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Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed) **Short title**: 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 prioritizes identifying members with Special Health Care Needs (SHCN) in order to ensure they have appropriate services based upon their diagnosis, service history, existing supports, and daily functioning. EOCCO fundamentally understands that members with SPMI should be supported with quality community based services that reduce the frequency of visits to the emergency department, and for inpatient psychiatric admissions. Not only are those services costly, they are also not the appropriate settings to manage SPMI long term. Members with SPMI have significantly better outcomes when they receive consistent appropriate services, in an appropriate care setting.

The EOCCO care coordination team continued to monitors key indicators that are predictive of ongoing inappropriate and costly behavioral health care services, and coordinates with CMHPs to engage in case planning to support the implementation of services that are appropriate and more likely to stabilize and manage the member, and increase their overall quality of life and ability to remain in the community. Those indicators come from enrollment and claims data, as well as daily ED monitoring, and communication with CMHPs.

EOCCO understands that a multi-faceted approach is needed to identify members most in need of

intensive outpatient services including Assertive Community Treatment (ACT).

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

EOCCO has made progress since the initiation of this project to implement a structure and process that supports the identification of members with SPMI in need of care coordination, open and ongoing communication between EOCCO care coordinators and service providers, primarily through Exceptional Needs Care Coordinators (ENCC) at CMHPs. EOCCO understands that a multi-faceted approach is needed to identify members with SPMI who are currently eligible for and in need of community based healthcare services to decrease the frequency of members needing treatment in care settings that are not intended or appropriate to manage their needs.

As we continue to develop a multi-faceted approach, EOCCO has implemented several approaches that support the development of structure and process for identifying and supporting members with SPMI who are likely to qualify for ACT or other intensive community based services. We continue to seek ways to identify members in need, and prioritize members for outreach and engagement. Targeting these members is labor intensive so EOCCO understands that we need to continue to narrow down to identify a list of members that is manageable and does not overburden CMHPs. In order to identify a workable list of members in need, we have adjusted some key indicators to filter out members, who despite an SPMI diagnosis are not appropriate for ACT, or ICC, and whose needs are already being met. We are aiming to identify the members most in need, which requires the ongoing fine tuning of inputs and approaches.

The implementation of daily clinical liaison meetings to review EOCCO member visits to ED is completed with the CMHPs, community partners, and EOCCO clinicians. It is overseen by a psychiatrist. These meetings help identify an appropriate course of clinical interventions. Supporting EOCCO members seen in the ED the previous day/night for behavioral health services has significantly increased our ability to engage these members in alternative services reducing returns to the ED. These daily meetings allow for identification of members and case planning in real time while members are still currently in the ED, or have been discharged in the last 1-3 days depending on if discharge occurred on the weekends. Monday liaison meetings tend to screen a significant number of members.

While the daily clinical liaison meetings are very productive and critical to supporting the urgent needs of members with SPMI, EOCCO continues to identify ways to proactively identify members and support them prior to being seen in the emergency department. In order to do so EOCCO has utilized the following additional approaches;

- Utilizing the special health care needs report as a starting point to anticipate likely eligible member eligibility
- Utilizing 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.
- Monitoring members with an IMP on their progress towards goals, and enrollment in
- appropriate 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 our 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 adjust the inputs for data pulls that will allow us to provide checks and balances, ensuring our members most in need of intensive community based services are identified. EOCCOs data team in conjunction with the integrated services team will continue to whittle inputs to narrow the list of members needing outreach for engagement in case management, and enrollment in intensive community based services. Data used to in this process includes;

- Specific ICD-10 Codes
- ED Visits (# and frequency)
- Specific Service Claims (Pharmacotherapy, Psychosocial therapy, Supported Employment Services， Social skills training, Peer Delivered Services, Case management)
- ACT Roles

The continued adjustments of data parameters and key touch points will allow us to identify a list of members that is more prioritized, and case plan in a formal manner with CMHPs who as the service provider will have additional information about those members needs if they have received services previously. Specifically for ACT there are factors related to functional impairments, employment, and safety of current living arrangements.

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

Activity 1 description: EOCCO data team will work in conjunction with the Intensive Services Director, and Care Coordination team to develop more narrow parameters that result in a refined list of members to help identify the most in need members. Care coordination teams will use this list to work with CMHPs to ensure the members are receiving appropriate services. The list of members based upon the development of more narrow parameters will be used as a checks and balances and supplement the work being done in daily liaison meetings to review members seen in the ED, and other existing structured communication with CMHPs to identify members needing intensive community based services.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Development and review of target members list, formal and informal communication with CMHPs.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2021 data pulls were too broad to identify a useful list of members to screen for ACT or alternative intensive community based services.	Development of data parameters that will allow for a narrower accurate list of members to screen. We are aiming for a list of around 100 members.	End of Q2 2022	Quarterly Data pulls provide a list of members needing to be screened by the care coordination team.	Q3 2022 Ongoing
Lists based on data pulls in 2021 were too large to use meaningfully in conjunction with CMHPs.	Quarterly lists will be shared with CMHPs to help them identify members in need of ACT or intensive community based services.	End of Q3 2022	EOCCO Care Coordination team will provide member outreach to support member engagement in appropriate services.	End of Q3 2022

A. Project short title: Enhancing Language Services for Spanish Speaking Members Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

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 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 understands the importance of delivering culturally appropriate services, which includes providing linguistic assistance to individuals with limited English proficiency (LEP). Members with LEP are identified through OHP enrollment files and supplemental information collected from clinics through the quarterly Language Access Reports. The Language Access Reports have provided a rich source of data for understanding a.) Which members are receiving or declining interpreter services and b.) The clinics' resources and modalities for providing interpreter services. This is particularly helpful in understanding which areas of our frontier landscape struggle to access adequate resources.

Though EOCCO provides interpreter services to assist members in receiving care in their preferred language, an internal analysis concluded that fewer members are accessing the service than we originally believed. Claims information suggest that of the 34,227 encounters for Spanish speaking members only 460 (1.3%) used an interpreter through EOCCO's language service provider, Passport to Languages. Upon further review we determined that most members are receiving some sort of language assistance (through the use of bilingual staff members, or a language service provider hosted by the clinic), however those providing interpretation were not always trained health care interpreters (HCI). This served as an opportunity to correct clinics who were out of compliance with EOCCO's Language Access policy and remind them of the federal and state requirements for providing members with timely access to professionally trained interpreters. While we will continue to work with clinics, EOCCO decided to outreach to members with LEP to inform them of services that are available to them at no cost.

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

This project seeks to raise awareness of CCO-covered services among Spanish speaking members. This will be addressed by a.) Tracking the utilization of interpreter services through the quarterly Language Access Reports and b.) Developing a member outreach campaign to increase awareness and utilization of support services.

Internally, EOCCO will closely monitor data through the Language Access Report. Our CCO has made it a practice to collect additional information on member encounters than what is required on the template provided by the state. This helps us determine which clinics have robust language access systems in place and which need additional support providing adequate interpreter services for members. For those clinics needing assistance EOCCO will provide education

on the appropriate use of health care interpreters and encourage they utilize our language service provider who contracts with OHA qualified and certified interpreters. We hope that this leads to an increased rate of utilization of interpreter services through EOCCO's contracted language service provider.

In the previous TQS submission EOCCO identified the need for creating an outreach campaign that notified Spanish speaking members that they have the right to a professional interpreter at no cost to them. In 2022, this project was expanded into a mini-resource guide to help member's access different services provided by the CCO. Referred to as the *Spanish Resource Guide*, this project will use transcription services to create a resource sheet letting members know that they have access to an interpreter, non-emergent medical transportation, traditional health worker (THW) services, and local community health partnership meetings (a pathway to the Community Advisory Council) along with instructions for accessing each of these services. The *Spanish Resource Guide* will be distributed to clinics, community based organizations, and community events tabled by EOCCO.

Modifications:

- This project was previously called the *Language Access Plan* in 2021 but has since been updated to *Enhancing*

Language Services for Spanish Speaking Members to avoid confusion with other language access efforts led by the CCO.

- I Speak cards will still be provided to clinics, however the outreach component for 2022 will focus on producing and disseminating the *Spanish Resource Guide*.

E. Brief narrative description:

Across all twelve counties Spanish is the most prevalent language, accounting for roughly 90% of members with a preferred language other than English. This is followed by Arabic, Somali, Marshallese, Chinese, (Cantonese and Mandarin) and Sign language which all individually account for less than 1% of our CCOs membership. For this reason, EOCCO has focused our efforts to help Spanish speaking members' better access services. This will be accomplished by monitoring the quarterly Language Access Reports to identify clinics who are not providing appropriate language services to their members and developing a member outreach campaign to increase awareness and utilization of support services. These tools will serve as a framework for expanding and developing resources in other languages as needed.

To improve access to our EOCCO services, this project considers the cultural and linguistic background of our members and specifically addresses the needs of individuals who have limited English proficiency (LEP). Our focus in 2022 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 requesting services that support whole-person care. This includes requesting a ride to and from appointments, Traditional Health Worker types, interpreter services, etc. This will meet CLAS Standards 5 and 6.

F. Activities and monitoring for performance improvement:

Activity 1 description: Identify clinics that are unable to consistently provide professional interpreter services and provide education on how to request an interpreter through EOCCO's language service provider. Using the Language Access Report and the LSP invoices, track the number of Spanish interpreter services provided to members at these clinics through Passport to Languages.

☐Short term or ☒ Long term

Monitoring measure 1.1	Increase utilization of EOCCO's language service provider for clinics who are not			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

Some clinics have been identified as having unreliable process for providing interpreter services, however a formal training has not been developed.	Partner with 3 clinics to provide education on requesting a professional interpreter through EOCCO's LSP.	12/2022	Provide formal education on requesting a professional interpreter through EOCCO's LSP for at least 6 clinics.	12/2023
No clinics are being monitored for using EOCCO's LSP to provide interpreter services.	Monitor 3 clinics who struggle to provide consistent interpreter services.	12/2022	Monitor 6 clinics who struggle to provide consistent interpreter services.	12/2023

Activity 2 description: To further assist members coordinating support services, EOCCO will create and mail a *Spanish Resource Guide* to all members with a preferred language of Spanish. Additional resource guides will be provided to clinics and community-based organizations to assist in distribution.

☒ Short term or ☐Long term

Monitoring activity 2 for improvement: Add text here

Monitoring measure 2.1	Develop and distribute resource guide			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
N/A	Resource guide developed and mailed to all Spanish speaking members	08/2022	EOCCO to partner with clinics and CBOs to distribute additional guides	12/2022

A. Project short title: Improvement and Stratification of Health Equity Data

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

If continued, insert unique project ID from OHA: Add text here 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. Over the past year, EOCCO began collecting additional data through the Accountable Health Communities (AHC) project.

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 OHA 834 enrollment files. After working with our CCO's Data Science team we were able to identify several challenges that will need to be resolved before integrating other data sources:

- EOCCO will need to create a standardized list of data collection points. Data collected from various sources will need to be organized within the predetermined fields.
- The Data Science team will need to determine a "source of truth" that allows the data warehouse to reconcile conflicting demographic data coming in from two or more sources.
- The Data Science team will need to ensure that all formulas are captured on the backend, so that analysts are able to identify which data source is being reflected in the member's file.

While EOCCO had originally hoped to use information from Arcadia to reduce the number of members who had 'unknown' listed as part of their demographic profile, this process proved to be more complex than we anticipated. A platform upgrade led to issues of missing data, leading EOCCO to question the validity of Arcadia. Additionally, the scope and complexity of integrating Arcadia data proves to be much more time-consuming than anticipated. For this reason, EOCCO chose to prioritize integrating AHC data until Arcadia's data quality issues have resolved.

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 2021, we have taken steps to improve the quality of our member data. Working closely with the EOCCO Data Science team we learned what steps needed to be taken to integrate updated REALD data from external sources. The Data Science team suggested prioritizing AHC data over Arcadia because this survey consistently captured data, whereas Arcadia's inputted data varied between clinics. Moving forward we will prioritize integrating AHC data first, then reconsider Arcadia as data quality issues resolve.

As of March 2022, AHC screenings were administered to 378 EOCCO members. Of the total number of members who received a screening 352 provided an answer for their race/ethnicity. Over the next year, EOCCO hopes to integrate these demographics into the data warehouse as the first external data source that would provide updated demographics. While we realize this is a small percentage of EOCCO's total population, EOCCO is focused on the *process* of achieving an effective integration of data before adding in additional, potentially larger batches of data.

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. As EOCCO continues to incorporate more trusted data sources, such as our Accountable Health Communities (AHC) screening data and information from our Health Information Exchange (HIE), Arcadia Analytics, we hope to improve the overall quality of our data. This project will strengthen our ongoing procedures to store, retrieve, and use demographic data of our EOCCO members that meet the REALD standards. 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 completed AHC screens to improve our member records in our data analytics warehouse.

Arcadia will save the most updated demographic data from any of the aforementioned data sources to store in the member's profile. Baseline data was pulled from 834 enrollment files in December 2021, which indicated that 44.8.3% of our membership reported "unknown" when identifying their race. EOCCO hopes to decrease the rate of members who report "unknown" for their race through the integration of AHC data.

