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EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Eastern Oregon Coordinated Care Organization

Transformation Quality Strategy

March 2023

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Section 1: Transformation and Quality Program Details

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: 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 is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, 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
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

EOCCO recognizes the profound impact that enhanced demographic data collection has on understanding the health of our members and the communities we serve. EOCCO realizes that the implementation of a new policy, workflow, or program may impact members in different ways. In some cases, this may adversely affect members of certain groups. While this is never the intention, EOCCO must remain accountable for tracking when members are negatively affected by a change in service. To better understand the needs of members, EOCCO continues to collect updated REAL-D information directly from members using screening tools such as Accountable Health Communities (AHC) with a supplemental REAL-D questionnaire. In 2022, AHC questionnaires were administered to individuals with two (2) or more emergency department visits within a 6-month period. This screening criteria was determined to help identify members who potentially had underlying needs with exasperated health conditions that lead to overutilization of emergency department services. While the REAL-D questionnaire was not required to complete the AHC screen, it proved to be a natural time to collect additional data. A full REAL-D analysis was conducted on the full population who received an AHC screen. Notably, these members were more likely to have a disability including difficulty walking or climbing stairs (32%) or difficulty concentrating, remembering, or making decisions (44.6%). Furthermore, 26% of survey respondents identify as Hispanic and Latino/a/x, with 19% identifying Spanish as their primary language.

Throughout 2022, EOCCO continued to refine the data collection process to provide a more accurate representation of membership. This included steps such as identifying all sources that provide member data, reviewing current data collection questions and available answers, building out the data warehouse to have a place to store data fields that were not previously recognized, and developing a hierarchy to determine the source of truth and reconcile files with competing information.

Several smaller initiatives were underway to help improve the collection of health equity data. By July of 2022, all 12 Eastern Oregon counties had onboarded with Unite Us (Connect Oregon), a community information exchange (CIE)

platform used to make closed-loop referrals among social service organizations. A REAL-D intake form has been uploaded into the CIE in English and Spanish to collect supplemental demographic information. EOCCO plans to upload the SOGI questionnaire into Unite Us once it is available. Additionally, EOCCO had the ability to gather some information from Arcadia Analytics, a health information exchange (HIE), however the quality of the data provided can be inconsistent. For this reason, data integration efforts with Arcadia have been paused for the time being. EOCCO will continue working to integrate new sources of data into the data warehouse, including SOGI data. EOCCO recognizes the significance that SOGI data yields when evaluating health equity data for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

In the previous year, EOCCO set the goal to reduce the total number of members with 'unknown' listed in the race/ethnicity field in their member profile by 1.5%. This would be accomplished by providing updated demographic data collected through AHC screenings which would then flow into EOCCO's data warehouse to update member's demographic profile. At the time, the 2022 TQS goals determined REAL-D demographic data was being collected, however it was not yet being integrated into the EOCCO data warehouse. Previously, 834 enrollment files were the primary source of information, and any updates EOCCO made to a member's demographic information would be overwritten when the next 834 file was received. Over the last year, an internal workgroup was formed to begin exploring how to support enhanced demographic data. The group identified several challenges including building out new data collection fields, building a hierarchy of data sources to determine how to reconcile competing sources, and accounting for missing or incomplete data. While there were several data sources available to pilot, the group prioritized the data received from the AHC screens as it provided the most complete, high quality data collection. In Q4 of 2022, the analytics team was successfully able to integrate updated demographic data from AHC screens into the members demographic profile without having it be overwritten by an incoming 834 enrollment file.

Baseline data taken from the December 2021 OHA Dashboard showed that 32,222 members, or 44.8%, did not have data listed in the race/ethnicity field. In 2022, AHC screenings were administered to 683 members, 132 of which were listed as having an 'unknown' race/ethnicity. Of this sample, 25.7% declined to provide updated race/ethnicity information or were unsure how to answer. For the 74.3% who provided updated race/ethnicity information, the highest change in percentage was for members who identified as Mexican (Hispanic and Latino) which accounted for 28.79% of the updated demographic profiles, followed by those who identified as White (Other white) which accounted for 16.67% of the updated profiles. A full list of updated demographic profiles can be found below in Table 1.

