 metrics. Reviewed 2020 measures. Brainstormed efforts to address pediatric, immunization, and BH measures. Will create separate workgroups to address BH measures.		Troy S	Courtney WR & Summer Prantl		Molly Johnson
Diversity Equity and Inclusion - ODS and Advantage have representation on subcommittee but do not have a co-chair - Nancy recommended Ana Ovalle-Barry to serve as oral health co-chair - Previous meeting update: Met on 3/24. Jorge provided overview of HE workplan and OHA guidance document. Assigned subject matter experts to certain areas and created workgroups for those focus areas.	Jorge R	Courtney WR	Ana Ovalle-Barry [recommended]		

● Assignment of New GOBHI Chair for subcommittees - If deemed necessary. ● Assign new Titles for Chairs - including Add Oral Health. ● Summer recommended adding a Health Information Technology (HIT) subcommittee as well. HIT was large component of CCO 2.0 RFA and Readiness Review. ○ Kayla and Todd both agreed that this would be beneficial. ○ This group would include Courtney, Fred Lively (GOBHI), Matt (GOBHI), Bill Dwyer (Moda), Lindsey Dew (Moda), Andy Davis (GOBHI), Prescott (ODS) ○ Todd also recommended adding EOCCO Privacy & Security Officer ○ Goal would be to align efforts across organizations and have dedicated group to work on HIT Roadmap ○ Will need to updated QIC Charter to reflect this additional sub-committee ● QAPI program - 410-141-3525 (5) (a-f) - Consensus on if these are subcommittee functions. ○ If QIC agrees that these are QIC functions, Todd would like to assign individuals to address these topics each meeting ○ Todd will send out list of topics that we need covered, then will have participants respond noting which topics they are responsible for ● Annual Report - (See QIC requirements below) - Each committee represents a unique reporting requirement which aggregates into an annual evaluation? 410-141-3525(11) (b). ○ Todd will keep this on QIC agendas moving forward so the committee can check in on regular basis	
● EQR process and Update	Kayla & Mina

○ Have begun to design EQR project plan and deliverables. Goal of this plan is to show that CCO has been able to implement policies detailed in 2019 Readiness Review ○ Have received evaluation tools for each of five Standards that HSAG review will focus on ・ Coordination and continuity of care, coverage and authorization of services, member rights and protections, grievances & appeal systems, member information ○ Upcoming timeline: ・ Record review documentation is currently due 6/30/2020 ・ Materials and documentation due 8/14/2020 ・ On-site visit is mid-September 2020	

OHA Transformation and Quality Strategy (TQS) **CCO:** Eastern Oregon CCO

● Overall QIC requirements and framework: 410-141-3525(11) (a-d) ○ Record & produce dated minutes: corrective actions with progression and outcomes. ▪ Should come up with a standard process to document corrective actions. Kali to add these items into regular meeting minutes. ▪ Subcommittees should also ensure that they are reporting corrective outcomes and actions to full QIC ▪ In the future, subcommittees should submit all meeting minutes to QIC. QIC will then submit these minutes to EQR. ▪ Todd to add agenda item to future QIC meetings to review last QIC minutes *and* each subcommittee's minutes. ● Subcommittee co-chairs will send Todd their minutes prior to each QIC meeting. Make sure to highlight actions needed at bottom of each subcommittee agenda to share at full QIC meeting. ● Co-chairs to send Todd their minutes from January/March as well. ○ ~~Annual written evaluation of QI program (TQS/QAPI report as outlined in contract) and of member care as measured against EOCCO P & P related to member care.~~ ○ Quarterly analysis of complaints and grievances as required by 410-141-3915. ○ Review written procedures, protocols and criteria for member care no less than every two years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles. ▪ Agreed that this annual review will mainly fall under Policy subcommittee with reporting to full QIC as necessary.	Summer & Todd
● Adjourn ○ Next meeting is tentatively 6/22/2020. Will plan on meeting in The Dalles if travel and group gatherings are permitted. Audrey Thomas to send out meeting invite placeholder.	

Roster	**Attendance**
Courtney Whidden-Rivera	Present
Todd Jacobson	Present
Jorge Ramirez	Present
Troy Soenen	Present
Kayla Jones	Present
Jennifer Howell	Present
Nick Gross	Present
Summer Prantl	Present
Molly Johnson	Present

Dr. Jim Rickards	Present
Nancy Avery	Present
Mina Zarnegin	Present

June 2020 QIC Agenda

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday, June 22, 2020
10am to 12:00pm
Phone conference: 1-866-691-2764, Meeting: 9593472#

AGENDA

● Introductions & additions to agenda	5’	All
● Review QIC Charter: ○ New Subcommittee review - HIT	10’	Todd Jacobson Attachment 1
● Quality Improvement Subcommittee Review ○ Are assignments correct? ○ Discussion on TBD listings...could be N/A at this time.	5’	Todd Jacobson Attachment 2
● Sub-committee co-chairs Report • Member Engagement • Policy • Network Management • Incentive Measures • Diversity Equity & Inclusion	45’	As Listed
● QIC Annual Report nudge Following TQS strategy as outlined in the contract for the QAPI and transformational care annual evaluation criteria: ▪ Evaluate quality consistent with priorities outlined in CHA,	10’	Todd Attachment 3 ~~**Someone**~~ who is

				familiar with TQS evaluation criteria.
○ Corrective actions with progression and outcomes, as necessary: (Compliance?) o Over/Under Utilization of services report: (TBD) ○ Evaluate performance and customer satisfaction consistent with contract standards and EQRO standards: (Kayla, Mina & Nick?) o Evaluate grievance, appeal, and contested case hearings: (TBD) ▪ 141-3915 (5) (a-c) - review completeness, accuracy, and timeliness of documents; compliance with written procedures for receipt, disposition, and documentation; compliance with applicable OHA rules [3875-3915] ○ Assess the quality and appropriateness of coordinated care services to all members eligible and requesting these services: (TBD) ○ Evaluation of member care against member care P & P: (see charter for P & P listing - TBD or policy subcommittee?) ○ Network Capacity - diversity, cultural responsive, trauma informed: (Network Management & Diversity Equity & Inclusion subcommittee?) ○ QAPI projects to improve access, quality, utilization of services: (TBD)				
● Adjourn - Next Meeting August 24, 2020 - 10am to Noon				

Roster	**Attendance**
Courtney Whidden-Rivera	
Todd Jacobson	
Jorge Ramirez	
Troy Soenen	
Kayla Jones	
Jennifer Howell	
Nick Gross	
Summer Prantl	
Molly Johnson	