☐Short term or ☒ Long term

Monitoring measure 1.1	Reduce overall percentage of members with an unknown response for race/ethnicity			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
44.8% unknown race	Reduced by 1.5% through AHC data	12/2022	Reduce by 11% through all data sources	12/2025

A. Project short title: Culturally Responsive Services by Community Health Workers

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

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 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? 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.

EOCCO continues to emphasize the recruitment, training, and retention of Community Health Workers (CHWs). Community Health Workers are an essential bridge to appropriately communicate information and assist members with navigating healthcare systems.

Due to a continued emphasis on COVID-19 and pandemic response, efforts to assess CHW capacity (activity 1) continued to be limited. EOCCO will carry this project forward and continue to prioritize this workforce assessment into 2022. EOCCO has gathered REAL-D data on the existing CHW provider network across all 12 counties and plans to use this data in a more complex capacity analysis. EOCCO has increased focus on continuing education opportunities for CHWs to support retention and support of the workforce, addressing activity 2 of this project.

In 2022, EOCCO will carry activity 1 forward and continue to analyze capacity needs based on REAL-D data. EOCCO made significant process on project 2 through CHW-specific billing trainings and has met the projected target for increasing CHW claims for reimbursement. EOCCO will continue to work towards the project benchmark, after which this component of the project will be fully matured and prepared for retirement.

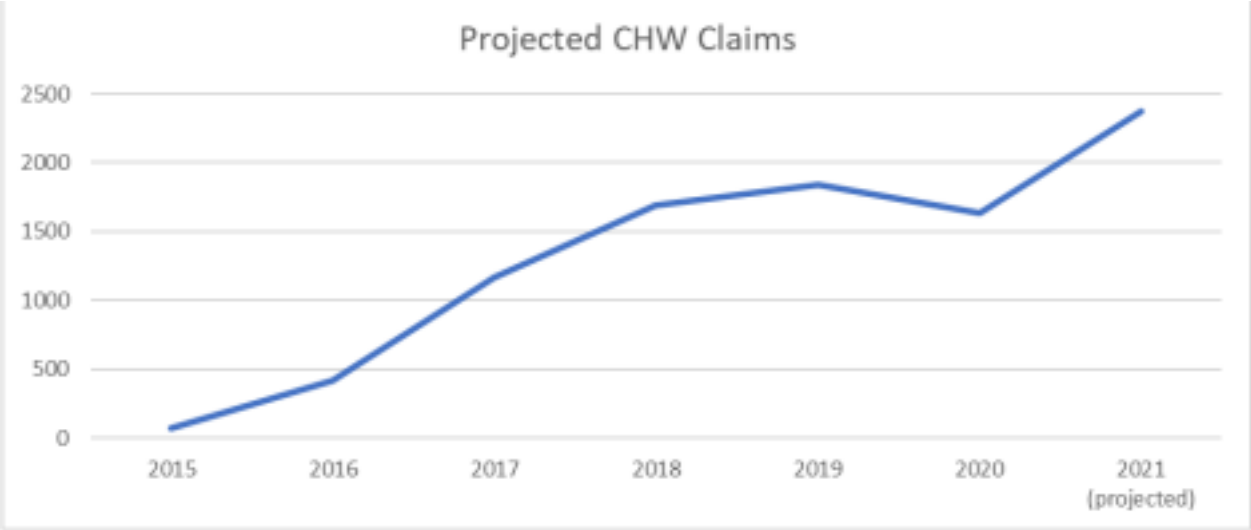
D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

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.

EOCCO has continued to emphasize the integration and utilization of CHWs in the larger provider network. The disproportionate impact of the COVID-19 pandemic on priority health populations has emphasized the importance of improving the care delivery system with culturally responsive and community-focused care. The below graph shows the upward trend of CHW utilization in the EOCCO service area; the expansion of CHW services across the service shows a need for continued emphasis on this provider type. The graph projects CHW claims into 2021 due to a 90-day claims runout period impacting data accuracy for 2021.



EOCCO continues to survey CHW employers annually to understand the needs of the workforce. In 2021, EOCCO included survey questions to better understand opportunities of need and interest for continuing education. Employers reported interest in CEU courses in substance use, social determinants of health, and community information exchange platforms. 42% of employers reported that their CHWs worked in the fields of ACES/Trauma Informed Care, suggesting there is opportunity for more training in this area as well.

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 (continue repeating until all activities included): Activity one is being carried over from the 2021 TQS submission. EOCCO has collected REAL-D data for the current CHW roster in the service area. 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 measure 1.1	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 demographic data has been collected for ALL Tier-1 counties. 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.	06/2022	Capacity needs analyses examined for ALL (2) *Tier-1* counties.	07/2023
CHW demographic data has been collected for ALL Tier-2 counties. 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.	06/2022	Capacity needs analyses examined for ALL (3) *Tier-2* counties.	07/2023

CHW demographic data has been collected for ALL Tier-3 counties. 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.	06/2022	Capacity needs analyses examined for ALL (3) *Tier-2* counties.	07/2023

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 LCHPs 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: Add text here

Monitoring measure 2.1	Evaluate current and future CHW training opportunities for alignment with identified priority populations.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
All OHA-certified CHWs have received training on cultural competency and	CCO offers continuing education to CHWs on one of the following topics	09/2022	CCO offers continuing education to CHWs on all the following topics for	09/2023

social determinants of health.	for priority populations: substance use disorders, trauma informed care, CLAS standards.		priority populations: substance use disorders, trauma informed care, CLAS standards.	
Materials and resources (e.g., written brochures) that meet cultural and linguistic standards for identified priority populations have been identified but not distributed.	Distribute materials and resources (e.g., written brochures) that meet cultural and linguistic standards for identified priority populations to inform of CHW services.	06/2022	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 the effectiveness and accessibility of materials.	06/2023
61.5% of annual CHW survey respondents answered that their employer organizations were billing claims for CHW services to EOCCO for reimbursement after targeted training on CHW billing.	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 submit claims for CHW-based services to 70%.	06/2022	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 submit claims for CHW-based services to 80%.	12/2022

A. Project short title: 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): Access: Quality and adequacy of services
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address? ☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

The COVID-19 pandemic and the "hold" of OHP redetermination has continued to show a rise in Medicaid enrollment across Oregon since early 2020. EOCCO's membership grew from 52,288 in December 2019 to 59,607 in December 2020 and currently stands at 66,855 as of January 2022. 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 automatically, 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, with the lingering COVID-19 pandemic and Omicron variant, the Primary Care Transformation Coordinator has still not been 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. However, with the launch of PCPCH Program updates in January of 2021 and most recent revisions (January 2022), one-on-one Technical Assistance is still requested by clinics on an ad hoc basis.

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 is still 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 most recent 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 the percentage of EOCCO members assigned to a Tier 4 or 5 Star clinic. In December 2020 77.1% of EOCCO members were assigned to Tier 4 or 5 Star clinic, while in January 2022 82.3% 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 2020, 37 EOCCO primary care clinics were certified a Tier 4 or 5 Star. In January 2022 49 clinics were certified a Tier 4 or 5 Star. *(*note: calculations of certified clinics has been adjusted from counting health system clinics to counting all clinics separately. This is an alteration from the data points submitted in 2021 and may reflect a larger increase in certified clinics than in actuality).*

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 2022 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 (continue repeating until all activities included): Increase the percentage 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 January 2022: No certification: 7.2% Tier 1: 0.0% Tier 2: 0.0% Tier 3: 10.5% Tier 4: 55.3% Tier 5: 27.0% Total: 100.0%	No certification: 6.7% Tier 1: 0.0% Tier 2: 0.0% Tier 3: 11.0% Tier 4: 54.6% Tier 5: 27.7% Total: 100.0%	12/2022	No certification: 6.0% Tier 1: 0.0% Tier 2: 0.0% Tier 3: 10.2% Tier 4: 55.3% Tier 5: 28.4% Total: 100.0%	12/2023

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 January 2022: Tier 1: 0 Tier 2: 0 Tier 3: 14 Tier 4: 38 Tier 5: 11 Total: 63	Tier 1: 0 Tier 2: 0 Tier 3: 15 Tier 4: 37 Tier 5: 12 Total: 64	12/2022	Tier 1: 0 Tier 2: 0 Tier 3: 14 Tier 4: 38 Tier 5: 13 Total: 65	12/2023

A. **Project short title**: 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.

The Compliance and Care Management Team reviewed the 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 1/1/21 - 12/31/2021 EOCCO recorded a total of 231 ED visits for members with SPMI or SUD-related complaints. Of that sample 109 visits (42.7%) were documented as having received adequate follow up within three days of discharge from the ED. This was an increase from the previous submission where we were meeting ED Follow Up requirements 25% of the time.

	Case Count	***Percentage***
Met 3-Day follow Up	109	42.7%
Exceeded 3-day follow up	122	47.3%

3-day follow up post ED compliance, 1/1/21 - 12/31/21

The COVID-19 pandemic continued to exacerbate the barriers felt by members facing SPMI and other SUD. Many individuals were not accessing care at this time as evidenced in the decline in total qualifying ED visits in 2021. 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. In filtering the ED Census Report, it became evident that the reasons for not meeting the 3-Day Follow

Up (122) were primarily the result of; Not Receiving a Clinical Note on Time (37.7%), Visit Date Beyond the 3 Day Timeframe (17.2%), Visit Time < 15 Min (2.4%), and Not Locating Members Despite Multiple Attempts (40.9%). This includes locating individuals without permanent homes, supporting members being seen in EDs outside of the region and ensuring enrollment in the proper CCO if they are no longer living in the EOCCO coverage area. EOCCO is engaging with CMHPs to identify ways to increase compliance when members are getting follow up and case coordination that meets the intent of the requirement and is meeting the member's needs, but not being counted as meeting the requirement due to issues like the note not being received although the services was provided (37.7%) and being unable to make contract despite documented attempts including members who are no longer residing in the EOCCO coverage area (40.9%). Only 17.2% of the follow ups for members were truly

due to the visit being beyond the time frame, but was more within the control of CMHPs.

Reason for Not Meeting 3- Day Follow Up	*Case Count*	*Percentage*
Not Receiving a Clinical Note on Time	46	37.7%
Visit Beyond the 3 Day Timeframe	21	17.2%
Visit Time < 15 Min	3	2.4%
Unable to Contact W/ Documented Attempts	50	40.9%
Other	2	1.6%

During 2021 EOCCO completed Activity 2 from the 2021 TQS submission and is now capable of identifying members with 1915i and SHCN designations. This activity has been removed from the current submission.

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 2021. 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 developed and implemented a structure and process using an automated report from 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.

The hospital ED is the wrong place to seek treatment for ongoing SPMI and SUD issues. However, it is a critical place 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.

This project engagement has led to identify a consistent misunderstanding among CMHPs related to differentiating 3-Day ED from Acute Care follow ups as it relates to meeting the members while still in the ED. While Acute Care requires follow up to be completed post discharge outside of the state hospital setting, ED follow up can be completed in the ED itself. Given the amount of members who do not receive follow up within 3 days due to being unable to find or make contact with them following discharge, and the effectiveness of being able to plan for providing continued support services prior to them leaving the ED EOCCO will continue to promote this approach. It is also unclear how many members were supported in this way, and were not counted as follow ups, the number of 3 Day Follow Ups that were met would have been higher if CMHPs were considering this approach as meeting the intent of the 3 Day Follow Up requirement.

E. **Brief narrative description**:

EOCCO will continue to utilize a daily report of all EOCCO members who were in an ED the previous day, and the daily ED Meeting with providers to continue to increase our compliance with the 3 Day Follow Up requirement and reduce the number of members being served for behavioral health needs in the ED. 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, at 10 AM the EOCCO Care Management staff meet with all CMHP's to staff cases and coordinate appropriate follow up, treatment planning, and enrollment into appropriate programs such as ACT, ICC, Peer Delivered and Supported Employment services. EOCCO Care Management continues to support and case plan with CMHPs 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 ED:

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 CMHPs 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 continue to 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).

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 was the baseline in 2020 and the current state (2021) is 42.7%	60% compliance for 3-day follow up post ED visit.	1/1/2023	70% compliance for 3-day follow up post ED visit.	1/1/2024

Activity 2 description: EOCCO Care Management team will monitor members with 3 or more ED visits to ensure those members have an Individual Management Plan (IMP). Care Management will also work with CMHPs ENCCs in order to support them in meeting their goals, and removing the IMP within the initial 6 month time frame.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: EOCCO Care Management team will monitor members with

IMPs in Essette. The team will work closely with ENCCs and other CMHP staff to help support the goals set to remove the IMP in a reasonable time frame.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
27% of the IMPs open in 2021 were closed within 180 days.	40% of the IMPs open in 2022 will close within 180 days.	1/1/2023	55% of the IMPs open in 2023 will close within 180 days.	1/1/2024

Average days a member has an IMP initiated and closed in 2021 is 178 days.	Average days a member has an IMP in opened and closed in 2022 is 165 Days	1/1/2023	Average days a member has an IMP in opened and closed in 2023 is 155 Days	1/1/2024

Project short title: 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.