Table 1.

Updated Primary Race/Ethnicity Data for Members Previously Listed as 'Unknown'

Primary Racial or Ethnic Identity	Count of Primary Race/Ethnicity	Percentage of Total
American Indian and Alaska Native: American Indian	8	6.06%
Asian: Filipino/a, Asian: Korean	1	0.76%
Black and African American: African American	1	0.76%
Hispanic and Latino: Central American	3	2.27%
Hispanic and Latino: Mexican	38	28.79%
Hispanic and Latino: Mexican, Other categories: Don't know	2	1.52%
Hispanic and Latino: Other Hispanic or Latino/a/x	3	2.27%
White: Eastern European	2	1.52%
White: Other White	22	16.67%
White: Slavic	3	2.27%
White: Western European	9	6.82%
Member identifies as Biracial or Multiracial (did not select a primary race/ethnicity)	6	4.55%
Other categories: Don't know	29	21.97%
Don't want to answer	5	3.79%
Grand Total	132	100.00%

One notable challenge was that due to a shift in funding, AHC screenings were paused from January – June 2022, giving EOCCO only 6 months of REAL-D data, instead of a full year as anticipated. Long term funding has since been secured, and the AHC project will continue for the foreseeable future. While EOCCO did not meet the goal of seeing a reduction of 1.5% in unknown race/ethnicity, EOCCO is optimistic that efforts in 2022 helped lay the groundwork needed not only to *collect* updated demographic information, but also to accurately reprogram the data warehouse to *display* reliable demographic information.

When comparing baseline data taken from the OHA dashboard, the AHC data remained consistent, but with a higher degree of specificity. For example, data revealed that 19% of AHC respondents indicated that Spanish or a Spanish dialect was one of the languages spoken in the household. This included households that only spoke Spanish or spoke Spanish in combination of one or more languages. AHC data noted several households speaking Mam or Q'anjob'al, two dialects that are often noted as Spanish in demographic intake forms.

EOCCO recognizes the significance that SOGI data yields when evaluating health equity data for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members. EOCCO will continue working to integrate new sources of data into the data warehouse, including SOGI data.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

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, including linguistic and culturally responsive components. As EOCCO continues to incorporate more trusted data sources, such as the Accountable Health Communities (AHC) screening data and information from the Health Information Exchange (HIE) and Arcadia Analytics, EOCCO hopes to improve the overall quality of data. This project will strengthen the ongoing procedures to store, retrieve, and use demographic data of the EOCCO members that meet the REAL-D standards. In 2023, EOCCO will begin the process of expanding the data warehouse to include data on sexual orientation and gender identity as well.

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 (continue repeating until all activities included): EOCCO is evaluating demographic data including race, ethnicity, and language from completed AHC screens to improve member records in the data analytics warehouse.

Baseline data was pulled from 834 enrollment files in December 2021, which indicated that 44.8.3% of 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% of EOCCO membership noted an 'unknown' race/ethnicity at baseline	Reduce by 1.5% through ACH data	12/2023	Reduce % of 'unknown' race/ethnicity by 11% through all data sources	12/2026

Activity 2 description: EOCCO will identify SOGI data collection points to begin building out the data warehouse. Once the data warehouse has the capability for storing SOGI information, EOCCO will begin integrating data from various sources into the member's profile.

Please note that this project is focused on building out the capabilities of the data warehouse to present SOGI data. EOCCO will continue collecting supplemental SOGI data prior to the expansion of the data warehouse, however EOCCO does not expect it to be available in the central repository right away.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Identify data collection points to build into the data warehouse			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current data warehouse does not have the capability of displaying SOGI data	Identify SOGI data points to build into EOCCO data warehouse	12/2023	Begin integrating SOGI data to be reflected in the member's profile	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 is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, 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
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

EOCCO continues to emphasize the recruitment, training, and retention of Community Health Workers (CHWs). CHWs are an essential bridge to appropriately communicate information and assist members with navigating healthcare systems. In 2022, EOCCO maintained an active partnership with Oregon State University, supporting the training of CHWs in Eastern Oregon. EOCCO expanded the relationship with Oregon State University in 2023 to begin a Healthcare Interpreter (HCI) training for Spanish-language workforce members, including CHWs, in Eastern Oregon to become certified or qualified interpreters. This additional training and expanded partnership intend to support the availability of these services to the 11.4% of EOCCO members that are primary Spanish-language speakers.