<table><tr><td>Dr. Jim Rickards</td><td></td></tr><tr><td>Nancy Avery</td><td></td></tr><tr><td>Mina Zarnegin</td><td></td></tr></table> CHIP, and Contract. (This is our QAPI - shall we establish one based on next agenda item requirements + CHA/CHIP?)			
● Q1 Grievance Report:		15’	Jenn & Jane
● Overall QIC requirements and framework: Make & Confirm Assignments ○ Record & produce dated minutes: (Kali & Todd)		30’	Summer & Todd

June 2020 QIC Minutes

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday, June 22, 2020
10am to 12:00pm

AGENDA

Introductions & additions to agenda ○ No additions to the agenda	5’	All
Review QIC Charter: ○ New Subcommittee review – HIT: ▪ Courtney Whidden-Rivera was nominated to co-chair this committee with Fred Lively and John Fullman. They have identified all members and will schedule their initial meeting soon.	10’	Todd Jacobson Attachment 1
● Quality Improvement Subcommittee Review ○ Discussion on TBD listings...could be N/A at this time. ○ New subcommittee meeting minutes approval process: Instead of approving previous subcommittee meeting minutes in each QIC meeting, Courtney and Jorge would like to have subcommittees approve minutes by email after each meeting. ○ This is Todd’s last QIC meeting, so we will have to continue this discussion in the future.	5’	Todd Jacobson Attachment 2

● Sub-committee co-chairs Report ○ Member Engagement (Mina): ▪ Last meeting was in April, next upcoming meeting is this Thursday. ▪ Upcoming items: Language access, health equity review (language accessibility implementation), update on using texting to communicate with members ○ Policy (Kayla): ▪ They have been focusing on streamlining policy approval process ▪ Have split P&Ps into 3 phases: ● Phase 1: EQR P&Ps (there are around 28 of these) from the Readiness Review ● Phase 2: Readiness Review P&Ps that are not being used for the EQR	45'	As Listed

● Phase 3: P&Ps that don't fall into either of the previous phases ▪ Subcommittee has created P&P update request form for Moda & GOBHI employees to use ▪ They have meeting week of 6/29 to review additional P&Ps ○ Network Management (Kayla): ▪ Subcommittee met last week to discuss DCO network management. Examined specialty types, counties served, any known network deficiencies. ▪ They will have presentations from NEMT and behavioral health soon. ○ e Measures (Courtney, Troy, Summer): ▪ Previous meeting was on May 19th ▪ Subcommittee has formed 3 workgroups: Childhood metrics, ED Utilization for Individuals Experiencing Mental Illness, and Initiation & Engagement in AOD Treatment ▪ DCOs also shared progress on 2020 incentive measures ▪ EOCCO's Quality Team learned on Friday June 19th that we will receive 125% of quality pool funding for 2019 ($12.8 million)! ● This is the largest percentage of funding EOCCO has ever received from the quality pool and challenge measures		

▪ The state (OHA) also recently announced that they will be suspending the quality withhold for the rest of 2020. This means that CCO's will receive these funds now to distribute among the delivery system to provide immediate relief. ▪ OHA will be voting on how they will adjust incentive measure program for 2020 on July 17th in light of the pandemic. We do know that they will only be incentivizing CCO performance from January – March. ○ Diversity Equity & Inclusion (Courtney, Jorge, Ana): ▪ Ana is the new tri-chair for this subcommittee ▪ Held supplemental meeting in April to discuss gather together focus area teams for Section 2 of the Health Equity Plan ▪ Also met on May 26th to review the remainder of the process for the HE Plan. Reviewed Section 3, which Jorge has been working on. ▪ Will have Section 2 draft ready by this Wednesday June 24th. Have created a 4 person review team for this draft in hopes of having a draft ready by July 1st.		

▪ Will be holding an additional supplemental DEI meeting tomorrow (June 23rd) to discuss recent unrest and systemic racism that is being brought to light.		
● QIC Annual Report nudge ○ Following TQS strategy as outlined in the contract for the QAPI and transformational care annual evaluation criteria: ▪ Evaluate quality consistent with priorities outlined in CHA, CHIP, and Contract. (This is our QAPI - shall we establish one based on next agenda item requirements + CHA/CHIP?) ○ Todd reminded the committee that this report is due end of January 2021 ○ Todd wanted to discuss how well our TQS reflects the CHA and our CHIP. How well do these three items intersect? ▪ Troy to look into this further and will look to identify additional person to take this work on ▪ Nick, Summer, and Kayla to work on aligning deliverables between TQS and annual Quality report. They will bring in DCO input as needed.	10'	Todd Attachment 3 **~~Someone~~** who is familiar with TQS evaluation criteria.

OHA Transformation and Quality Strategy (TQS) CCO: Eastern Oregon CCO

● Q1 Grievance Report: o Jane and Jenn provided a review of Q1 appeal, grievance, and denial performance o 179 total grievances. EOCCO typically sees the highest number of grievances in Q1. ▪ Top grievance types were access to care, provider quality. ▪ Only 1 grievance exceeded the 30 day turnaround time. o 1,397 denials (NOABDs) o 1.45 appeals per 1,000 members. This is slightly above average for Q1. About 50% of appeals were overturned, and all met 30 day turnaround time. ▪ Saw an increase in mental health appeals this quarter which was likely due to COVID and change in continuity of care policy.	15’	Jenn & Jane
● Overall QIC requirements and framework: Make & Confirm Assignments o Record & produce dated minutes: ▪ Kali to continue recording minutes ▪ Troy, Summer, and Nick will discuss who should take over as QIC coordinator ▪ Kali will send out agenda for upcoming August meeting with top agenda item being selecting a new QIC coordinator ▪ Summer requested that whoever is onboarded in Todd’s place has coordinating the QIC as one of their job requirements	30’	Summer & Todd

○ Corrective actions with progression and outcomes, as necessary: ▪ Nick and Compliance to take ownership of this ○ Over/Under Utilization of services report: ▪ Moda: Kayla & Summer to work on this report for physical health. They will loop Jenn in if necessary. ▪ GOBHI: TBD ○ Evaluate performance and customer satisfaction consistent with contract standards and EQRO standards: Kayla & Mina (Nick is optional) ▪ Summer recommends utilizing CAHPS survey to inform this process ○ Evaluate grievance, appeal, and contested case hearings: Jane and Jenn to continue this process ▪ 141-3915 (5) (a-c) - review completeness, accuracy, and timeliness of documents; compliance with written procedures for receipt, disposition, and documentation; compliance with applicable OHA rules [3875-3915] ○ Assess the quality and appropriateness of coordinated care services to all members eligible and requesting these services: Network Management subcommittee (Kayla & Beatriz) ○ Evaluation of member care against member care P&Ps: TBD ▪ First need to identify which P&Ps tie into member care and which do not ○ Network Capacity - diversity, cultural responsive, trauma informed: Network Management and Diversity Equity & Inclusion subcommittees ○ QAPI projects to improve access, quality, utilization of services: TBD		
● Adjourn - Next Meeting August 24, 2020 - 10am to Noon ○ Summer motioned and seconded to adjourn		