EOCCO continues to respond to the needs of our region, utilizing data to understand Social Determinants of Health, as they relate to our communities, and seeking ways to improve the overall health of members and our communities. The 2021 EOCCO Community Health Assessment (CHA) indicated that 22.3% of EOCCO members indicated that they had issues related to hunger, and 48.6% indicated that they had food insecurity. The relative geographic isolation in our communities leads towards “food desserts” in an untraditional sense, as that is typically a description applied to urban areas. There is a clear need to work towards reducing hunger and food insecurity in our region.

In 2021 COVID-19 continued to exacerbate barriers to participants being able to access supports related to food and nutrition. Many community programs including our Veggie Rx program struggled due to office closures and staff reductions. Reduced contact with potential participants made it more difficult to provide direct support and community connection. Prescribers continued to contact participating households on a monthly basis and directly mailed voucher booklets to them. That led to increased utilization as shown by the reimbursement of used vouchers to the vendors compared to the previous year.

Funding continues to be an issue, and an increase in funding would be needed to serve the number of people eligible and likely to engage. Prescribers in all four counties are reporting that there are many more eligible for the program than what the program can currently serve. In Sherman County, one of the main barriers and gaps was the lack of markets in the town of Rufus. 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 and new avenues being made available for participants to access produce.

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

There were considerable issues with the data from Pre and Post Surveys that were implemented in 2021. Pre

survey responses tended to capture data multiple times per household skewing the data, and Post-Survey responses have been limited. Prescribers report a struggle with the ability to capture surveys from participants, and participants responding indicated that the survey was too extensive. EOCCO recognized that there were too many questions included, and that data was not all directly tied to outcome measures that there was a capacity to monitor. EOCCO recognized that more limited data should be collected, at the time of enrollment on an annual basis. Doing so would allow for more streamlined data collection, and the ability to capture data from all participants. Capturing important data related to indicators of program effectiveness annually during the enrollment period will allow for consistency in data collection, ability to establish future benchmarks, and ability to determine whether or not benchmarks were reached with valid data.

Data captured through enrollment forms from 2021-2022 program participants was able to provide some baseline data related to additional formal community support programs that each participating household was receiving, as well as baselines for participants' perception of their own food security. EOCCO was also able to establish baseline data for the amount of funds dispersed and the amount of funds utilized by participants.

E. **Brief narrative description**:

EOCCO's long-term goal is to improve the utilization and health impact of the FVRx program on our members and the community in general. In this project, we will evaluate the effectiveness of the Frontier Veggie Rx as it relates to improved access and consumption of fruits and vegetables, an increase in food security, an increase in overall perception of participants' physical and mental health, and the ability to connect participants to additional formal community support programs. This project will also monitor and seek to improve the amount of funds given as it relates to the amount of funds used by participants during each program year. The next enrollment period will be July 1, 2022 and the year will end on June 30, 2023.

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 LCHPs, Local Community Health Partners, prescribers, and users; thus, it involves social and community health components of SDOH as well.

EOCCO will continue to seek ways to increase the number of participants through looking to add additional funding, prescribers, and participating stores. Lake County, while having begun enrolling participants for the first time in 2021 which expanded the number of participants we are able to reach, has struggled to find grocery stores to participate. There are two stores almost ready to begin filling prescriptions. Lake County is in need of this program to help change the structural environment as it relates to food scarcity and insecurity. This project will also continue to provide educational opportunities to learn about healthy eating and nutrition.

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

Activity 1 description (continue repeating until all activities included): EOCCO will collect data utilizing an amended annual enrollment form to understand if participants increase their consumption of fruits and vegetables, and have increased their sense of food security.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Annual Enrollment Form Data

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
22.64 % of enrolled participants report that within the past 12 months they often worry food would run or food did run out before they had money to purchase more.	18% of re enrolled participants report that within the past 12 months they often worry food would run out or food did run out before they had money to purchase more.	July 2022	15% of re enrolled participants report that within the past 12 months they often worry food would run out or food did run out before they had money to purchase more.	July 2023

Activity 2 description: The Program Manager will work with Local Community Health Prescribers to ensure that households are being referred to appropriate community programs and resources.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Annual Enrollment Form Data

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Participants had an average of 1.36 additional formal supports out of 7 choices.	Participants will average 2 additional formal supports.	July 2022	Participants will average 2.5 additional formal supports.	July 2023

0 Prescribers currently using Connect Oregon to make appropriate referrals.	Prescribers have access to the platform and are trained to make referrals.	End of 2022	Benchmark for number of Connect Oregon referrals made by referrals is set.	End of 2023

Project short title: 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

If continued, insert unique project ID from OHA: 98

A. Components addressed

i. Component 1: Utilization review
ii. Component 2 (if applicable): SCHN: Full benefit dual eligible
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

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

In 2021 EOCCO utilized reporting to identify members with emergency room visits and/or inpatient stays with COPD, CHF, Sepsis, or any combination of the three conditions. EOCCO established criteria of two or more events (emergency room and/or inpatient stays) in a three-month period for care coordination intervention. Case Management monitored the Collective Platform for members that met the criteria and assigned them to a case manager. EOCCO also developed reporting to identify members that have been assigned to case management due to the trigger diagnosis criteria and monitor case management engagement.

The goal for case management is to help members better manage their condition by educating members, and coordinating care with PCPs and specialists, thus reducing ED and hospital utilization.

Although EOCCO was able to identify the target population and offer care coordination, case managers found it was difficult to get members to participate. Due to low participation rates in case management, EOCCO will develop different approaches to educating members and care coordination engagement.

Additionally, a new workflow was recently developed for working with full benefit dual eligible (FBDE) members, however this process has not yet began collecting referrals. Within this population EOCCO is interested in assessing the rate at which members with special health care needs (SHCN) fall into this cohort of having at least one ED/inpatient event with a triggering diagnosis. Given that members with SHCN often have multiple chronic conditions or comorbidities it is possible we could see a sizable portion of our members with one of the three trigger diagnoses that could benefit from additional support. The types of conditions that qualify members as having SHCN (chronic

conditions, mental illness or substance use disorder or other high health care needs) can drastically affect how a member seeks care. Identifying members with SHCN will help us further understand the unique barriers faced by this population and allow us to further refine our approach to provide these members with appropriate care coordination. This sub focus is meant to supplement the ongoing outreach to all EOCCO members with a specialized focus on FBDE members with SCHN, in hopes of strengthening care coordination between Medicare and Medicaid services for high utilizers.

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

In 2021 EOCCO identified 209 members with at least one event from a trigger diagnosis. Of the 209 members 38% had two or more events, and 22% (46 members) had two or more events in a three-month period.

Of the 46 members, 8.7% participated (enrolled) in care coordination, 45.65% declined to participate, and 32.61% were unable to contact or lost contact.

Enrollment Status	Number of members	Percent of members assigned
Deceased	2	4.35%
Declined	21	45.65%
enrolled	4	8.70%
LTC or Residential Placement	2	4.35%
Moved out of area	2	4.35%
Unable to contact/loss of contact	15	32.61%
Grand Total	**46**	

Although care coordination engagement was low, there was a decrease in the event rate from 2020. In 2020 51% of members identified with a trigger diagnosis had two or more events compared to 38% in 2021.

For 2022, EOCCO will also examine a subset of this population to identify FBDE members that have at least one event with a trigger diagnosis for SHCN. This will be done by cross-referencing Collective reports against the SHCN file sent by the state to identify trends in service utilization among members with SHCN. Trends may include over-utilization of ED/Inpatient services among the cohort, lower rates of engagement in care coordination, or similarities between members with different needs. While individuals with identified needs will be referred to appropriate services in a timely manner, the larger data set is intended to help us determine how to proceed in the next TQS cycle.

D. Brief narrative description:

Because care coordination participation is low, EOCCO has found an opportunity to provide some education and support to members regardless of care coordination participation. EOCCO has created educational fliers based on content developed by Aging and Disability Services for COPD and CHF. EOCCO will monitor and identify members with their first ED visit or inpatient stay with COPD and/or CHF. These OHA approved fliers provide information about symptoms to watch for, what the symptoms mean, and what to do about them. The fliers also provide contact information of the care coordination team. The care coordination team will continue to monitor for two or more events within three months and assign members to care coordination.

EOCCO will develop a standard care plan for members with sepsis and monitor a collective platform for members with a sepsis diagnosis. Care coordinators will target outreach before a member discharges from the hospital and utilize a developed standard care plan to ensure follow up visits with member's PCP and coordinate discharge planning.

E. Activities and monitoring for performance improvement:

Activity 1 description: Send COPD/CHF educational fliers to members after first ED or Hospital visit with COPD/CHF diagnosis. Continue to monitor event rates for members with COPD and/or CHF.

☒ Short term or ☐Long term

Monitoring measure 1.1	Send educational fliers to members after first ED/Hospital visit with COPD/CHF diagnosis			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
EOCCO is not currently sending educational fliers to members with an ED or Hospital visit with COPD or CHF	Mail educational fliers to members after initial ED or Hospital event with COPD and/or CHF diagnosis in 2022.	7/1/2022	Continue to Mail educational fliers to all members after initial ED or Hospital event with COPD and/or CHF diagnosis	4/1/2023
Monitoring measure 1.2	Analyze event rates for members with CHF/COPD diagnosis			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In 2021 38% of members with COPD, CHF, Sepsis or any combination of the three had two or more events (ED or Hospital visit).	Reduce rate of two or more events by 5%	6/1/2022	Reduce rate of two or more events by 10%	12/31/2022

Activity 2 description: Develop and implement a standard sepsis care plan for case managers to utilize when working with members.

☒ Short term or ☐Long term

Monitoring measure 2.1	Develop and implement standard sepsis care plan for case managers to utilize.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently EOCCO does not have a standard sepsis care plan for case managers to utilize.	Develop standard sepsis care plan for case managers to utilize in care coordination.	6/1/2022	Implement standard sepsis care plan in care coordination with members who have had a hospital and/or ED visit with sepsis diagnosis.	7/1/2022

Activity 3 description: Review all FBDE members with one event to determine if they are listed as having SHCN. Look for

utilization trends among various members. Work with analytics as needed.

☒ Short term or ☐Long term

Monitoring measure 3.1	Track FBDE members entering the cohort for SHCN			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No processes in place for identifying SHCN	Verify SHCN status 100% of all members	12/2022	Identity trends between groups of members with SCHN	01/2023

among dual eligible members	who had one event or more during 2022			

A. Project short title: Increase Testing and Improving Accessibility of Hepatitis C Care Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project

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): Grievances and appeals 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

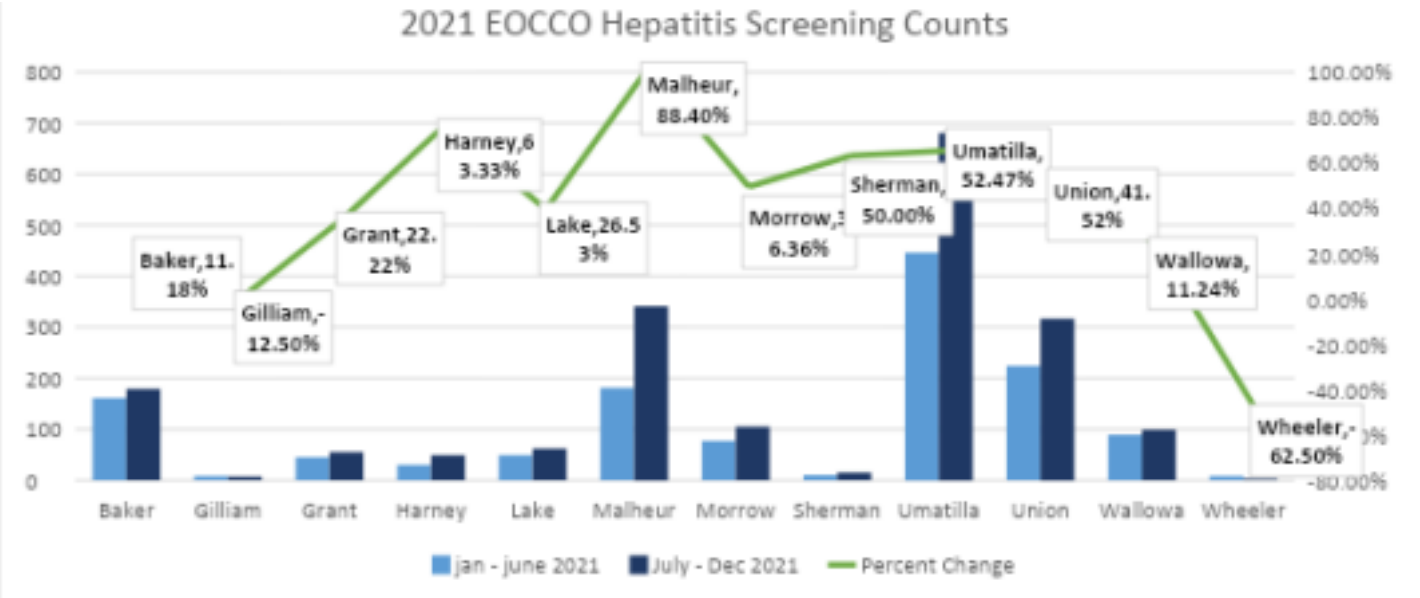
C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

To help identify any barriers to Hep C screening or Hep C treatment, EOCCO developed and distributed a provider survey, and monitored appeals and grievance data related to Hep C. The survey asked if clinics were testing certain demographics, if there are any barriers to testing, and some of the reasons they are not testing. EOCCO also published an article in the provider newsletter in May reminding providers of the updated CDC and USPSTF Hep C testing guidelines.