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 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, EOCCO chose the CHW program as a focus for this quality improvement project that addresses culturally responsive care. EOCCO will apply a health equity lens to the CHW program and address both: (a) ongoing examination of the demographic profiles of the 12 counties served in Eastern Oregon and that are rural or frontier by REAL-D standards and (b) further support the existing CHW workforce by delivering target training and education opportunities.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

EOCCO evaluated the REAL-D data of all CHWs in the service area in 2022 by leveraging existing THW reporting requirements and an annual survey to gather data on the race, ethnicity, language, and disability status of the workforce in the region. Furthermore, EOCCO stratified all member-level data by REAL-D categories for each county, allowing for a comparison of EOCCO membership with the CHW workforce in the region to better understand the workforce needs and gaps. The analysis of this data will be ongoing, but EOCCO intends to retire 2022's Activity 1 of this TQS project as all data is available and capacity needs are being examined across the entire service area.

Preliminary results of the analysis found that 29.3% of CHWs in the EOCCO service area reported speaking Spanish, with 83.3% of those CHWs OHA certified or qualified HCIs. Furthermore, 14.6% of the CHW workforce in the EOCCO region identified as Hispanic/Latino, suggesting that the workforce is well-poised to support the 19.3% of EOCCO members who identify as Hispanic/Latino. While the CHW workforce is racially, ethnically, and linguistically well-matched to the EOCCO member population, 0% of the workforce reported living with a disability. Other THW types, such as Peer Support Specialists, reported rates of disability in the workforce as high as 37.5%. It is possible that CHWs did not feel comfortable reporting disability status to the CCO, and efforts will be undertaken in the coming reporting year to improve data accuracy for this workforce group. EOCCO recognizes the significance that SOGI data yields when evaluating culturally responsive services by CHWs for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members.

EOCCO continued to provide site-specific technical assistance (TA) for CHW billing, meeting with clinics, pharmacies, individual providers, and community-based organizations (CBOs) interested in CHW billing. From June of 2021 to June of 2022, EOCCO saw a fall in clinics reporting billing for CHWs from 61.5% of annual survey respondents to 53.8% of annual survey respondents. However, in the same period, clinical encounters with CHWs doubled and the CHW workforce continued to grow. Taken altogether, it is most likely that more clinics are hiring CHWs and need support to bill for their services; the measurable denominator on this monitoring measure has grown rapidly which results in the appearance of a relatively smaller group of providers billing for CHW services when the raw data suggest that not to be the case. EOCCO will continue to work towards the project targets and benchmarks, recognizing that the rapid expansion of CHW services in the region may result in a longer timeline for component maturity and completion. In tandem with billing TA, EOCCO will evaluate billed CHW claims through a REAL-D lens, understanding the demographics of members who are accessing CHW care in the clinical setting.

EOCCO offered a THW-specific summit in the summer of 2022, offering continuing education to CHWs and other THWs on a variety of priority topics. Training topics included scopes of practice of THWs in behavioral health settings and social needs referrals for members in behavioral health or substance use treatment. Furthermore, EOCCO hosted a THW panel at the Clinician and Staff Summit, training CHWs and other staff on the innovative use of CHWs to meet the health needs of priority populations including Hispanic/Latino/a birthing people, people abusing substances, and use of CHWs in school-based settings. EOCCO will continue to offer continuing education to CHWs for priority populations. EOCCO informed priority population members such as members living with diabetes, members living with end stage renal disease, and Spanish-speaking members in Umatilla County of available CHW services through the distribution of targeted materials, attendance at health fairs and community events, and partnerships with CBOs working closely with identified priority populations. In the coming year, EOCCO will target the development and distribution of materials to Compacts of Free Association (COFA) and Healthier Oregon Program (HOP) members to inform them of culturally and linguistically appropriate CHW services in their region. Due to staff turnover, EOCCO had limited ability to track the distribution and use of written materials. EOCCO will continue to prioritize this element of the project while developing materials more targeted to specific member populations.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

To increase the capacity to provide culturally responsive care through CHW-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 13, while ensuring members receive culturally responsive services.