Roster	**Attendance**
Courtney Whidden-Rivera	Present
Todd Jacobson	Present
Jorge Ramirez	Present
Troy Soenen	Present
Kayla Jones	Present
Jennifer Howell	Present
Nick Gross	Present
Summer Prantl	Present
Molly Johnson	Present
Dr. Jim Rickards	Absent
Nancy Avery	Absent

OHA Transformation and Quality Strategy (TQS) **CCO:** Eastern Oregon CCO

Mina Zarnegin	Present

Additional attendees: Ana Ovalle (ODS), Jane Moesche (Moda), Becky Miller (GOBHI), Beatriz Olivan

August 2020 QIC Agenda

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday, August 24, 2020
10am to 12:00pm

AGENDA

• Introductions & additions to agenda	5’	All
• Review and approve prior meeting minutes	5’	Summer Prantl Attachment 1
• Q2 2020 Grievance System Report	25’	Jenn Howell and Jane Moesche Attachment 2
• Compliance update: Compliance Committee Meeting update Dental credentialing audit	15’	Nick Gross
• Sub-committee co-chairs Report ○ Member Engagement ○ Policy ○ Network Management ○ Incentive Measures ○ Diversity Equity & Inclusion ○ HIT	60’	As Listed
• EQRO and Mental Health Parity updates	10’	Kayla/Mina
• Adjourn - Next Meeting October 26, 2020 - 10am to Noon		

Roster	**Attendance**
Courtney Whidden-Rivera	
Jorge Ramirez	

Troy Soenen	
Kayla Jones	
Jennifer Howell	
Nick Gross	
Summer Prantl	
Molly Johnson	
Nancy Avery	
Mina Zarnegin	

August 2020 QIC Minutes

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday, August 24, 2020
10am to 12:00pm
Phone conference: 1-866-691-2764, Meeting: 9593472#

AGENDA

• Introductions & additions to agenda ○ Summer is serving as the interim Chair of the Quality Improvement Committee until Wendy Chavez is re-onboarded with GOBHI. ○ Summer introduced Courtney Valenzuela and Astrid Sosa, two new members of the EOCCO team. Courtney is a Health Promotion & Quality Improvement Specialist and Astrid is the Health Equity Administrator.
• Review and approve prior meeting minutes ○ Courtney Whidden-Rivera noted that we need to add Fred Lively and John Fullman as co-chairs of the HIT committee. ○ Courtney W.R. moved to approve the meeting minutes with those edits. Kayla Jones seconded the motion.

- Q2 2020 Grievance System Report
  - Jane Moesche presented a report on Grievances.
    - Only two grievances exceeded the 30-day turnaround time; one was due to a lack of oversight by the Grievance Coordinator, and one was due to underreporting by Customer Service.
  - Jenn Howell presented information on Notices of Adverse Benefit Determination (NOABDs)
    - NOABDs decreased by 26% from Q1 to Q2. Most denials were due to lack of medical necessity.
    - Pharmacy, outpatient, and imaging service types had the highest percentage of NOABDs in the current quarter.
    - Troy asked if denials related to Hepatitis C are common in the EOCCO patient population. Jenn responded that they are not that common, especially since OHA relaxed their qualification criteria for which Hepatitis C treatments are covered.
  - Jane shared information on Appeals data from Q2
    - EOCCO saw a significant decrease in appeals during Q2
    - Pharmacy overturned 45% of appeals, and mental health overturned 100% of appeals.

• The group reviewed final 2019 incentive measure performance and quality payments. EOCCO met 14 out of 19 measures, including meeting all four challenge pool measures, resulting in EOCCO receiving $12.8 million from the quality pool. • The subcommittee also discussed several decisions made by the statewide Metrics & Scoring Committee for the 2020 and 2021 measurement years. 2020 will be a "report-only" year for quality measures, meaning that we will not need to meet improvement targets. CCOs will still need to report on the EHR-based and chart review measures, though we will not need to meet improvement targets. The EOCCO Board will financially incentivize reporting for clinics. The 2021 incentive measure set will be the same as 2020, with the addition of one new health equity-focused measure titled Meaningful Access to Health Care Services for Persons with Limited English Proficiency. • Molly also shared a DCO metric update at the July 21st meeting. Although all measures are report-only for 2020, she still feels confident that EOCCO will perform well on these measures.		

- This subcommittee also has three workgroups focusing on specific incentive measure(s).
    - Audrey Egan coordinates the Childhood Metrics Workgroup, which is working on many projects right now. These include piloting a "swag bag" for first time mothers and creating a mailing campaign to remind parents of pediatric care guidelines. ● Mary Elsethagen (GOBHI) coordinates the ED Utilization for Individuals Experiencing Mental Illness. This group is currently surveying primary care clinics and community mental health providers (CMHPs) on how they track emergency department use.
    - Tracey Blood (GOBHI) coordinates the workgroup for the Initiation & Engagement in Drug and Alcohol Treatment measure. This group is awaiting updating data from Moda Analytics.
- Courtney W.R. also reminded the group that the EOCCO

○ Summit will be held remotely on September 17th .

Diversity Equity & Inclusion: Jorge Ramirez Garcia gave updates.

- The subcommittee has completed a draft of the EOCCO Health Equity Plan.
- The subcommittee has launched their training and education plan on cultural responsibility and implicit bias in an effort to be socially responsible to the recent increased attention on racial injustice.
- The group also hosted a cultural competency training on Thursday 8/20 and Friday 8/21, which was very well-received.
- Astrid Sosa and Courtney Valenzuela will be joining the subcommittee.

○ - HIT: Courtney W.R. gave updates on this new subcommittee.

The group met for the first time on August 3rd and primarily reviewed the subcommittee charter and key OHA deliverables.

- One of the main deliverables is the HIT Roadmap, which is a tracking mechanism for EHR adoption, EHR vendor names, use of health information exchanges (HIEs) for care coordination, and other HIE tools for care coordination and hospital event notifications.
- Several members of the subcommittee attend statewide workgroups on HIT.