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

EOCCO sent the survey to 158 providers and staff and received 0 responses.

EOCCO analyzed testing prevalence for 2021. EOCCO did see an increase in testing after the article was published in the provider newsletter. There was a significant increase in testing in Umatilla, Malheur, and Union Counties. Testing increased 42.85% overall in the second half of 2021.



E. Brief narrative description:

In 2022 EOCCO will focus efforts on increasing testing further in Umatilla and Morrow counties. EOCCO will develop materials that will educate members on the CDC and USPSTF guidelines and prompt them to talk to their PCP about testing. Once developed and approved by OHA, these materials will be mailed to members 18 and over in Umatilla and Morrow Counties. EOCCO chooses to focus on Umatilla and Morrow counties because of access to treat Hep C and because of our partnership with EOIPA that serves providers in those counties. EOCCO will continue to survey providers in Umatilla and Morrow Counties to identify barriers in testing for Hep C and/or providing care for members with Hep C.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Develop materials to educate members on the updated testing guidelines of the CDC and USPSTF. Distribute materials to members 18 and over in Umatilla and Morrow Counties.

☒ Short term or ☐Long term

Monitoring measure 1.1	Develop member materials			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
EOCCO does not currently have member materials indicating updated CDC and USPSTF guidelines	Develop member materials with updated Hep C testing guidelines	4/1/2022	Mail guidelines to members 18 years of age and older in Umatilla and Morrow Counties	6/1/2022
Monitoring measure 1.2	Continue Monitoring testing prevalance in Umatilla and Morrow Counties			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2860 EOCCO members were tested for Hep C in 2021	Increase testing by 20%	1/1/2023	Increase HepC testing by 30%	6/1/2023

Activity 2 description: Survey providers in Umatilla and Morrow counties to identify any barriers in testing or Hep C care.

☒ Short term or ☐Long term

Monitoring measure 2.1	Update survey questions and distribute to providers in Umatilla and Morrow Counties			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current survey is outdated	Update provider survey questions	5/1/2022	Distribute Survey to providers in Umatilla	6/1/2022

			and Morrow Counties	
Monitoring measure 2.2	Monitor response rate for provider survey			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No response rate from provider survey	70% response rate for provider survey	7/1/2022	80% response rate for provider survey	9/1/2022

A. Project short title: 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

If continued, insert unique project ID from OHA: 370

B. Components addressed

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

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

EOCCO faced barriers to the progression of the previous year's special health care needs (SHCN) project due to reprioritizing of internal resources for competing priorities. Steps were made to reach targeted goals outlined in the 2021 TQS but intended outreach and creation of resources were not carried out. EOCCO made strides in implementing internal workflows and policies that would build a baseline for a project to continue into 2022. EOCCO continued into 2021 to deliver education to providers about members with SHCN and the availability intensive care coordination (ICC) services. Instead of using specific diagnoses codes, 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. EOCCO seeks to continue taking the time to fully review and analyze the list of outreach to fully understand the scope of this population and therefore, direct them to case-specific resources or determine other avenues of support. Collaboration and coordination of care between physical health and behavioral health while placing emphasis on culturally and linguistically appropriate materials will continue to be the focus of this project

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

Over the past year, EOCCO has identified and categorized members who are on SHCN plans, to successfully conduct outreach in progressions and increase overall member engagement. The EOCCO analytics team was able to include the Chronic Disease Registry that flags at the member level to indicate if members have a chronic disease, a social determinant of health indicator (SDOH), or other comorbidity. Further refining this list and dividing members into groups based on the number of comorbidity and chronic disease flags, has allowed EOCCO to cross reference these lists of members and compare it to those who have been connected to Case Management services at any level. EOCCO Operations will collaborate with Health Care Services to develop relevant materials and resources for those who have not been in touch with case management services and conduct potential outreach to those who have five or more chronic conditions or comorbidities if the Case Management team has not made contact over the past year.

Over the next year, the goal is to review other avenues to increase member engagement and provide support such as developing condition specific resources in alignment with EOCCO Clinical Practice Guidelines. EOCCO will also look

further into claims details and review reasons of not accepting case management services for those who have five or more chronic conditions or comorbidities

For those other populations with fewer indicators, EOCCO will develop culturally and linguistically appropriate resources and materials that members can use to access resources or additional information. An example resource consideration is if these populations (those who have a behavioral health condition, hypertension, etc.) could benefit from a specific in lieu of services.

Table 1: Pivot table of SHCN members enrolled as of 12/2021

Sum of Anxiety	Sum of Asthma	Sum of COPD	Sum of Depression	Sum of Diabetes	Sum of Hyperlipidemia	Sum of Hypertension	Sum of Kidney	Sum of RA	Sum of Schizophrenia
4541	671	684	3550	2201	2113	3815	264	130	222

Table 2: SHCN Members enrolled as of 12/2021

SHCN Members with >6 conditions	SHCN Members with 3-5 conditions	Members with <2 conditions
58	1948	30547

E. Brief narrative description:

EOCCO regularly reviews and analyzes SHCN data to identify trends, assess utilization and share information with primary care providers whose members are flagged as SHCNs. The objective of this project is to connect those at high risk to Case Management services and identify the most prevalent chronic conditions and comorbidities among this population to formulate appropriate resources.

Before conducting outreach of Case Management services for those who have five or more chronic conditions or comorbidities, claims data will be reviewed to see if members have been recently connected with their Primary Care Provider (PCP) and review other claim types, such as any emergency department or specialty visits related to their chronic condition.

Culturally and linguistically appropriate condition-specific educational material will be developed to do targeted outreach to members with limited English proficiency regarding the top condition related to physical health and the

other top condition related to behavioral health. 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.

F. Activities and monitoring for performance improvement:

Activity 1 description: Analyze the report of members on SHCN plans and utilize the Chronic Disease Registry through the analytics team that flags at the member level to indicate if they have a chronic disease, a social determinant of health indicator (SDOH), or other comorbidity.

☐Short term or ☒ Long term

Monitoring measure 1.1	Conduct direct outreach to those who have been connect to case management services previously.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
SHCN Members with Chronic Disease Registry indicators	Cross reference with the outreach list from the Physical Health and Behavioral Health Case Management Team	04/2022	Implement focused intervention by screening of identified target population and making ICM referrals as needed. Conduct individual outreach to those who have 5 or morbidities and have not been contacted yet been referred to Case Management services over the past calendar year.	10/2022
Monitoring measure 1.2	Review and monitor claims data for SHCN members			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
SHCN Members with Chronic Disease Registry indicators	Review claims data to ensure members with 5 or comorbidities have been connected to their PCP over the last calendar	04/2022	Review the trends in utilization of PCP, specialists, and emergency department visits.	09/2022

	year			

Activity 2 description: Develop educational materials in a culturally and linguistically appropriate manner for SHCN members based on the top physical health conditions and the top behavioral health condition.

☐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. Review monthly language access reports to review utilization of interpretation services.

Monitoring measure 2.1	Determine top physical health and behavioral health condition and prevalent languages among the SHCN population			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
SHCN Members with Chronic Disease Registry indicators	Evaluate current data and determine primary comorbidity	05/2022	Develop print educational outreach materials for members	10/2022

	among members with limited English proficiency baseline		with SHCNs and limited English proficiency regarding available resources and reminders of interpreter/translation and NEMT services	

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A. Project short title: Increasing Adult Dental Utilization through Dental Van Expansion in Malheur County Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project

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

B. Components addressed

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

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

Overview and brief evaluation of CCO's work in the component area over the last year and existing gaps:

Over the past year EOCCO has worked to implement an equitable health care delivery model that seamlessly and holistically integrates physical, behavioral, and oral health. EOCCO has 9 integrated primary care clinics that provide oral health care as well as primary care services and continue to collaborate with primary care clinics to expand these services. EOCCO has also devoted time towards providing first tooth training to primary care providers so that they can perform oral evaluations and provide topical fluoride varnish. EOCCO worked with Advantage Dental to train 13 primary care practices over the past year and plans to continue to offer the first tooth training to any interested clinics in an effort to further integrate care. Additionally, one of EOCCO's DCO partners, Advantage Dental, hosts many school-based dental clinics throughout the year where they provide oral health assessments, sealants, fluoride varnish, and education to school-aged children. Lastly, in order to continue to increase access to care, EOCCO's other DCO partner, ODS, opened a new dental clinic in our most populated county, Umatilla.

EOCCO identified a need to increase access to dental services outside of the traditional dental office for the adult population since dental services are underutilized. EOCCO's current adult dental utilization rate is 29.5%. EOCCO and its DCO partners have dedicated many efforts to increasing access to care for school-aged children and plan to leverage the success from those programs to increase access for adults as well through a dental van. EOCCO recognizes that there are many barriers to getting care, some of which are related to social needs or a member's ability to get to their appointment, especially in our rural service area. Some of the ways social determinants of health for rural residents impact their ability to attend necessary health appointments are based on:

- Whether an individual can take time off work to go to an appointment
- Reliable transportation
- Health literacy to communicate their needs to a health care provider
- Receive quality care no matter their background

The dental van would allow members to receive care in more convenient locations with access to health care professionals committed to providing excellent care and skilled in triaging and connecting members to support services. Additionally, transportation is a considerable barrier for rural residents dependent on cars to make it to their appointments. Many low-income rural residents find that the cost of gas, maintenance, and the unreliability of their

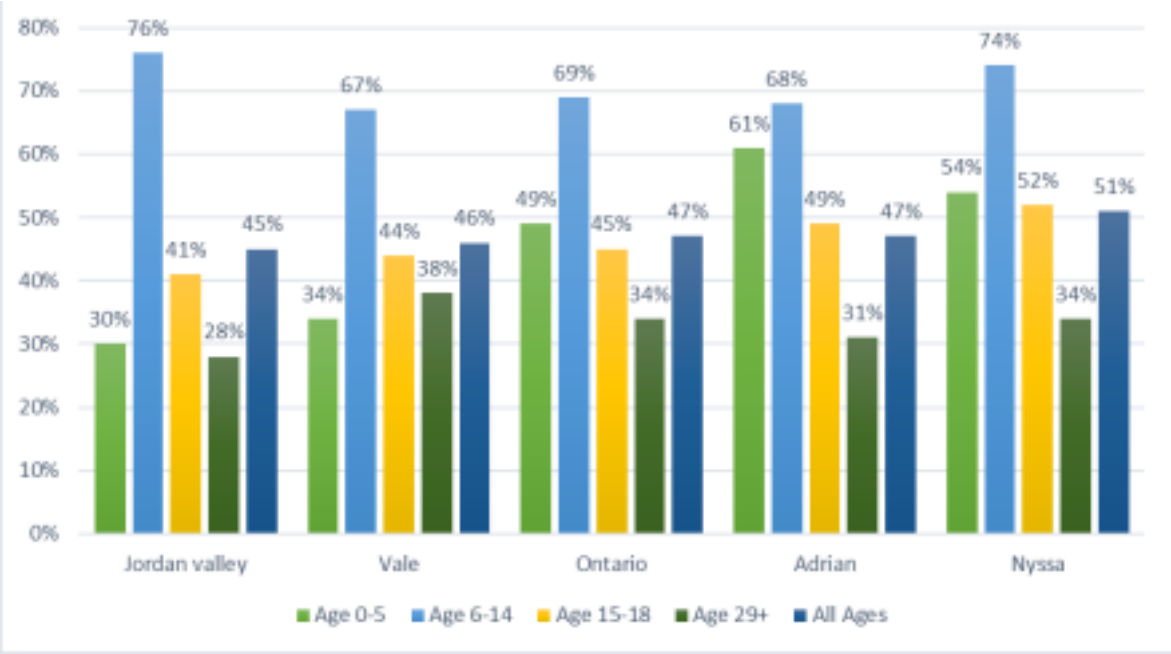
vehicle makes it too difficult to drive to the next town, or for some residents, a couple of hours, to their appointments. Thus, bringing the dental van to the location of the residents will help ease these barriers and connect them to other potential services needed (e.g., non-emergency medical transportation).