How CLAS Standards are addressed by this project:

- CLAS Standard 13- Communicate available CHW services to priority populations in partnership with trusted CBOs.
- CLAS Standard 3- 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.

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

Activity 1 description (continue repeating until all activities included): Ensure sustainability of CHW-based culturally responsive care via TA for CHW billing. EOCCO's THW Liaison and Lead Provider Relations Representative will continue to provide learning opportunities to clinics to bill CHW services for reimbursement, discussing options for capturing and paying for the scope of culturally responsive care being provided in clinical settings by the workforce.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Track number of clinical partners billing CHW services for reimbursement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
53.8% of clinics report billing for CHW services	60% of clinics report billing for CHW services	06/2023	70% of clinics report billing for CHW services	06/2024

Monitoring measure 1.2	Evaluate billed CHW services through a REAL-D lens			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No CHW claims evaluated through a REAL-D lens	10% of CHW claims evaluated through a REAL-D lens	12/2023	20% of CHW claims evaluated through a REAL-D lens	12/2024

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.

☒ Short term or ☐ Long term

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)**
CCO offered continuing education on CHWs on the following topic for priority populations: substance use disorders	CCO offers continuing education to CHWs on all the following topics for priority populations: trauma-informed care, older adults	09/2023	CCO offers continuing education to CHWs on all the following topics for priority populations: CLAS standards	03/2024
Monitoring measure 2.2	Distribute member materials and track delivery			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Materials and resources (e.g., written brochures) that meet cultural and linguistic standards for identified priority populations distributed to inform of CHW services	Materials and resources developed for targeted populations including COFA and HOP members	12/2023	Track the channels and methods in which materials and resources (e.g., written brochures) that meet cultural and linguistic standards to inform identified priority populations of CHW services are delivered and used; this will inform effectiveness and accessibility of materials	12/2024

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

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

If continued, insert unique project ID from OHA: 94

B. **Components addressed**

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

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

Through 2022, the "hold" on the Oregon Health Plan (OHP) redetermination remained in place, resulting in a continued rise in Medicaid enrollment and EOCCO membership. As of January 2023, EOCCO membership stood at 77,169, an increase of 10,314 members over the year before. As a result, a larger number of members have been assigned to PCPCH clinics. The CCO's primary care clinic auto-assignment process enrolls patients in the highest-tiered PCPCH clinic in their area by design, so the continued growth in EOCCO membership has led to an increase in member assignment to PCPCH clinics with higher tier designations. As EOCCO's membership grows, the diversity in race, ethnicity, languages spoken, and disability status grow as well. EOCCO has heard a need for additional resources such as OHA certified/qualified interpreters to provide culturally and linguistically appropriate and responsive services to members.

Due to the Primary Care Transformation Coordinator leaving EOCCO during 2022, opportunities for in-person learning collaboratives related to PCPCH applications and tier requirements have been limited. To adapt to staffing changes and limitations, EOCCO worked to provide Technical Assistance (TA) as requested by clinics on an ad hoc basis. Additionally, EOCCO Quality Improvement Specialists visited PCPCH clinics in-person in the Spring and Fall of 2022. These visits created opportunities for clinics to receive in-person TA and connect with the CCO to have questions about tier status and requirements answered in a more focused meeting than virtual visiting alone could provide.