▪ The subcommittee also discussed Arcadia updates. Arcadia is a population health management platform that ten PCP clinic systems and hospitals use. One of the goals of working with this platform is to have it function as an HIE, which is more feasible now that GOBHI will be integrating data from its community mental health providers (CMHPs) and DCOs are integrating their dental claims. ▪ Lastly, Community Information Exchanges (CIEs) were discussed. The group will do additional research on available platforms and use cases. ▪ Nick brought up a new CMS Interoperability rule that will be discussed at the next HITAG meeting. He will send Courtney additional information on this prior to the HITAG meeting.		
● EQRO and Mental Health Parity updates ○ Mina Zarnegin shared that they submitted their EQR report to HSAG several Fridays ago. They submitted 289 individual documents as evidence of meeting the five EQR standards and are now preparing for the HSAG onsite visit. They are working on resolving several compliance issues and gaps prior to the onsite visit, and will be reaching to many people ○ Mina also shared that they are finalizing their Mental Health Parity documentation and are getting ready to submit on August 31st . ○ This group will discuss both the EQR and Mental Health Parity items at the next QIC meeting. Summer will also ensure the final submitted items are shared with the group for review prior to the meeting.	10’	Kayla/Mina
● Adjourn - Next Meeting October 26, 2020 - 10am to Noon		
○ Upcoming agenda items: Over- and under-utilization review for both physical health and behavioral health.		

Roster	**Attendance**
Courtney Whidden-Rivera	Present
Jorge Ramirez Garcia	Present
Troy Soenen	Present
Kayla Jones	Present
Jennifer Howell	Present
Nick Gross	Present
Summer Prantl	Present
Molly Johnson	Present
Nancy Avery	Present
Mina Zarnegin	Present

Becky Miller	Present
Beatriz Olivan	Present
Fred Lively	Absent
John Fullman	Absent

Additional attendees: Jane Moesche, Astrid Sosa, Courtney Valenzuela, Kali Paine,

October 2020 QIC Agenda

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday, October 26, 2020
10am to 12:00pm

AGENDA

• Introductions & additions to agenda	5’	All
• Review and approve prior meeting minutes	5’	Wendy Chavez (Kali distributed and displayed)
• Q2 2020 Grievance System Report	5’	Jenn Howell update
• Compliance update: Compliance Committee Meeting update	5’	Nick Gross
• Sub-committee co-chairs Report ○ Member Engagement ○ Policy ○ Network Management ○ Incentive Measures ○ Diversity Equity & Inclusion ○ HIT	30’	As Listed Kayla Kayla, Becky, Jenn Kayla, Beatriz Courtney Jorge, Ana, Courtney Fred, Courtney
• Mental Health Parity updates	5’	Nick

• Behavioral Health Plan	3’	Wendy
• PIP Update	3’	Courtney
• Adjourn - Next Meeting December 28, 2020 - 10am to Noon		

Roster	**Attendance**
Courtney Whidden-Rivera	X
Jorge Ramirez	X
Troy Soenen	X
Kayla Jones	X
Jennifer Howell	X
Nick Gross	X
Summer Prantl	X
Molly Johnson	
Nancy Avery	
Mina Zarnegin	
Wendy Chavez	X
Beatriz Olivan	X
Courtney Valenzuela	X
Ana Ovalle Barry	X
Fred Lively	X
John F	X
Troy Soenen	X
Kayla Jones	X
Jennifer Howell	X

October 2020 QIC Minutes

EASTERN OREGON COORDINATED CARE ORGANIZATION
Quality Improvement Committee
Monday, October 26, 2020
10am to 12:00pm
Phone conference: 1-669-900-6833, Meeting: 873 9802 1151, Passcode: 907752

AGENDA

• Introductions & additions to agenda o Wendy introduced herself – Director of Compliance and Quality for GOBHI. She will be taking over from Summer as QIC chair. o Yuberca was introduced as new member of ODS team, is Manager OHP Contract & Quality Dental Services	All

OHA Transformation and Quality Strategy (TQS) **CCO:** Eastern Oregon CCO

● Review and approve prior meeting minutes ○ Kayla moved to approve, Fred seconded the motion	Wendy Chavez
● Grievance System Report: ○ This new report is due to OHA on November 15th and Jenn will present this to the QIC at the December meeting. ○ Wendy to forward December meeting to Jane Moesche in Appeals	Jenn Howell
● Compliance Committee: ○ No updates – Nick is working to schedule this next meeting	Nick Gross
● Sub-committee co-chairs Report: ○ Member Engagement: Kayla shared that the subcommittee completed a member and provider material development checklist. Document will ensure that all materials developed by EOCCO adhere to OHA guidelines around member communication before they are sent to Moda Health Marketing team. ・ This subcommittee is also working on creating an annual member survey for the first time. The survey will address PCP services, cultural competency, and other health equity-related topics. Wendy asked who from GOBHI will be contributing to the behavioral health questions – Kayla will follow up with her on that. Yuberca inquired as to whether there will be dental questions on the survey – Kayla responded that there won't. ・ Marketing team is also evaluating EOCCO website to ensure content is accessible to all members. They will also be getting all content translated to Spanish. ・ Next subcommittee meeting is this Wednesday, Audrey Egan will be presenting on ○ Policy: Kayla shared that HSAG approves of the policies so far.	As Listed

・ All EOCCO policies have been moved to the shared Google Drive. People without access should reach out to Becky and/or Jenn to have the folder shared. ・ All policies will be moved to PolicyStat platform at the end of Q4 2020. There will be a kickoff meeting to introduce everyone to this platform once this is active. ・ Becky noted that this subcommittee will also be working to track all business areas that a policy may impact in the future.	

○ Network Management: Kayla shared an update that the subcommittee has reviewed BH, NEMT, and physical health networks since the last QIC meeting. ▪ Reviewed Q1 & Q2 Appeals & Grievances. Will be reviewing Q3 data once it is available from Jane's team. ▪ Submitted DSN Capacity Report in August. Will not receive narrative feedback until December most likely, but have a few quick updates to make in the meantime. ○ Incentive Measures: Courtney W-R provided updates. The last meeting was on 9/24 and the subcommittee discussed the Metrics & Scoring Committee's discussion on 2021 benchmarks. The Committee has since voted to use 2019 as a baseline for 2021 improvement targets and to roll forward initial benchmarks chosen for 2020 into 2021. ▪ Troy gave Field Team update and promoted the 9/29 RCAC meeting with Early Learning Hubs. ▪ Molly and Tania gave DCO updates on Preventive Dental and Oral Evaluation for Adults with Diabetes metrics. ▪ There are 3 smaller workgroups that also provided updates. ▪ Childhood Metrics group has developed a pilot Baby Care Kit for new parents. ▪ ED MI workgroup is working with PCPs and CMHPs on their workflows and is drafting a strategic plan for the group. Dr. Davidson from GOBHI has also joined this group. ▪ IET workgroup is working on ways to provide actionable data to providers on this metric. ▪ Kali will be taking over IM subcommittee as physical health chair and will become a member of the QIC by default. ○ Diversity Equity & Inclusion: Jorge shared that Astrid & Courtney V (Val) from the Moda Health side are working very hard on the Health Equity Plan (HEP). ▪ The subcommittee is also working on cultural competency and responsibility trainings for the EOCCO workforce. ▪ Subcommittee is also working on SDoH-E projects with local communities and are developing an agenda for the next RCAC meeting in hopes to move community projects forward.	