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

Why did EOCCO choose this project, include justification for selecting the project and how it addresses gaps from the prior year, addresses unique characteristics, identified needs and service gaps of community, members, target population for the project, or network providers:

EOCCO's local community health partnerships that are made up of community members, healthcare partners, and EOCCO consumers, have identified access needs in various communities in Eastern Oregon including Malheur County, which is EOCCO's second most populated county. EOCCO is a primarily frontier and rural geography which poses its own unique challenges to access such as transportation needs. As a result of the response we heard from the community, EOCCO consulted with ODS regarding a mobile dental van that could travel to different towns in Malheur County to provide oral health services. This would not only increase access to care in Malheur County but also provide services outside of a traditional dental office that will meet the needs of our Medicaid members. EOCCO worked with ODS to evaluate utilization rates across the different age ranges and cities within Malheur County and determined that focusing on adult dental utilization is where EOCCO's largest gaps are. More specifically, EOCCO plans to focus on diabetic patients who need an oral health evaluation by a dentist. Individuals with diabetes are at an increased risk for oral health issues such as gum disease which makes it harder to control blood sugar. We will work with primary care providers in Malheur County to educate their diabetic members on the importance of oral health and encourage them to refer their members to the dental van. The primary care providers and dental providers will evaluate and address additional social needs that may arise during the visit that could be a barrier for the member. Each individual involved in the member's care team can use the Unite Us platform to facilitate closed loop referrals to ensure appropriate communication and coordinated care.

Malheur County Dental Utilization Rates



E. Brief narrative description:

EOCCO will work with ODS and the Arrow Dental Clinic in Hermiston to staff a dental van that will provide dental services in Malheur County to adult patients, ages 18+. EOCCO will have an increased focus on referring diabetic members to the van in order to complete their oral health evaluation by a dentist. EOCCO will work closely with the primary care practices in Malheur County to ensure close collaboration between the dental van and the primary care practices. This will include sharing educational resources with primary care on the importance of oral health among members with diabetes and provide an opportunity for each primary care practice to have the dental van onsite for a period of time so they can encourage their diabetic patients to complete their evaluation on the same day. The van allows members to access oral health care outside of the traditional dental office by meeting members where they are at whether that is outside of a primary care clinic, at a fairground, or a school.

The second component of this project is addressing other barriers to care related to social needs. EOCCO recognizes that social determinants of health (SDoH) play a major role in an individual's overall health and their ability to seek care. EOCCO is implementing the Unite Us community information exchange platform in Malheur County in July 2022. This

project enables dental providers to share member health information with primary care, behavioral health, and other social service providers through health information technology via the Unite Us platform. Members will be screened for social needs during their visit on the dental van and then the Unite Us tool will allow the providers to send closed-loop referrals to other providers that are part of the member's care team and to community-based organizations to help address social need barriers to receiving oral health care.

Members will receive targeted non-oral health care from their dental provider through social determinants of health screenings and a focus on diabetic member education. Additionally other providers including primary care and behavioral health providers can send referrals to the dental providers through Unite Us.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included):

EOCCO will work with PCP clinics in Malheur County to refer EOCCO members to the Arrow Dental Van to increase overall adult oral health utilization by 5.5% by 3/31/2024. EOCCO will notify all diabetic members ages 18+ in Malheur County of the Arrow Dental van to increase oral evaluations for adults with diabetes in Malheur County to 35% by 3/31/2024.

☐Short term or ☒ Long term

Monitoring measure 1.1	Dental van utilization rate by EOCCO members in Malheur County			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of EOCCO members in Malheur County	3% of EOCCO members in Malheur County	03/2023	10% of EOCCO members in Malheur County	03/2024
Monitoring measure 1.2	EOCCO adult dental utilization rate			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

29.50% of adult EOCCO members have utilized oral health services in 2021	32.00% of adult EOCCO members who utilize oral health services	03/2023	35.00% of EOCCO members who utilize oral health services	03/2024
Monitoring measure 1.3	EOCCO Oral Evaluation for Adults with Diabetes quality measure rate in Malheur County			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
29.55% of EOCCO diabetic members in Malheur County have completed a	32.00% of EOCCO diabetic members in Malheur County who complete a comprehensive dental exam	03/2023	35.00% of EOCCO diabetic members in Malheur County who complete a comprehensive dental exam	03/2024

comprehensive dental exam in 2021				

Activity 2 description:

By 12/31/2022, 50% of EOCCO members treated at the Arrow Dental van who present with social needs will be referred to support services using the Unite Us Community Information Exchange (CIE) platform.

☐Short term or ☒ Long term

Monitoring activity 2 for improvement: EOCCO will grant the providers on the van access to the Unite Us tool so dental providers can screen members for social needs on the van and refer members to services to attain the targets and benchmarks.

Monitoring measure 2.1	Unite Us Platform Utilization			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of EOCCO members treated at the Arrow Dental van who voiced social needs were referred to services	50% of EOCCO members treated at the Arrow Dental van who voiced social needs were referred to services	03/2023	75% of EOCCO members treated at the Arrow Dental van who voiced social needs were referred to services	03/2024

A. Project short title: Expansion of Behavioral Health Integration using THWs and HIT Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project

If continued, insert unique project ID from OHA:

B. Components addressed

i. Component 1: 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. 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 2021, the Eastern Oregon Coordinated Care Organization (EOCCO) signed contracts with 10 Patient-Centered Primary Care Home (PCPCH) clinics for behavioral health integration (BHI). EOCCO intended to develop contracts with nine PCPCH clinics for BHI; with the signing of these contracts, EOCCO surpassed all stated goals in the 2021 BHI TQS submission and closed out these projects. Moving forward, EOCCO is considering creative strategies to integrate Traditional Health Workers (THWs) and Health Information Technology (HIT) into BHI PCPCH clinics and create new avenues for members to access integrated services. EOCCO's continued goal is to expand the integration of behavioral health services into primary care across the entire service area. By integrating THWs and HIT into BHI clinic workflows, EOCCO plans to address current gaps in cross-sector provider education and cross-sector provider communication, improving models of integration and patient care.

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

The goal of EOCCO's new project is to open avenues for the newly established BHI clinics to provide comprehensive and well-integrated services to members. EOCCO plans to achieve this goal in two ways: through expanding CHWs/THWs scopes of practice in BHI clinics and through integrating and utilizing Unite Us, an HIT tool, to improve care coordination and transitions of care across physical, dental, and behavioral healthcare providers. By centering THWs in BHI strategy, EOCCO is centering health equity and culturally responsive care and expanding expertise of providers on a member's care team. This approach will address current gaps in cross-sector provider education by supporting the expansion of scopes of practices for THWs initially trained to work in the physical health space who are now working more closely with behavioral health needs under the new BHI contracts. Additionally, through centering Unite Us as a pillar in BHI clinics, social needs will be more easily met and providers will have access to closed-loop referrals, allowing them to follow up with their patients and develop collaboration across many different areas of care. This approach will address gaps in cross-sector provider communication by holding providers accountable to best practice standards of referrals and follow up care across the physical, oral, behavioral, and social health settings.

E. Brief narrative description:

In 2021, EOCCO signed contracts with 10 PCPCH clinics to integrate behavioral health services. By integrating these 10 clinics, more than 75% of EOCCO members are now assigned to a BHI PCPCH clinic. Within this contracting model, BHI clinics must track closed-loop referrals for treatment, recovery, and social care needs. Adjacent to the BHI rollout across

the EOCCO service area, EOCCO has worked closely with Unite Us to integrate their Community Information Exchange (CIE) tool and the affiliate network, Connect Oregon, into the service area. By the end of 2022, all 12 Eastern Oregon counties will be on boarded with Unite Us to allow for providers and community-based organizations to send and receive closed-loop physical, social, oral health, and behavioral health referrals. EOCCO plans to support all BHI clinics in integrating Unite Us into their clinic workflows and best practices, supporting usage of the network and providing high quality care for members receiving integrated services. Unite Us will provide a uniform platform to facilitate referrals between BHI clinics, community mental health providers (CMHPs), substance use disorder (SUD) treatment programs, and other social needs providers.

In addition to leveraging Unite Us to provide high-quality care to members receiving services at BHI clinics, EOCCO intends to support training of CHWs at BHI clinics to support complex systems navigation. EOCCO is piloting Family Support Specialist (FSS) cross-training for eligible CHWs in primary care clinics across the service area in 2022 and plans to prioritize the training in BHI clinics. For CHWs who are not eligible, EOCCO will lean on existing relationships with OSU and CEU courses that have already been developed to support CHWs in receiving similar information and skillsets. With this approach, EOCCO intends to center culturally responsive care and health equity through integrating peer-delivered services in non-traditional spaces, aligning with the goals of BHI more broadly.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Train CHWs in behavioral health systems navigation with an emphasis on working with youth and families. EOCCO will survey BHI clinics to evaluate which CHWs already have training in BH systems navigation. Following this evaluation, EOCCO will support BHI clinics and their CHWs in connection to training with either the Oregon Family Support Network (OSFN) or Oregon State University (OSU). EOCCO will communicate this training opportunity with all CHWs who are not already trained in BH systems navigation.

☐Short term or ☒ Long term

Monitoring activity 1 for improvement: Tracking of clinics providing BH navigation training to their CHWs

Monitoring measure 1.1	Evaluate the training status of CHWs in BHI clinics for complex systems navigation education			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No clinics evaluated	50% of clinics evaluated	12/2022	100% of clinics evaluated	12/2023
Monitoring measure 1.2	Cross-training of CHWs with Family Support Specialist certification or Navigating Care and Services for Children with Special Health Needs CEU course			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No training offered	Training offered in 50% of clinics	06/2023	Training offered in 100% of clinics	06/2024

Activity 2 description: Integrate Unite Us into BHI clinic workflows. EOCCO will facilitate onboarding meetings between BHI clinics and Unite Us team members to develop workflows. EOCCO will leverage relationships with BHI clinics and Unite Us staff to check on onboarding statuses for BHI clinics onto the platform. EOCCO will provide technical assistance (TA) to BHI clinics seeking support and use cases for Unite Us and will prioritize this TA in clinic visits over the next two

calendar years. EOCCO will continue to advocate for the integration of Unite Us across the 12-county service area, supporting the development of a robust network of care providers across the region.

☐Short term or ☒ Long term

Monitoring activity 2 for improvement: Assessment of Unite Us integration

Monitoring measure 2.1	Onboard BHI clinics onto Unite Us CIE tool and integrate CIE into clinic workflows			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No clinics on boarded	50% of clinics on boarded	04/2023	100% of clinics on boarded	04/2024

A. Project short title: Behavioral Health Network Access Data Reporting

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

If continued, insert unique project ID from OHA:

B. Components addressed

i. Component 2 (if applicable): Timely

ii. Component 3 (if applicable): Choose an item.

iii. Does this include aspects of health information technology? ☒Yes ☐ No

iv. 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

v. 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 Community Mental Health Providers (CMHPs) in EOCCO's coverage regions were struggling to provide consistent and accurate access data, and the capacity to report timely access data varied significantly. CMHPs interpretations of 410-141-3515 and the approach to meeting and tracking those access requirements also varied significantly. Overall there was not consistency among our 12 CMHPs in terms of defining requirements. structure and process for collecting data, as well as reporting this data to EOCCO. Two CMHPs reported that they had determined there were likely errors and inaccuracy in the Routine 7 Day Access data they had reported in 2020-2021. Because of these issues EOCCO identified that in order to establish accurate baselines, technical assistance and network wide improvement planning around timely access data reporting would be fundamental to identifying an accurate baseline to utilize for establishing improvement benchmarks. There was a previous TQS project (89) that set benchmarks for improvement. Due to the concern for accurate baseline data used to establish benchmarks in that project, EOCCO intends to ensure that there is more capacity to report on timely access measures other than Routine 7 Day, and that there is consistency among CMHPs increasing the validity of data.

In order to understand the current reporting capacity EOCCO's twelve CMHPs were asked to complete surveys to understand their current capacity to report on each of the nine access measures. The survey asked them to identify if they could report for Q4 2021, would be able to for Q1 2022, or had no plan to be able to report for each measure. Their responses are in the table below. Other than Routine 7 Day access, and Urgent 24 Hour access CMHPs are not currently all capable of reporting on the other 6 access measures EOCCO requires them to report.

1Access Measure	Capable to Report Q4 2021	Will be Ready for Q1 2022	Won't be Ready for Q1 (no current plan to comply)
Urgent 24 Hour	10	2	0
Routine 7 Day	11	1	0
Specialty Care for	3	1	8

Priority Populations			
IV Drug Use	4	1	7
Opioid Use Disorder	5	1	6
Med Assisted Treatment	6	1	5
LMP Request	5	1	6

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

In order to set benchmarks for improvement, EOCCO first must have solid baseline data. That data must be collected using consistent definitions, and consistent measurements across all CMHPs. EOCCO sees this project as fundamental to being able to expand into future TQS projects that would set benchmarks for improving timely access.

E. Brief narrative description:

EOCCO will establish a Bx Health Compliance and QI Network Meeting aimed to identify barriers, develop consistent approaches to gathering access data and understanding of access requirements, and provide technical support both network wide and to each individual CMHP. This approach will allow for EOCCO to support CMHPs, and also build structure for collaborative learning and information sharing between CMHPs. This structure will also provide a foundation for future quality improvement efforts across the network. Monthly EOCCO Bx Compliance and QI meetings consist of ongoing agenda items, as well as agenda items introduced by CMHPs that allows for clarity in communication, and opportunities for support from other network providers that was not previously possible.

EOCCO will utilize 2022 to establish structure and process for collecting access data from both behavioral health providers as well as from integrated care settings in order to have accurate baseline data.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): EOCCO will work with Behavioral Health Network compliance teams to develop consistent common definitions and data gathering process, and reporting structure to ensure accurate and valid data are reported, providing baseline data that can be used to identify target quality improvement goals in the future.