In 2023, PCPCH providers and staff were offered CME credit for training on cultural responsiveness with a specific emphasis on SOGI data at the EOCCO Provider and Staff Summit. EOCCO recognizes the significance that SOGI data yields when evaluating PCPCH assignment and care for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members. Furthermore, EOCCO conduced a REAL-D analysis of all members in 2022, giving CCO staff a repository of information from which to conduct equity analyses. REAL-D and SOGI data will be central to connecting members to PCPCH care in a culturally appropriate way.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

Throughout 2022, EOCCO increased the number of members assigned to a Tier 4 or 5 Star PCPCH clinic. In January 2022, 82.3% of members were assigned to Tier 4 or higher clinics. As of January 2023, 83.3% of EOCCO members are assigned to a Tier 4 or higher PCPCH clinic. While the percentage increase of members assigned to a Tier 4 or higher PCPCH clinic is only 1.5%, this percentage change reflects 9,646 total members assigned to a higher tier PCPCH, meeting the 2023 benchmark/future state goal of having 83.7% of EOCCO members assigned to a Tier 4 or higher PCPCH-certified clinic. This growth in member population assigned to clinics continued in the wake of the Primary Care Transformation Coordinator leaving EOCCO during 2022, a position that remains unfilled. As more EOCCO members are assigned to PCPCH clinics, PCPCH providers are providing care to a more diverse patient population with a variety of language and accessibility needs. As of December 2022, EOCCO Analytics reports show that 12.7% of EOCCO members speak a primary language other than English and 10% of EOCCO members are living with a disability. As such, TA to support improving care delivery for these member populations are necessary.

EOCCO also experienced an increase in the percentage of Tier 4 and 5 Star PCPCH-certified clinics with members assigned for primary care. In January of 2022, 77.8% of PCPCH clinics were certified at Tier 4 or higher. As of January 2023, 81.5% of PCPCH clinics are certified at Tier 4 or higher. This improvement will be augmented by interventions new to 2023 to provide new avenues for technical assistance to clinics working to advance their tier status. As a note, calculations of certified clinics have been adjusted from counting all clinics separately to considering the percentage of clinics certified at each tier. This is an alteration from the data points submitted in 2022.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In 2023, EOCCO intends to execute two new activities to meet the goals of increasing the number of members assigned to PCPCH clinics and enhancing PCPCH tiers for lower-tier clinics. Beginning in April of 2023, EOCCO's clinical consultant will provide proactive technical assistance to PCPCHs for tier advancements. The EOCCO clinical consultant has worked closely with clinics on Behavioral Health Integration contracts, a component that is often missed by clinics when intending to advance tiers. The clinical consultant will contact three priority clinics, Strawberry Wilderness Community Clinic, Valley Family Health Care, and Grande Ronde Hospital, looking closely at opportunities for tier advancement at a clinic-specific level and supporting targeted interventions to improve PCPCH tiers. This technical assistance will be on a direct one-on-one basis with the clinics, providing highly tailored support. EOCCO's goal is to support the movement of Strawberry Wilderness Community Clinic from Tier 4 to a 5 Star (roughly 1,600 impacted members) in 2023. Then, between now and 1/1/2025, EOCCO will support the movement of Valley Family Health Care and Grande Ronde Hospital, two of the largest clinic systems in the region, from Tier 4 to 5 Star (roughly 15,300 impacted members). These advances will lead to a total of 16,900 additional members receiving care from clinics with 5 Star ratings by 1/1/2025.

Additionally, EOCCO plans to ensure that members are assigned to the correct PCPCH clinic where they are most frequently receiving care. Currently, roughly 92.5% of EOCCO members are assigned to PCPCH clinics and EOCCO will work with their internal analytics team to conduct a two-part analysis of clinic assignment. First, Analytics will look at membership assigned to each clinic based on REAL-D criteria, understanding the diversity and specific healthcare needs at a clinic-by-clinic level. Second, Analytics will check and correct PCPCH assignment, making sure that members are assigned to the clinics they are utilizing most frequently. EOCCO will then consider the demographics of members not assigned to a PCPCH and conduct a targeted and culturally specific member education campaign that outlines the benefits of visiting a PCPCH, encouraging the 7.5% of members currently not assigned to a PCPCH to seek care.

As tracking measures, EOCCO will monitor the percentage of EOCCO members assigned to a PCPCH clinic and stratify these assignments by REAL-D and SOGI categories. EOCCO will also monitor the percentage of Tier 4 or higher PCPCH clinics with EOCCO members assigned for primary care.