▪ Courtney W-R also shared that the subcommittee reviewed Section 2 in their last workgroup meeting and Astrid & Val will be getting the draft ready to submit soon. ▪ Courtney also shared that she is passing off her subcommittee chair position to Val, who will also become a member of QIC. o HIT: Courtney presented updates. At the last meeting the group discussed work on the HIT Roadmap file that will be submitted to OHA. ▪ Courtney also shared with the group that OHA will be discontinuing the CQMR submission site and will be moving back to Excel format due to changes in national reporting requirements. ▪ SDoH data collection discussion. Need to survey landscape to see which screenings are currently available and being implemented in our service area. ▪ Anne King from ORPRN will be presenting at next subcommittee meeting on an SDOH tool that they are using in a grant project.	
● EQRO Update: o There is an upcoming meeting on 11/4 from 1-3pm with HSAG o Nick has reached out to HSAG to ask if they have specific questions/topics they would like to discuss, but hasn't heard back yet.	Nick Gross
● Behavioral Health Plan: Wendy shared that GOBHI is working to develop and release a full BH plan by the December holidays. o Nick noted that GOBHI can submit this plan to him for submission to HSAG.	Wendy Chavez
● Other updates: o Courtney W-R shared that EOCCO Quality Team is hard at work on the Performance Improvement Project (PIP) submissions that are due this Friday 10/30. o Courtney W-R also shared that Val submitted the first Language Access report to OHA and is still working on data collection. Wendy asked Bea to work with Val on data collection from BH providers. o Wendy shared that GOBHI is working on a Crisis PIP and hope to have it submitted soon.	All
● Adjourn - Next Meeting December 28, 2020 - 10am to Noon	Wendy Chavez

Jennifer Howell	Present
Nick Gross	Present
Summer Prantl	Present

Molly Johnson	Absent
Nancy Avery	Absent
Mina Zarnegin	Absent
Becky Miller	Present
Beatriz Olivan	Present
Wendy Chavez	Present
Yuberca Pena	Present
Fred Lively	Present
John Fullman	Present
Ana Ovalle Barry	Present

Additional attendees: Courtney Valenzuela, Kali Paine

B. OPTIONAL: Attach other documents relevant to the TQS components or your TQS projects, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.

Attachments include:

1. **EOCCO Behavioral Health Integration Pilot Project with Wallowa County**
   This provides background on the EOCCO and Wallowa County pilot outlined in *Project 4: Behavioral Health Integration withing EOCCO Primary Care Clinics.*
2. **EOCCO Depression Screening in Dental Offices Pilot Project Overview**
   A FAQ guide and scripting for Project 7: *Behavioral Health Screenings in Dental Offices*
3. **Oral Health Depression Screening Workflow**
   A visual guide to understanding the workflow supporting *Project 7: Behavioral Health Screenings in Dental Offices*

Attachment 1 Behavioral Health Integration Pilot Background

EOCCO Behavioral Health Integration Pilot Project 2020
Wallowa County
Updated: January 2021

Background and Situation: In 2018, Greater Oregon Behavioral Health, Inc. (GOBHI), a majority owner of the EOCCO, developed a 'boilerplate' contract with primary care clinics in the EOCCO region that had intentions of providing behavioral health serves integrated into their primary care clinic and offering a [redacted] rate for each clinic to subsidize these services. In 2019, with the assistance of
Dr. Rachel Morenz and Dr. Kim Humann, GOBHI modified current contracts to include an increase from

[redacted](on a case by case basis), evidence based methodology through the Collaborative Care Model (also called the IMPACT model) to provide a more robust process for data gathering, process monitoring and patient outcomes. These contracts were revised for adult only populations. With the recent restructuring of GOBHI, and the new requirements under CCO 2.0, these developments have propelled the need for a fresh, innovative approach to the Behavioral Health Integration work within the EOCCO. This includes a review of current efforts and contract language and establishing/maintaining a collaborative partnership between primary care and other local behavioral and mental health services including our Community Mental Health Programs.

Recommendations: It is the recommendation of the GOBHI Behavioral Health Integration Team to develop a pilot program in Wallowa County, focusing on the collaboration of Wallowa Valley Center for Wellness and the recently contracted Wallowa Memorial Hospital, who oversees integrated behavioral health services for Mountain View Medical Group in Enterprise and Joseph. This process will incorporate evidence based guidelines and recommendations from service industry experts (*see Appendix A*). The Behavioral Health Integration Project Manager will host a series of meetings, with regular check-ins at 3, 6 and 9 months with the goals to understand the relationship between primary care and the CMHPs, revamp the current contract to be more equitable for all agencies AND the patient served, create a community care team that serves the patient in alignment with CCO 2.0 guidelines and other state and county requirements and create a systems-level integration strategy that is applicable and adaptable to other integrated programs in the EOCCO region.

The Vision for EOCCO Behavioral Health Integration should include:

- Incorporation of a collaborative care team to meet the needs of each patient and situation with:
  - A suitable range of behavioral and physical health care expertise; ○ Shared operations, workflows, and practice cultures; and ○ Formal and on-the-job training ● A shared patient population and mission, and ● A systematic clinical approach:
  - Employing methods to identify patients who have need or may benefit from care; ○ Coordinating with local Community Health Programs;

○ Engaging patients and their families in identifying their needs for care; ○ Involving patients and clinicians in decision making; ○ Utilizing an explicit, unified, and shared care plan; and ○ Systematic follow-up and adjustment of care plan if needed