☒Short term or ☐Long term

Monitoring measure 1.1	Network QI and Compliance Meetings, 1:1 Technical Support, Quarterly Access Reports			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

1/12 CMHPs capable of reporting all access data measures.	12/12 CMHPs capable of reporting all access data measures.	End of Quarter 2	Baseline Data collected during Q3 and Q4 2022.	2/15/2023
EOCCO CMHPS do not have shared standardized definitions of access requirements, or data gathering procedures resulting in inconsistencies in data being reported in the network.	EOCCO will develop an access guide along with CMHPs that will detail a standard interpretation of OARs, contract requirements, and valid data gathering processes to be used across the EOCCO network.	End of Quarter 2	Accurate and valid data submission providing accurate baseline data.	2/15/2023

A. Project short title: Diabetes Self-Management Program

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

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

B. Components addressed

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

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

The 2020 intervention strategy centered on implementing a diabetes self-management (DSM) program in Harney County, specifically targeting EOCCO members who seek care at Harney District Hospital (HDH). The goal of this intervention was improved self-management and lifestyle changes among members with type II diabetes to decrease potentially avoidable costs associated with hospital visits. All but one of the key milestones were achieved from the previous MEPP submission. EOCCO identified a 12-week DSM program through the Oregon Wellness Network that took place in Q4 2021. The DSM program aimed to improve treatment adherence and decrease the possibility of complications via targeted member outreach to all diabetic members in Harney County encouraging enrollment into a DSM program. Additionally, Harney District Hospital staff was briefed on the program and asked to refer interested members to the program. As a result, 63.9% of Harney District Hospital's diabetic patients have a controlled HbA1c. The

only milestone that was not completed by the end of 2021 for the previous MEPP submission was the 90-day follow-up with all HDH members who participated in the first DSM cohort. This was due to time constraints and challenges presented by COVID-19. EOCCO is continuing interventions for diabetes because it accounts for $9.6 million in Adverse Actionable Events (AAE), which is 1/3 of the total spending. Furthermore, $2.7 million of AAE occurred in Baker and Malheur County, making up nearly 1/3 of total diabetic-related AAE in Eastern Oregon. As a result, Saint Alphonsus Medical Group Baker City and Saint Alphonsus Medical Group Fruitland Health Plaza will be the focus of the project moving forward.

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

The EOCCO has continued to have difficulty meeting the OHA Diabetes: HbA1c Poor Control Incentive Measure for multiple measurement years. Primary Care Physicians (PCP) are underutilized with a low utilization rate of 50%, posing barriers to managing patients with chronic diseases such as diabetes. In addition, due to the rural nature and minimal provider capacity, there is a lack of DSM courses and the ability to connect members with health care professionals (e.g., case management, health coaching, PCP).

Recognizing these barriers, EOCCO is in the process of implementing a DSM program through the contracted vendor Livongo. Other lines of business in Eastern Oregon that are part of the Moda family have contracted with Livongo and implemented DSM programs for their members (e.g., OEBB/PEBB, Summit Health). Additionally, EOCCO received clinical

buy-in from the Clinical Advisory Panel, the EOCCO Board, clinic surveys, and multiple one-on-one clinic meetings justifying the implementation of a DSM program for EOCCO members.

Saint Alphonsus was identified as a top utilizer for diabetic-related AAE in the Eastern Oregon service area and expressed interest in working closely with EOCCO on this project, narrowing the project's focus to diabetic members assigned to Saint Alphonsus. Of these 191 diabetic members assigned to Saint Alphonsus, a total of total $713,608.37 between January 2021 and September 2021 for all diabetic-related AAE was incurred. The program's primary goal is to decrease emergency department (ED) and inpatient utilization spending by 3% among diabetic EOCCO members assigned to Saint Alphonsus Medical Group Baker City and Saint Alphonsus Medical Group Fruitland Health Plaza.

E. Brief narrative description:

EOCCO members between the ages of 18-75 with a diagnosis of type 1 or type 2 diabetes who are assigned to PCPs at Saint Alphonsus Medical Group Baker City or Saint Alphonsus Medical Group Fruitland Health Plaza will be referred to the DSM program. Livongo is the contracted vendor offering virtual DSM; more specifically, Livongo offers health coaching, glucose monitoring, and data sharing with care teams within the program.

An EOCCO Quality Improvement Specialist (QIS) will host monthly meetings with Saint Alphonsus Medical Group to field all questions or concerns and provide updates. Saint Alphonsus is also equipped with educational materials and workflow processes to facilitate communication between the PCP and patient. Additionally, EOCCO will provide an eligibility file to Livongo of all diabetic members, including Saint Alphonsus patients, to conduct outreach and referrals. Once a member is enrolled with Livongo, they will engage with the DSM program with the assistance of a health coach who will teach the member to manage their chronic condition and engage in preventive health habits. The results and findings related to the proposed project will be tracked using Livongo enrollment reports, claims data, and the MEPP dashboard. The data will be shared with the EOCCO Quality Improvement Committee.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included):

By 12/31/2022, EOCCO will refer all diabetic members assigned to Saint Alphonsus to the DSM program with a goal of a 5% enrollment rate in order to decrease Saint Alphonsus' ED and inpatient utilization spending by 3%.

By 12/31/2025, EOCCO will refer all diabetic members assigned to Saint Alphonsus to the DSM program with a goal of a 15% enrollment rate in order to decrease Saint Alphonsus' ED and inpatient utilization spending by 6%.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Diabetes Self-Management (Livongo) Enrollment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of EOCCO members ages 18-75 assigned to Saint Alphonsus are enrolled with Livongo	5% of EOCCO members ages 18-75 assigned to Saint Alphonsus enrolled with Livongo	12/2022	15% of EOCCO members ages 18-75 assigned to Saint Alphonsus enrolled with Livongo	12/2025
Monitoring measure 1.2	Decrease Adverse Actionable Events Spending			

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
$713,608.37 of EOCCO diabetic related AAE at Saint Alphonsus	Decrease EOCCO diabetic-related AAE at Saint Alphonsus by 3% ($692,200.12)	12/2022	Decrease EOCCO diabetic-related AAE at Saint Alphonsus by 6% ($670,791.87)	12/2023

A. Project short title: Umatilla Community Paramedics Program

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

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

B. Components addressed

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

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

Over the course of 2021 EOCCO monitored utilization trends for individuals with a diagnosis of hypertension who presented at any Emergency Department for a hypertension-related claim. Since this review focused on members with an existing diagnosis of hypertension, EOCCO identified members who may be accessing the emergency department for management of chronic conditions, resulting in an over-utilization of services. Using the OHA dashboard, which included data from 2018 – 2020, it was determined that 752 members diagnosed with hypertension incurred approximately $1,400,000 in potentially avoidable Emergency Department encounters.

Since the previous year EOCCO completed all but one of the milestones related to the 2021 MEPP submission. This included the development of materials that were sent to patients with hypertension educating them on when to seek primary, urgent, or emergent care. Additionally, members who had two or more emergency department visits were contacted by phone to complete a social needs screening in an attempt to identify underlying social determinants of health that may be contributing to the health; however, these screens did not yield any significant results. The only milestone that was not completed by the end of 2021 for the previous MEPP submission was the three-month and six month follow-up with all members. This was due to time constraints and challenges presented by COVID-19. EOCCO has decided to continue to focus on hypertensive episodes but has refined our focus to Umatilla County where we are seeing the highest utilization rates. The 2021 MEPP project will be replaced with the Umatilla Community Paramedics program.

Though the 2021 MEPP project was not included in the previous TQS submission, these components did attribute to our overall utilization review efforts.

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

Given the expansive service area covered by EOCCO, the utilization review focused on services within Umatilla County; EOCCO's most populated county. In prior years EOCCO partnered with the Umatilla County Fire District #1 to provide follow up services for patients discharged for one of the area hospitals. For the purpose of this MEPP project, EOCCO and the Umatilla County Fire District will enhance the program known as the Community Paramedic Program, to focus on providing OHP members with timely follow up care once a member is discharged from the hospital. Depending on the member's needs this may include in-home labs, medication review, or referral coordination. For a full list of services

See *Attachment 21 Proposed Umatilla Community Paramedic Program Service Tier Structure*. Please note that this tier structure is pending final contract approval.

By ensuring members direct access to quality care provided by the Umatilla Community Paramedic Program, EOCCO aims to reduce complications that could lead to potentially avoidable Emergency Department costs. This model helps regulate the quantity and appropriateness of follow up care for members following their discharge. Results for the overall spend associated with potentially avoidable costs were pulled from EOCCO's internal claims system given the lag in data in the MEPP dashboard. Potentially avoidable costs were calculated from ED and inpatient encounters occurring between January – September 2021 in the two Umatilla County hospitals which totaled $363,489.

E. Brief narrative description:

The Umatilla Community Paramedic Program is a partnership established in 2018 between the Umatilla County Fire District #1 and the Eastern Oregon Coordinated Care Organization. After a successful three-year pilot, the Umatilla County Fire District decided to enroll as an EOCCO contracted provider. The pilot, which provided care to *all* community members regardless of payer type, has been refined to focus specifically on OHP members. In addition, under the contract the Umatilla Community Paramedic Program will expand their scope of services to provide targeted support and care coordination to EOCCO members. For the purpose of this MEPP project the Community Paramedic Program will focus specifically on reducing ED visits and overall costs for EOCCO members with a diagnosis of hypertension.

The Umatilla Community Paramedic Program will reach out to members prior to hospital discharge to establish a relationship. Once the member returns home the paramedics will arrange for follow up care. Based on the member's needs, follow up care will fall into one of four service tiers which can range from an in-home lab draw to comprehensive

point of care testing and follow up with the member's PCP (see *Attachment 21 Proposed Umatilla Community Paramedic Program Service Tier Structure)*.

Through this partnership the two organizations will be able to sustain a case load of up to 40 members. Services will continue up to 30 days after hospital discharge. The Umatilla Community Paramedic team will track individuals served by the program and report the data to the Network Adequacy Committee that reviews and detects over and underutilization of services.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): By supporting members through the Umatilla Community Paramedic Program EOCCO hopes to provide timely follow up care to members post-discharge and reduce potentially avoidable costs associated with ED encounters. The following activities will need to be completed before measuring progress made in the first year of the program:

- Establish a formal contract between Umatilla County Fire District #1 and EOCCO
- Develop referral pathways for Umatilla Community Paramedics to refer members to case management
- Secure data sharing and documentation of services

☐Short term or ☒ Long term

Monitoring measure 1.1	Reduce potentially avoidable costs for hypertensive related ED encounters			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
$363,468	Reduce costs by 3% in the first year	03/2023	Reduce costs by 8% from baseline	06/2025

	(Costs not to exceed $352,584)		(Costs not to exceed $334,390)	
Monitoring measure 1.2	Increase number of members served by the Umatilla Paramedic Program in the first year			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
New Program – No EOCCO patients are receiving services	40 hypertensive patients have received services	06/2023	80 hypertensive patients have received services	06/2025

A. Project short title: Opioid and Stimulant Use Disorder Housing Support Program

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

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

B. Components addressed

i. Component 1: Utilization review

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

iii. Component 3 (if applicable): Choose an item.

iv. Does this include aspects of health information technology? ☐ Yes ☒ No

v. If this project addresses social determinants of health & equity, which domain(s) does it address? ☒ Economic stability ☐ Education

☒ Neighborhood and build environment ☐ Social and community health

vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

EOCCO chose to discontinue the previous MEPP project focusing on the Substance Use episode at the end of 2021. This project was discontinued because the grant period ended and all of the key milestones were achieved. During the course of the project the team contracted with an MAT medical expert, hired a Certified Recovery Mentor (CRM) to work in the Emergency Department in Umatilla County, convened a planning committee to develop MAT treatment capacity, developed an Eastern Oregon Learning Collaborative on coordinating SUD services, and collected Government Performance and Results Act (GPRA) data related to the project. This data collection continued through 12/31/2021 and the project team met with OHA regularly.

In addition to closing out the previous MEPP SUD project, EOCCO also monitored utilization trends for individuals with substance use disorder (SUD) throughout 2020 and 2021. More specifically, EOCCO focused on analyzing utilization trends among members with opioid use disorder (OUD) and stimulant use disorder (MA-SUD) diagnoses, as members with these diagnoses have a higher risk of experiencing houselessness and other forms of marginalization. From January 2018 through December 2020 the MEPP dashboard reflects that EOCCO members incurred over $21.8 million in SUD related spending, $10.2 million (or 46.7%) of which was classified as avoidable or 'adverse actionable event' (AAE) spending. The MEPP dashboard also indicates that EOCCO members with OUD and/or MA-SUD diagnoses incurred $315,000 in SUD-related AAE costs during that same time period.

The EOCCO Analytics team further refined this utilization review by examining claims spending from January 2020 through September 2021 for EOCCO members with OUD and/or MA-SUD diagnoses who were also flagged for housing insecurity. The analysis found that this cohort incurred over $822,000 in health care costs, $548,000 (or 66.7%) of which were potentially avoidable. Furthermore, EOCCO calculated that each member in this cohort averaged $421 in potentially avoidable costs and $632 in total costs per month during the measurement period. EOCCO will continue to monitor utilization data for members with SUD diagnoses and housing flags for the purposes of this MEPP project and other Utilization Review requirements.