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

Activity 1 description (continue repeating until all activities included): By January 2025, EOCCO will increase the percentage of members assigned to a Tier 5 PCPCH clinic.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Measure the percentage 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 2023) No certification: 7.5% Tier 1: 0.0% Tier 2: 0.0% Tier 3: 8.7% Tier 4: 60.8% Tier 5: 23.0% Total: 100.0%	No certification: 7.5% Tier 1: 0.0% Tier 2: 0.0% Tier 3: 8.7% Tier 4: 58.8% Tier 5: 25.0% Total: 100.0%	01/2024	No certification: 7.5% Tier 1: 0.0% Tier 2: 0.0% Tier 3: 8.7% Tier 4: 39.0% Tier 5: 44.8% Total: 100.0%	01/2025
Monitoring measure 1.2	Stratify member assignment to PCPCH clinics with REAL-D and SOGI categories			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No clinics stratified by REAL-D/SOGI categories	50% of PCPCH clinic assignments stratified by REAL-D categories	03/2024	100% of PCPCH clinic assignments stratified by REAL-D categories and 50% stratified by SOGI categories	06/2025
Monitoring measure 1.3	Member education			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
A culturally specific member education campaign that outlines the benefits of visiting a PCPCH does not exist	Draft the PCPCH member education campaign	01/2024	Finalize the PCPCH member education campaign and distribute to the members who are not currently assigned to a PCPCH	06/2024

Activity 2 description: By January 2025, EOCCO will increase the percentage of certified PCPCHs to achieve Tier 4 or higher certification.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Track the percentage of certified 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 2023) Tier 1: 0 Tier 2: 0 Tier 3: 11 Tier 4: 32 Tier 5: 12 Total: 55	Tier 1: 0 Tier 2: 0 Tier 3: 11 Tier 4: 31 Tier 5: 13 Total: 55	1/1/2024	Tier 1: 0 Tier 2: 0 Tier 3: 11 Tier 4: 29 Tier 5: 15 Total: 55	01/2025

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

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 is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, EOCCO continued to identify members with serious and persistent mental illness (SPMI) and support them prior to being seen in the emergency department (ED). To do so, EOCCO has utilized the following additional approaches 1) utilizing the special health care needs report as a starting point to anticipate likely eligible members 2) utilizing Collective Medical ED reports to determine which EOCCO members with SPMI diagnoses and/or a history of SUD have visited the ED for behavioral health services 3) utilizing Arcadia, a health information exchange platform, and Essette to identify members with SPMI 4) and review reports from care management (CM) database to ensure Assertive Community Treatment (ACT) and other alternative community-based services are offered to likely eligible members for continual improvement.

EOCCO coordinates with Community Mental Health Partners (CMHPs) and organizations to ensure ongoing active, efficient, and effective CM and coordination results in mitigation of the impact of SPMI on members daily living, functioning, employment, housing, transportation, and a reduction in potentially avoidable ED visits. EOCCO accomplishes this by 1) monitoring members with an individual management plan (IMP) on their progress towards goals and enrollment in appropriate services 2) 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 3) engage in regularly scheduled and real time, case-by-case care coordination for high-needs EOCCO members who may be candidates for ACT and other alternative community-based services 4) engage with both internal and external teams to identify gaps in 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 5) weekly meetings with County Mental Health 6) coordination with COPES, a peer-led recovery center, hosted through the Oregon Washington Health Network 7) coordination with Oregon State Hospital (OSH) residential facilities 8) oversight of the civil commitment process 9) and attending Interdisciplinary Team (IDT) meetings.