Date (or date range)	Activity	Data checkpoint	Issues Covered
End of Augustearly September 2020 (Internal GOBHI staff)	● Review of pilot project by GOBHI Leadership ● Development of MOU-signed by all parties ● Overview of current contract obligations for BHI-primary care sites ● Present all written materials with explanation to EOCCO Behavioral Health Integration Subcommittee	● Internal review of baseline data for EOCCO patients (2018-now) for scheduled FFS	
Mid-September (Sept 28, 2020)	Launch of pilot: ● Introductions and purpose/mission of pilot ● Review of current contract from GOBHI ● Discussion of changes to contract language ● Overview of current issues not resolved	● Process for access to services (hours available for patient care)	● Psychiatry workaround (WVCW vs WMH patients) ● Crisis care-need for coordination between entities ● Definition/Model for integration (include in contract) ● Notification of services to patients on supervision of services
Monthly Check-in (Oct 29, 2020)	● Updates on issues from last meeting ● Overview of data tools to enhance communication/collaboration (PreManager) ● Continued discussion of definition/model for integration		● Claim codes needing preauthorization: what is this process? ● Denied claims for services within contract: work with Moda (Noah)-*now embedded in medical contract and adjusting medical claims as of 12/18/20*
Midterm reporting to Internal GOBHI BHI Team and EOCCO BHI Subcommittee			
One-on-one check-ins monthly was recommended (Dec 17, 2020)	● WVCW activity topics include: ○ Use of ED for detox-expensive ○ Residential treatment facility for SUD services-how to manage SUD services with primary care? ○ Need for coordination of care for continuity of care; determine standards of care		● Will review internally with GOBHI team and schedule update after the holidays (pending Feb 2021)
Midterm reporting to Internal GOBHI BHI Team and EOCCO BHI Subcommittee *(*see detailed list below of contract change considerations for EOCCO/GOBHI leadership review)*			
6-month check-in (March 2021)	● Continued discussion and review of contract item changes and potential short term and long term impacts ● Troubleshoot any concerns/issues with team ● Recommendations for systematic approach to primary care integration	● Data points TBD based on identification of integration model	
Midterm reporting to Internal GOBHI BHI Team and EOCCO BHI Subcommittee			
9-month check-in (June 2021)	● Continued discussion of workflow and data tracking ○ Troubleshoot any concerns/issues with team	● Data points TBD based on identification of integration model	

Midterm reporting to Internal GOBHI BHI Team and EOCCO BHI Subcommittee			
12-month checkin (September 20201)	● Present final recommendations to GOBHI/EOCCO of systematic approach to primary care integration ○ Contract changes ○ Data tracking ○ Access to care	● Data tracking workflow ● Comparison to baseline data ● Potential cost analysis?	

Timelines: The launch of this pilot program will begin in mid-September, with a tentative start date of September 15, 2020. All timelines are tentative due to the COVID-19 pandemic and are to remain flexible to all involved parties. While the check-ins are every three months, all involved parties will have regular technical assistance from the BHI Project Manager and other GOBHI/EOCCO staff.

Pilot Benefits: Outlined list of incentives primarily for BHI-primary care clinic

- [redacted] for assigned EOCCO members, with potential opportunity for growth pending impact of BHI implementation CCO-wide
- "No Wrong Door" approach to provide comprehensive patient care, including same-day consultation, and warm handoffs
- Strengthening the collaboration with local Community Mental Health Programs and streamlining workflows, information sharing and overall process for improving the health and wellness of patients
- Potential for meeting/exceeding EOCCO Incentive Measures (specifically ED Utilization for Mental Illness, SBRT screening and Initiation and Engagement to Treatment)
- Technical Assistance from GOBHI/EOCCO staff for quality and process improvement, PCPCH recognition and workflow development and maintenance

*Contract Change Considerations: Updated Contract (July 2021)

(Based off first five months of pilot work and one-on-one interactions with current, contracted clinics)

1. Contract comparison between CMHP contract and PCPCH PMPM contract -- ensure there is complimentary information between both entities
    a. CPT codes need to match up with all nine contracts
    b. Inclusion of new CPT codes for pediatric practice integration work (transition of care, developmental delay assessment, surveillance codes for follow-up with parents via phone/email, etc…)
    c. Inclusion of H0023 for Behavioral Health Outreach [request from WVCW]
2. New BAA agreements for all organizations
    a. Include coordination of care language between CMHP and PCPCH
    b. Provide "role of CMHP" presentation and PCBH Training Manual (*see attached)* with new contract
3. Payment level varies based on PCPCH tier status
    a. PCPCH the best model to use? Change contract language to Tier 4 and higher as a requirement of integration? Remain at Tier 3, 4 and 5 Star with staggered payment?
    b. Other levels of integration [5 stages from co-location to full integration] could also be included
4. Review of data with contracted PCPCH clinic on a regular basis. Determination of data to review:
    a. Metrics based incentives for EOCCO Quality Measures [ex: ED Utilization for Mental Illness, DHS Measure, Initiation and Engagement to Treatment, etc…]

   b. PHQ-9, GAD-7, other recommended screening rates over time to monitor improvement?
      i. How often? Quarterly? Monthly? Who would track this data and report out?
      ii. Should yearly contract renewal be manual to enforce data review, QI expectations and additional training needs by clinic? If so, who would do this work?
5. Adding CCO 2.0 Compliant standard terms and conditions, including appropriate references to Exhibit M
6. Inclusion of clinic roster updates with BHC changes within 10 days of change
7. Consideration of including CHW CPT codes (in effect September 2020)
8. Determination of model: Primary Care Behavioral Health (PCBH) model is widely implemented in most of the contracted clinics
   a. Review what data is recommended to track/review/monitor
   b. Is this a best practice model for pediatrics clinics?
   c. Evidence based for pediatric practices?
9. Consideration to have separate contracts for FQHCs, RHCs and pediatric practices?
   a. Varied level of reimbursement for FQHCs vs. RHCs vs. private practice-are there liability concerns since all funds come from CMS? Consult with Craig?
   b. Varied CPT codes for pediatric vs. adult practices for integration?
   c. Differences in integration work between pediatric and adult practices using PCBH model?

Funding Considerations (additional information from Dr. Hoffman)

- Current EOCCO PCPCH rates as of 4/20/20: [redacted] (from Chuck Hoffman)
  - Distribution is [redacted] Tier-based and [redacted] Risk-adjusted.
  - PMPM Adjustments, if any, for the 4/1/21 contract year have not been determined but we hope to have at least a [redacted] increase.
  - Distribution, subject to Board approval, will be [redacted] Tier-based and [redacted] Risk-adjusted. It hasn't been determined if there will be a performance-based component due to OHA's decision to make 2020 a report-only year. The original plan was to institute a [redacted] performance-based component on 10/1/21 based on 2020 metric performance.
- Current EOCCO PCPH BHI rate: [redacted]

Additional Concerns/Recommendations

- *Concern*: Licensing of new BHC providers being paid through FFS model and no clinical oversight from CCO. Licensed clinicians receive a higher FFS Rate for psychotherapy than the rate they receive through the CMHP.
- *Concern*: Crisis/acute care support for CMHP who hold the contract for crisis work (significantly impacts patient care and budget); *(crisis rates have increased by 200% in some counties in 2020)* need to identify contract language, coordinate care with CMHP and provide training/resources for primary care clinics.
- *Concern:* Many clinics are eager or have already implemented the PCBH Model, while other clinics seem resistant and want to be a primary BH clinic for members.
- *Concern:* Some Primary Care Clinics and/or private clinicians serve members with a SPMI Diagnosis without including care coordination with the member's CMHP. If a member goes into crisis and is admitted to hospital, the crisis worker will not be familiar with their symptoms and/or case. Since our CMHPs are responsible for acute inpatient psychiatric and long term psychiatric care, they have expressed concern about these members not being in their care.
- *Recommendation*: If clinics agree to serve a member with a SPMI Diagnosis, require coordination of care with the CMHP; language will be included in contract/BAA with CMHP.
  Require signed ROI from member once initial assessment is completed