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

The proposed project builds off of a previous Statewide Opioid Response (SOR) Grant that was successfully implemented from 2019 to September 2021. The original intervention served 106 members and families by providing utilities, rental assistance, and temporary housing to individuals with OUD. The updated project has been expanded to include

individuals with MA-SUD as well as those with OUD and will focus on meeting housing-related needs of the target population.

As mentioned in section C, individuals with MA-SUD and/or OUD diagnoses as well as housing insecurity have significantly higher avoidable healthcare costs than individuals without housing insecurity flags. Housing is a major need in the Eastern Oregon service area and providing stability and safety via housing support is proven to help individuals with MA-SUD and OUD gain access to and increase adherence to SUD treatment. This increased engagement in treatment should reduce unnecessary health spending among this population in the long term. The overall goal of this

project is to reduce the total per member per month (PMPM) cost of care among EOCCO patients with OUD and/or MA SUD diagnoses and flags for housing insecurity by 3% (to $613 PMPM) by September 2024.

E. Brief narrative description:

This project will consist of coordinating with treatment providers in the EOCCO service area to identify and fulfill housing needs for up to 50 individuals/families diagnosed with OUD and/or MA-SUD. This grant-funded intervention will provide $250,000 in housing support for this population in the form of rental support, housing deposits, temporary housing, and other fees.

Providers can refer members with a current OUD and/or MA-SUD diagnosis to this program. This will be based on completion of an assessment with a provider in the past 12 months and if the provider determines that the member is underutilizing SUD treatment services and over utilizing other health services. Members must also meet at least one of the following criteria for housing support, as identified by claims and/or patient chart notes: member is transitioning from residential care or corrections facility to community, member is transitioning to a recovery-oriented housing program, member is experiencing houselessness or is at risk of experiencing houselessness, or member is at risk of re entering higher level of care or hospital setting.

The SOR grant team at GOBHI will track individuals served by this program throughout the grant cycle and report the data to the Network Adequacy Committee that reviews and detects over and underutilization of services. The EOCCO Analyst will then determine total claims spending for individuals in the grant cohort at the end of the project period. This will be compared to the baseline claims outlined in Section C for individuals who have housing insecurity flags and OUD and/or MA-SUD diagnoses as well as updated MEPP dashboard AAE data. The data will be monitored throughout the project period to determine if this population is experiencing a reduction in their overall cost of care and AAE spending that can be attributed to receiving housing support.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): The project team will promote this program via physical flier, email blasts/announcements, and word of mouth to each county's contracted Community Mental Health Program (CMHP) across all 12 Eastern Oregon counties by June 2022.

☒ Short term or ☐Long term

Monitoring measure 1.1	Number of Community Mental Health Programs (CMHPs) in Eastern Oregon counties given information (emails, flyers, word-of-mouth announcements) about this grant program.

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 CMHPs contacted	12 CMHPs contacted	06/2022	12 CMHPs contacted	06/2022

Activity 2 description: The grant project team will provide housing support services to 50 individuals or families with MA-SUD and/or OUD diagnoses and housing support needs by September 2022.

☒ Short term or ☐Long term

Monitoring measure 2.1	Number of housing support referrals sent to grant program email and processed by project team.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0 referrals processed	50+ referrals processed	09/2022	50+ referrals processed	09/2022

Monitoring measure 2.2	Amount of housing support funding disbursed to approved referred individuals or families.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
$0 distributed	$250,000 distributed	09/2022	$250,000 distributed	09/2022

Activity 3 description: EOCCO will reduce the total PMPM cost of care among its members served by this grant program by 3% by September 2024.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Average per-person cost of care for EOCCO patients served by grant project based on claims incurred in the two years after the grant period (October 2022 – September 2024).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
$631.83 *Because the grant project cohort will be selected throughout the grant period, the baseline PMPM cost is based on spending for all EOCCO members that met the target population criteria from the year prior to grant period (10/2020 – 09/2021).*	$622.35	09/2023	$612.87	09/2024

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: Access to Initial Behavioral Health Assessment within (7) Seven Days B. Project unique ID (as provided by OHA): #89

C. Criteria for project discontinuation: Project has failed to meet its expected outcomes and cannot be adapted to meet the outcomes.

D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): This project did not include reporting from PCPCHs and CMHPs reported inaccuracies in their data during 2020 and 2021. Without valid and accurate baseline data, targets and benchmarks identified are nullified. EOCCO has replaced this project with another project that will address the same component; Timely Access to Care. The new project will establish structure, process, and consistent access data gathering

from all outpatient behavioral health providers in order to establish accurate baselines for access. Once that short term project is completed EOCCO will revisit setting targets and benchmarks for access improvement.

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

B. Project unique ID (as provided by OHA): 90

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): EOCCO intended to expand the PCBH model to nine PCPCH-integrated practices under BHI contract. EOCCO expanded the PCBH to 10 PCPCH-integrated practices, fully realizing the project's intended outcomes. Additionally, EOCCO planned to provide quarterly check-ins with contracted clinics, a meeting cadence that has been established and will be adapted as needed. EOCCO will provide TA to BHI clinics on an ongoing basis and no longer needs the structure of the meetings explicitly stated in the TQS submission.

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

B. Project unique ID (as provided by OHA): 369

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): EOCCO has closed out the year-long dental depression screening pilot project with the three participating dental practices, Advantage Dental Milton Freewater, Advantage Dental Hermiston, and Arrow Dental. The three dental practices that participated in the pilot screened 374 patients for depression over the course of the program. We achieved our benchmark of 25% of patients who screened positive receiving a referral to behavioral health by 42% with our rate ending at 66%. Our rate not only surpasses our own benchmark, but it also surpasses the benchmark identified by the Metrics and Scoring Committee for the depression screening and follow-up quality measure by 1.4%. The EOCCO Clinical Advisory Panel will evaluate how to scale the project across EOCCO's entire 12-county service area.

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's quality improvement committee documentation as outlined in TQS guidance.

B. OPTIONAL: Supporting information

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

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Last Approved: *09/2021*
Last Revised: *07/2019*
Next Review: *09/2022*
Owner: *Kristi Swank: Quality & Compliance Project Manager*
Area: *EOCCO Care Coordination*
References: *Behavioral Health*, *Healthcare Services*, *Medical*
Applicability: *EOCCO*

EOCCO Utilization Management Delegation Policy

I. Policy Statement and Purpose

Eastern Oregon Coordinated Care Organization (EOCCO) may delegate utilization management (UM)

activities to outside entities to provide optimum services to its members. EOCCO is accountable for those delegated services and conducts oversight of the delegated activities. EOCCO's delegation oversight committee conducts regular meetings to provide this oversight.

II. Definitions

A. **CMS:** The Centers for Medicare & Medicaid Services (CMS) is part of the Department of Health and Human Services. CMS provides coverage determination guidelines in either National Coverage Determination or through Local Coverage Determination for a specified region.

B. **Delegation:** Grant of authority by one party (the delegator) to another (the delegatee) for agreed purpose(s).

C. **UM:** Utilization management (UM) is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called "utilization review."

III. Procedures

A. Approval of UM Program

1. The delegation oversight committee annually reviews each delegatee's UM program or the portions of its programs specific to the activities delegated to the delegatee.

2. If the committee finds the policies and procedures the delegatee uses to perform the delegated UM activities meet EOCCO standards, the committee will approve the delegatee's UM program.

3. If the committee determines that the policies and procedures do not meet EOCCO standards, the committee will identify where the program is lacking and pursue corrective action with the delegatee.

4. The committee will approve the delegatee's UM program upon resolution of discrepancy in the UM program.

B. Pre-Delegation Evaluation

1. EOCCO evaluates organizations considered for UM delegation for their ability to successfully

accomplish the delegated activities prior to delegation. The pre-delegation evaluation includes:

a. Review of the written delegation agreement to review for description of delegated activities, reporting timelines, protected health information safeguards, scope of delegated responsibilities, and process to evaluate the delegated entities performance.

b. Review of the delegatee's understanding of standards and delegated tasks

c. Assessment of staffing capabilities

d. Review of performance record

e. Comparison of the delegatee's UM program and schedule with the EOCCO program and schedule

f. Subsequent amendments to the delegation agreement that include additional UM activities receive a pre-delegation evaluation.

2. The evaluation may be accomplished through any combination of a site visit, document exchange, and

pre-delegation meetings.

3. The pre-delegation evaluation is documented in the delegation oversight committee's meeting minutes

C. Annual Delegation Evaluation

1. The delegation oversight committee evaluates delegatee performance at least annually. a. Evaluation is generally performed after one year.

b. Evaluation may be more frequent based on extent of delegation or performance issues. 2. The evaluation is based on:

a. Performance stipulations as stated in the delegation agreement

b. CMS Standards

3. The evaluation may include:

a. Documentation review

b. Committee meetings

c. Site visit

d. Telephone/email consultation

4. The evaluation includes identifying opportunities to improve both the delegatee's performance and EOCCO's processes.

5. Improvement opportunities are identified in meeting minutes as action items.

6. The delegation oversight committee follows up on improvement opportunities and documents progress made in meeting minutes.

D. Annual File Audit

1. The delegation oversight committee annually audits delegates' denial and appeal files against CMS standards.

2. The committee representative audits five percent or 30 (whichever is less) of both denial and appeal files.

3. The annual audit is based on the delegation responsibilities identified in the delegation agreement

and relevant CMS standards.

4. The committee representative then provides the audit report to the delegation oversight committee.

E. Providing Member Experience and Clinical Performance Data to Delegatee

1. On written request of a delegatee, EOCCO will provide member experience and/or clinical performance data, as applicable, to the delegatee so that the delegatee may assess its performance.
2. Member experience data may include member complaints and CAHPS or other member survey results pertaining to members' experience with the delegatee's services.
3. Clinical performance data may include HEDIS measures, claims, provider satisfaction surveys, and prior authorization reports.

IV. Related Policies & Procedures, Forms and References

N/A

V. Affected Departments

Healthcare Services
Quality Programs
Medicaid Compliance

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
EOCCO QIC Policy Subcommittee	Becky Miller: GOBHI Policy Analyst	09/2021
	Jessica Baurer: Sr Manager Utilization & MM	05/2021

Applicability

EOCCO

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Area: *EOCCO Network Management*
References:
Applicability: *EOCCO Medical/Dental/ Behavioral Health*

EOCCO Utilization and Medical Management Staff Audits and Quality Measures

I. Policy Statement and Purpose

EOCCO Medical Management nurse trainer/auditor, quality coordinator, and/or supervisory staff perform staff audits on cases reviewed by Inpatient and Outpatient Nurse Care Coordinators (RNCC), and Government Prior Authorization Coordinators (GPAC). Interrater Reliability Reviews are also completed by RNCC, Utilization Managment Behavioral Health Coordinatiors (UMBHC), Contracted Psychiatrists, and Medical Directors (MD). The purpose of the audits and Interrater Reliability (IRR) is to ensure consistency in application of criteria and adherence to policies, procedures, and processes. Staff audits and/or IRR are completed at least quarterly. Staff audits may also include review of written transcripts and/or recordings of telephone communications between Medical Management staff and providers and/or members.

II. Definitions

A. **RNCC:** Medical Management staff nurses responsible for completing prior authorization requests for coverage for services and/or supplies and/or responsible for monitoring and reviewing ongoing inpatient hospitalizations for the EOCCO member population

B. **GPAC:** Medical Management non-clinical staff responsible for initial review and disbursement of incoming prior authorization requests for coverage of services and/or supplies for the EOCCO member population

C. **MD:** Medical Management physicians responsible for reviewing requests for coverage for services and/or supplies for the EOCCO member population

D. **UMBHC**: Utilization Management Behavioral Health Coordinators.

III. Procedure

A. Interrater Reliability (IRR)

1. Medical

a. Medical Management designee(s) review the available case studies provided by MCG i. Each RNCC, Clinical pharmacist and MD is assigned at least one case study for review

ii. The purpose of the IRR is to ensure consistent and appropriate use of MCG by assessing the RNCC, Clinical pharmacist and/or MD knowledge, understanding, and application of MCG

iii. Passing score is 90% or above

2. Behavioral Health

a. Medical Management designee(s) review the available case studies provided by MCG

i. Each UMBHC, Contracted Psychiatrist, and/or MD will be assigned at least one case study for review per quarter.

ii. The purpose of the IRR is to ensure consistent and appropriate use of MCG by assessing the UMBHC, Contracted Psychiatrist, and/or MD knowledge, understanding, and application of MCG

iii. Passing score is 80% or above

B. Audits

1. Medical

a. The Medical Management Nurse Trainer/Auditor and/or Nurse Supervisory staff audit at least three cases per month per nurse. These cases are selected randomly from completed cases in

Content Manager.

b. Reviews focus on ensuring appropriate data are being collected to assess program outcomes, ensure policies, procedures, and processes are up to date and to identify areas of opportunity for training and education.

c. The results of nurse audits are shared between the Nurse Trainer/Auditor and the appropriate supervisor. Supervisors and the Nurse Trainer/Process Auditor work together to identify and schedule follow up training and education for individuals as necessary.

d. Nurse audit results are shared with the individual nurse. Opportunities for training and education, questions, clarifications, etc. are reviewed and follow up training and education is scheduled as necessary.

e. Additional cases are reviewed as necessary and appropriate based on Nurse Supervisor and/or Nurse Trainer/Process Auditor discretion.