- *Recommendation*: Adaptation of Primary Care Behavioral Health Implementation Manual through Patient Centered Primary Care Institute (PCPCI): http://www.pcpci.org/pcbhimplementation-kit-library
- *Recommendation*: Ongoing support and training by GOBHI/EOCCO staff regarding onboarding of new staff, referral requests, coordination of care assistance, case management, CMHP roles and responsibilities, and other needs as available

Appendix A: Eight Core Competencies for Behavioral Health Providers Working in Primary Care
http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-forBehavioral-Health-Providers-Working-in-Primary-Care.pdf

1. **Identify and assess behavioral health needs as part of a primary care team**. BH providers apply knowledge of cognitive, emotional, biological, behavioral, and social aspects of health, MH, and medical conditions across the lifespan; and incorporate their clinical observations into an overall, team-based primary care assessment that may include identifying, screening, assessing, and diagnosing.
2. **Engage and activate patients in their care**. BH providers engage patients in their care, helping them understand how their BH factors affect their health and illness, and how the BH aspects can be integrated in a team-based care plan.
3. **Work as a primary care team member to create and implement care plans that address behavioral health factors.** BH providers work as members of the primary care team to collaboratively create and implement care plans that address BH factors in primary care practice. These factors may include mental illness, substance use disorders, and physical health problems requiring psychosocial interventions.
4. **Help observe and improve care team function and relationships.** BH providers help the primary care team monitor and improve care team function and collaborative relationships. By knowing their own and others' roles, they help the team pool knowledge and experience to inform treatment, engage in shared decision-making with each other and with patients, and share responsibility for care and outcomes.
5. **Communicate effectively with other providers, staff, and patients.** BH providers in primary care communicate effectively with providers, patients, and the primary care team with a willingness to initiate patient or family contact outside routine face-to-face clinical work. BH providers communicate in ways that build patient understanding, satisfaction, and the ability to participate in care.
6. **Provide efficient and effective care delivery that meets the needs of the population of the primary care setting**. BH providers in primary care use their available time and effort on behalf of the practice population, setting prioritized agendas (with roles and goals) with patients and the team, managing brief and longer patient encounters effectively, and identifying areas for immediate and future work with appropriate follow-up care for which BH availability is maintained.
7. **Provide culturally responsive, whole-person and family-oriented care**. BH providers in primary care employ the biopsychosocial model – approaching healthcare from biological, psychological, social, spiritual, and cultural aspects of whole-person care, including patient and family beliefs, values, culture, and preferences.
8. **Understand, value, and adapt to the diverse professional cultures of an integrated care team**. BH providers act in ways consistent with the collaborative culture and mission of primary care with an attitude of flexibility. BH providers adapt their work style to meet patient needs while building confidence and comfort in working in primary care culture, with providers, and medical situations.

Appendix B: List of Current PCPCH sites with Integrated Care Contracts [as of 1/1/21]

OHA Transformation and Quality Strategy (TQS) **CCO:** Eastern Oregon CCO

Clinic Name	County	EOCCO Members (as of 12/19)	Point of Contact	Additional Information
Columbia River CHC	Morrow	1274	Terri Dickens	FQHC; Tier 3 PCPCH
Winding Waters CHC	Wallowa	1592	Keli Dennis	FQHC[redacted]participate in MindEye program (CCM for pregnant mothers) through Aims Center; 5 Star PCPCH
Grande Ronde Hospital	Union	3584	Jim Sheehey	RHC; [redacted] 5 Star PCPCH
Snake River Pediatrics	Malheur	2323	Chelsey Bidwell	RHC; [redacted] Tier 4 PCPCH
Valley Family CHC	Malheur	4457	Sara LudovicYoung	FQHC;[redacted] Tier 4 PCPCH
Yakima Valley Farm Workers: Mirasol Clinic	Umatilla	4795	Carlos Oliveras; Irma Solis	FQHC;[redacted] 5 Star PCPCH
Pioneer Memorial Clinic/Morrow County Health District	Morrow	2279	Emily Roberts	FQHC;[redacted] Tier 4 PCPCH
Lake Health District	Lake	1083	Charlie Tveit	RHC; [redacted]; Kim Humann is Medical Director; Tier 4 PCPCH
Wallowa Memorial Medical Clinic	Wallowa	487	Joe Wanner	RHC; [redacted]; Tier 4 PCPCH

Attachment 2 Oral Health Depression Screening Pilot FAQs

EOCCO Depression Screening in Dental Offices Pilot Project Overview

Patients with behavioral health issues can access the behavioral health system in numerous ways and places but there remains an important missing portal to mental health and addictions treatment, specifically the oral health system. Dentists are an integral part of the health care system yet those who see OHP enrollees have no easy way to refer EOCCO members to behavioral health services.

This pilot project proposes to implement behavioral health screening methods, specifically depression screening, in five dental offices. Office-based patient health questionnaire screening methods are already in use by physical and behavioral health providers in EOCCO's service area and don't need to be re-invented for oral health providers. What does need to be determined is what to do when a dental patient has a positive screen. Pilot dental offices will be provided direct access to GOBHI's Care Management (CM) staff. GOBHI's CM staff can immediately determine whether a member is already receiving behavioral health services or has in the past and from there collaborate with the dental office to plan the best way to make a behavioral health referral work.

A simple phone call to one of GOBHI's Care Coordinators with the member's identifying information and the concern is all that will be necessary to initiate a referral. From there the Care Coordinator will contact the member and discuss the possibility of access to the behavioral health system. If successful, the Coordinator will then contact the appropriate program to make the referral, documenting along the way. A GOBHI CM staff person will maintain contact with a referred member though the transition to the behavioral health system intake and ongoing treatment process if necessary.

The intention of this pilot project is to modify workflows based on what appears to be working while making adjustments or retiring strategies that are not successful.

Frequently Asked Questions

1. **Why is this proposal being considered?** EOCCO is committed to Oregon's vision of coordinated health care and breaking down the silos between dental, physical, and behavioral health. We know that depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning. Identifying and treating depression in its early stages is critical. Our goal is to provide these screenings at all points of health care access.
2. **Has this been done before?** Several clinics in EOCCO's service area have integrated dental, physical, and behavioral health. These clinics have been providing standardized depression screening for several years.
3. **How long will the pilot run?** We anticipate the pilot will run for 12 months with continuous improvement throughout the course of the project. The start date is 5/3/21.
4. **Will dental offices be required to obtain a Release of Information (ROI)?** An ROI is not necessary between EOCCO providers in order to share personal health information for the purpose of care coordination as set out by HIPPA. A release is familiar to our members however, and it provides a

convenient way to discuss the topic and explain to the member why a referral is being recommended by the dental provider.

5. **Who should be screened?** The United States Preventative Services Task Force (USPSTF) recommends age-appropriate screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years, adults 18 years and over, and all pregnant and postpartum women at least annually.
6. **What screening tools should be used?** The Patient Health Questionnaire (PHQ) is a self-administered screening tool for signs and symptoms of depression. This link includes the PHQ screening tools and an overview of scoring https://www.med-iq.com/files/noncme/material/pdfs/LI042%20IG%20tools.pdf. You can find the PHQ screening tools in multiple languages here as well https://www.phqscreeners.com/.
7. **How should I administer the PHQ?** The PHQ-2 refers to the first two questions of the PHQ-9. The dental practice can provide a printed copy of the PHQ-2 at check-in as a self-administered preliminary screening tool before entering the exam room. If the patient scores a 0-2 then they do not need to continue through the remaining questions. If the patient scores a three or greater, then the patient needs to answer the remaining seven questions of the PHQ-9 in the exam room with the provider.
8. **How should I score the PHQ-9 and what follow-up is needed?** A dental provider needs to review the screening results. If a patient receives a score of 10 or greater on the PHQ-9 then a referral to GOBHI's Case Management team needs to be made via your DCO Case Management team. If the patient scores above 0 on question #9 then a referral to GOBHI's Case Management team also needs to be made for suicide risk. A dental provider may refer any patient regardless of their score on the screening if the provider recognizes a need.
9. **How will EOCCO monitor the program?** Dental practices will submit the PHQ-9 to the DCO Case Management team for them to track the positive screenings. EOCCO uses a care management program that will be used to track members who are referred to GOBHI's Case Management staff through the pilot. We hope to see improved oral health as a result and will share the information with pilot participants.

Patient Talking Points

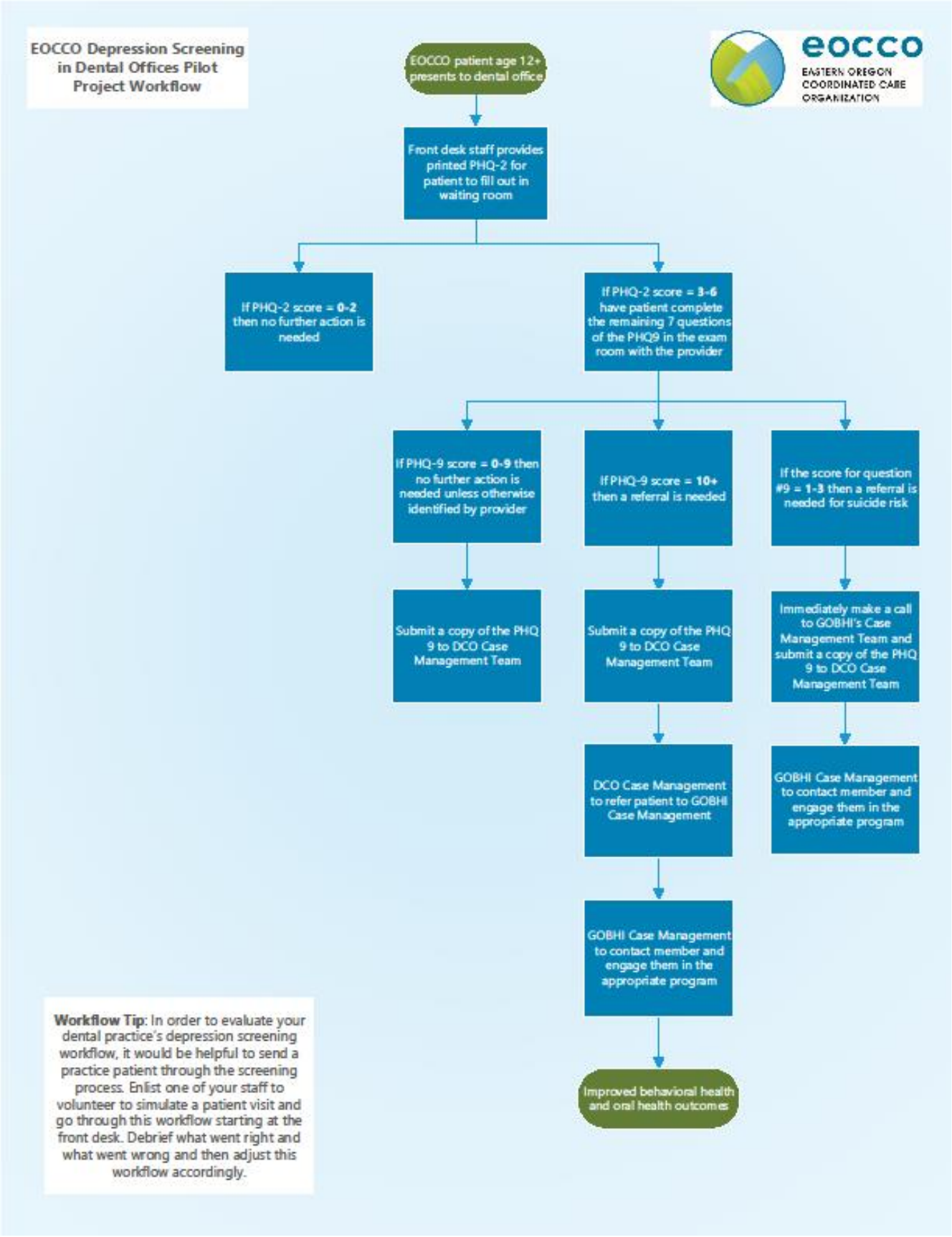
Patient Question: Why do I need to fill this out? If I don't feel like I have these problems, should I still fill this out?
Answer: This information is just important as taking your blood pressure or temperature. It helps your dentist understand your overall health and well-being.

Patient Question: Do I have to fill this out even if I'm not comfortable answering these questions? Answer: You never have to fill out a form or answer questions that you're not comfortable with. If you have concerns about completing this, I'll tell your dentist you would like to talk about it.

Patient Question: I would rather just talk to my provider about these questions instead of filling this out. Is that OK?
Answer: Yes, of course.

Patient Question: I don't understand some of these questions. Can you help me?
Answer: If you have questions about the specific items on the form and how they apply to you, it would be best to talk about that with your dentist.

Attachment 3 Oral Health Depression Screening Workflow



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

Submit your final TQS by March 15 to CCO.MCODeliverableReports@state.or.us.