2. Behavioral Health

a. The Integrated Services Director and / or management staff will audit at least one case per month per UMBHC. These cases are selected randomly.

b. Reviews focus on ensuring appropriate data are being collected to assess program outcomes, ensure policies, procedures, and processes are up to date and to identify areas of opportunity for training and education.

c. The results of audits are shared between the Supervisors and the UMBHC will work together to identify and schedule follow up training and education for individuals as necessary.

d. Audit results are shared with the individual UMBHC. Opportunities for training and education, questions, clarifications, etc. are reviewed and follow up training and education is scheduled as necessary.

e. Additional cases are reviewed as necessary and appropriate based on Integrated Services Director discretion.

C. GPAC Audits

1. The Medical Management Quality Coordinator and/or GPAC supervisory staff audit at least three cases per month per staff member. These cases are selected randomly from completed cases in Content Manager.
2. Reviews focus on ensuring appropriate data are being collected to assess program outcomes, ensure policies, procedures, and process are up to date and to identify areas of opportunity for training and education.
3. The results of PAC audits are shared between the Quality Coordinator and the appropriate supervisor. Supervisors and the Quality Coordinator work together to identify, and schedule follow up training and education for individuals as necessary.
4. PAC audit results are shared with the individual PAC. Opportunities for training and education, questions, clarifications, etc. are reviewed and follow up training and education is scheduled as necessary.
5. Additional cases are reviewed as necessary and appropriate based on Supervisor and/or Quality Coordinator discretion

D. Aggregate results of the audits and/or IRR are reported quarterly to the Medical Quality Improvement Committee (MQIC) along with interventions identified and/or implemented to address opportunities for additional training/education

E. Aggregate results of the audtis and/or IRR for Behavioral Heatlh will be reported quarterly to the Utilization Management Committee along with interventions identified and/or implemented to address opportunities for additional training/education

F. The Medical Management Audit Tools are reviewed and revised as necessary to maintain relevance

IV. Related Policies & Procedures, Forms and References

V. Affected Departments

Healthcare Services

Attachments

No Attachments

Approval Signatures

Step Description Approver Date EOCCO QIC Policy Subcommittee Becky Miller: GOBHI Policy Analyst 05/2021 Kristi Swank: Quality & Compliance Project Manager 05/2021

Applicability

EOCCO, GOBHI

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Area: *EOCCO Operations*
References: *Behavioral Health*, *Dental*, *EOCCO Quality improvement Committee*, *Medical*, *Pharmacy*
Applicability: *EOCCO*

EOCCO Transformation and Quality Strategy

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.

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

A. 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

1. 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

1. The EOCCO TQS structure includes the following:

a. EOCCO Quality Improvement Committee

i. 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.

ii. 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:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10. 11. Administrative services

Appeals & grievances
Care coordination
Case management
Compliance
Medical director
Member services
Provider credentialing
Provider relations
Quality and performance improvement
Utilization management

Senior management

12.

iii. An EOCCO QIC member, elected by the group every two years, chairs the committee.

iv. 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.

v. The President, EOCCO, is the executive sponsor of the EOCCO QIC.

b. Utilization review oversight committee

i. 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.

ii. 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.

iii. The committee is comprised of physical health, behavioral health, oral health and pharmacy services clinical and non-clinical utilization management, compliance and quality representatives.

iv. The committee includes EOCCO senior level physical health, behavioral health, and dental

health directors and/or chief officers.

v. 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.

c. EOCCO clinical advisory panel

i. 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.

ii. 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.

iii. 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.

iv. 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. d.

EOCCO incentive measures workgroup

i. 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.

ii. 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.

iii. The health promotion and quality improvement specialists facilitate workgroup meetings.

iv. The workgroup appoints dedicated committees to research, design and implement specific quality improvement projects.

v. 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.

vi. Contemporaneous minutes provide a record of the workgroup activities. Incentive measures workgroup activities are reported to the EOCCO QIC and board of directors.

vii. 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.

e. Physician Leadership

i. 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.

f. Credentialing Program

i. 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.

g. Quality assurance and performance improvement initiatives

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

1. 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.

2. 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.

h. Grievance system

i. 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.

i. Care Member

i. Behavioral Health Services

1. 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.

2. EOCCO has a written quality improvement plan for the crisis management system to address the requirements identified in OAR 410-141-3840, which will be provided to OHA upon request. The quality improvement plan includes but is not limited to:

i. Collection and review of access data on a quarterly basis

ii. Routine collaboration and follow-up with behavioral health providers at the Behavioral Health Network Compliance/Quality Improvement meeting regarding crisis services and CCO contract requirements.

iii. Review by EOCCO QIC of access data to identify areas for improvement and

development of strategies.

Medical and Disease Management Services

ii.

1. 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:

a. Health coaches who work with members with chronic health conditions

b. Care coordination for members who receive multiple services

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

iii. Collaborations

1. 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

iv. Dental Case Management

1. 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

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

i. What is the current situation needing improvement? Complete root cause analysis or

i. 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

addressed

d. Act

i. 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?

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

2. Work Plan

a. 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:

i. System activities used to implement and ensure quality coordinated health care, including behavioral health and oral health care

ii. 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

iii. Assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access, and cultural considerations

iv. 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 A

v. demonstration of improvement in an area of poor performance in care coordination for members with serious and persistent mental illness (SPMI)

vi. Grievance system information, including complaints, notice of actions, appeals, and hearings

vii. 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

viii. EOCCO QIC monitoring of the TQS.

ix. Committee minutes on utilization review guidelines, treatment protocols and policies.

x. Participation as a member of the OHA Quality and Health Outcomes Committee.

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

3. Determining Aspects of Care

a. 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

a. 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

a. 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.

i. Identification and rationale for the aspect of clinical care or non-clinical services being studied, including gap and root cause analyses

ii. Specific quality indicators to measure performance

iii. Collection of baseline data

iv. Identification and implementation of appropriate system interventions to improve performance

v. Repeated data collection to assess the immediate and continuing effect of the interventions and determine the need for further action

vi. 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.

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

E. Delegation

1. 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

1. 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

1. 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. Affected Departments:

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

At

tachments No Attachments

Approval Signatures

Step Description Approver Date EOCCO QIC Policy Subcommittee Becky Miller: GOBHI Policy Analyst 02/2022 Summer Prantl: Sr Manager Medicaid Services 02/2022

Applicability

EOCCO

Current Status: *Active* **PolicyStat ID:** *10918236* **Origination:** *09/2015*

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Last Revised: *12/2021*
Next Review: *12/2022*
Owner: *Nick Gross: Medicaid Compliance Officer*
Area: *EOCCO Compliance*
References: *Behavioral Health*, *Dental*, *Legal*, *Medical*, *Pharmacy*
Applicability: *EOCCO*

EOCCO Subcontractor Oversight and Monitoring Policy

I. Policy Statement and Purpose

EOCCO may delegate functions to third parties related to its OHP (Medicaid) Plans. OHP program requirements apply to subcontractors who contract with EOCCO to provide certain administrative or health care services for enrollees on behalf of EOCCO. This policy describes how EOCCO complies with OHP program requirements for subcontractors and states EOCCO's expectations and requirements of its subcontractors.

EOCCO may enter into contracts with subcontractors to provide administrative or health care services for OHP Members on behalf of EOCCO. However, EOCCO retains ultimate responsibility for adhering to and otherwise complying with all terms and conditions of its contract with the State . OHA may hold EOCCO accountable for the failure of its subcontractors to comply with Medicaid program requirements. EOCCO requires all subcontractors to comply with all applicable OHA requirements. Areas of non-compliance will result in corrective action and review. Continued non-compliance will result in further corrective action up to and including termination of the contract with EOCCO.

II. Definitions

A. **Abuse:** Actions that may, directly or indirectly, result in: unnecessary costs to the Medicaid Program, improper payment, payment for services that fail to meet professionally recognized standard of care or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

B. **Audit:** A formal review of compliance with a particular set of standards (e.g., policies and procedures, regulations and/or service levels) used as base measures.

C. **Fraud:** Knowingly and willfully executing or attempting to execute as a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

D. **FWA:** Fraud, waste, abuse

E. **Monitor:** To conduct regular reviews as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

F.

OHA: Oregon Health Authority

G. **Subcontractor:** Any participating provider, individual, entity, facility or organization that has entered into a subcontract with EOCCO for any portion of work under EOCCO's contract with OHA.

H. **Waste:** The overutilization of services or other practices, that directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is not generally considered to be caused by criminally negligent actions but rather the misuse of resources.

III. Procedures

A. Compliance with EOCCO Policies and Required Training

1. Subcontractors must comply with the EOCCO Medicaid Compliance Plan and this policy.

Subcontractors are also required to complete all CMS and OHA required training. Subcontractors shall track completion of training and will be required to demonstrate proof of training attendance and completion as part of the annual EOCCO delegation oversight review.

B. Oversight and Monitoring Subcontractor

1. The EOCCO Compliance Officer or delegated staff will monitor and audit EOCCO's subcontractors to ensure they are in compliance with applicable laws, regulations and service levels with respect to its delegated responsibilities.

a. EOCCO shall monitor the performance of all subcontractors on an ongoing basis and perform, at least once a year, a formal review of compliance with all subcontracted obligations and other responsibilities, performance, deficiencies, and areas for improvement. Such review shall be documented in an Annual Subcontractor Performance Report, which must be completed within sixty (60) days after the annual anniversary of the effective date of the subcontract. EOCCO shall make a conclusion in each Annual Subcontractor Performance Report as to whether a subcontractor has complied with all the terms and conditions of this Contract that are applicable to the work performed by subcontractor.

i. EOCCO will ensure that employees, Subcontractors, and providers are trained to provide culturally and linguistically appropriate behavioral health services.

ii. EOCCO will ensure employees, Subcontractors, and providers are trained in integration, and Trauma Informed Care and provide regular, periodic oversight and technical assistance on these topics to providers.

iii. If EOCCO chooses to delegate any other portion of the grievance and appeal process to a subcontractor, EOCCO, in addition to the general obligations established under OAR 410-141-3505, do the following:
1) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3875 through 410-141-3915;

iv. EOCCO will communicate it's record keeping policies to employees, Subcontractors and providers on a regular basis and will monitor subcontractors record keeping policies and procedures as part of its ongoing monitoring process.

b. The Annual Subcontractor Performance Report must include at a minimum the following elements:

i. An assessment of the quality of subcontractor's performance of contracted Work;

ii. Any complaints or Grievances filed in relation to subcontractor's work;

iii. Any late submission of reporting deliverables or incomplete data;

iv. Whether employees of the subcontractor are screened and monitored for federal exclusion from participation in Medicaid;

v. The adequacy of subcontractor's compliance functions; and

vi. Any deficiencies that have been identified by OHA related to work performed by subcontractor.

c. EOCCO shall provide a copy of each Annual Subcontractor Performance Report to OHA via Administrative Notice, within thirty (30) days of completion. EOCCO shall oversee and be responsible for the satisfactory performance of any functions or responsibilities it has delegated to a subcontractor.

C. Reporting of Compliance Issues and FWA

1. All subcontractors and their employees are required to report any suspected or potential compliance issues. Subcontractors may report suspected compliance violations anonymously through EthicsPoint (1-866-294-5591 or www.ethicspoint.com) or by calling EOCCO's anonymous compliance and FWA reporting hotline (1-855-8012991). In addition to or in lieu of submitting a report via EthicsPoint,

subcontractors may also directly report compliance issues to the EOCCO Medicaid Compliance Officer at medicaidcompliance@modahealth.com and suspected fraud, waste and abuse to the Special Investigations Unit at stopfraud@modahealth.com.

D. EOCCO Disciplinary Policies

1. Failure to report suspected Medicaid program violations and/or FWA may result in disciplinary action up to and including termination of a subcontractor contract with EOCCO. EOCCO has a strict policy of non-intimidation and non-retaliation against subcontractors and employees for good faith reporting and participation in the compliance program. EOCCO expects all subcontractors to have disciplinary standards in place and publicized for employees and related subcontractors.

E. Identifying and Investigating Compliance Issues

1. Compliance issues with respect to subcontractors may be discovered through auditing and monitoring or otherwise disclosed to EOCCO. Regardless of the source of notification, EOCCO will investigate such matters to determine if a true issue of non-compliance exists. The subcontractor will be required to fully cooperate with EOCCO in any such investigation. Failure to do so could result in disciplinary actions, up to and including termination of the contract with EOCCO.

F. Corrective Action

1. When identified compliance or performance issues are confirmed, including FWA, EOCCO will determine the appropriate corrective action plan, with such action designed to correct the underlying problem that resulted in program violations and to prevent future non-compliance. A corrective action plan must be tailored to address the particular non-compliance, FWA, problem of deficiency