Using the 834 enrollment files, race, ethnicity, language, and disability data were evaluated for EOCCO members with a SPMI diagnosis: totaling 7,280 members. Race and ethnicity data showed that majority of members with a SPMI diagnosis identified as Caucasian (61.3%) with a preferred language of English (96.2%). That said, research shows that prevalence of mental health concerns is similar across race and ethnicities, however, assessment, engagement, and treatment data vary drastically.[1] This leads EOCCO to believe that the disparity in SPMI diagnosis between Hispanic Spanish-speaking members compared to non-Hispanic English-speaking members is likely due to engagement in health care. This lack of engagement is likely due to system navigation, understanding of available benefits, and stigma within the Hispanic community. EOCCO recognizes the significance that SOGI data yields when evaluating the 3 Day Follow Up Post Emergency Department (ED) Visit project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts overseen by the EOCCO DEI Committee. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

In 2022, EOCCO continued to improve approaches to support members with SPMI who were seen in the ED. EOCCO hosted daily meetings overseen by Greater Oregon Behavioral Health, Inc.'s (GOBHI) medical director in partnership with community stakeholders and local CMHPs to ensure members who visited the ED for a SPMI and/or SUD-related condition received follow up within 3 days. ENCCs and EOCCO Care Coordinators communicated daily to share information and identify barriers and solutions to engage members after ED discharge.

While the ongoing development of these processes has improved the coordination of care post ED visit, the data shows that EOCCO did not meet the goals established for this project in 2022. In 2021, baseline data noted that 42.7% of members with SPMI who were seen in the ED received 3 day follow up, with benchmarks of 60% in 2022 and 70% in 2023. However, in 2022, only 38% of members received a follow up visit within 3 days of visiting the ED, which did not meet the benchmark. CMHPs and providers were unable to contact 22% of members who were seen in the ED in 2022. Care teams were unable to engage these members despite documented attempts of reaching them by phone, at known residence, or by seeking to locate patient in the community.

In 2022, EOCCO did not receive a follow up clinical note for 35% of members seen in the ED. EOCCO believes there may be administrative barriers in which follow up is taking place, but it is not being noted, or the billable note is not being received by EOCCO. Table 1 shows 2022 ED Follow Up data by county and by network. Additionally, in 2022, EOCCO added an activity to monitor and close IMPs within 180 days. While EOCCO feels that the additional oversight of IMPs and coordination of services with providers has improved, the data shown in Table 2 does not indicate improvement. EOCCO aimed to see 40% of IMPs closed within 180 days while actual results from 2022 showed that only 20% of IMPs were closed within 180 days.

Table 1.

EOCCO 2022 ED Follow Up Data							
County	**Total**	**Met**	**% Met**	**Clinical Note Not Received**	**Unable to Contact**	**Visit Beyond Time Frame**	**Other**
Wheeler	4	0	0	3	1		
Wallowa	66	19	29%	41	6		
Sherman	20	2	10%	14	4		
Union	285	152	53%	83	48		2
Malheur	406	167	41%	89	136	6	8
Lake	48	24	50%	14	9	1	
Grant	39	10	26%	22	7		
Gilliam	10	1	10%	8	1		
Baker	131	42	32%	66	16	2	5
Umatilla	669	237	35%	243	136	25	28
Morrow	101	38	38%	31	30		2
Harney	78	22	28%	34	20	1	1
Network	1857	714	38%	648	414	35	46

Table 2.

EOCCO 2022 IMP Data	
IMPs Closed within 180 Days	33/162; 20%
Average Number of Days for Open IMP	183

As noted in part C, data indicates that Hispanic and Spanish-speaking members are largely missing from the SPMI population, which may suggest lower rates of screening, assessment, and diagnosis of SPMI. EOCCO will continue to invite community partners and members to Local Community Health Partnership (LCHP) meetings to identify barriers and solutions to engage Hispanic and Spanish-speaking members in each county. EOCCO will also begin to support peer learning opportunities through office hours for clinics to build an information sharing network led by clinics who are exemplary in engaging Hispanic and Spanish-speaking members such as Mirasol Family Health Center (Yakima Valley Farm Workers). EOCCO recognizes the significance that SOGI data yields when evaluating the 3 Day Follow Up Post Emergency Department (ED) Visit project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In addition to continuing daily ED Rounds, EOCCO will still utilize the automated reports from the PreManage/Collective platform that uses ICD-10 codes to capture emergency department visits that suggest a SPMI or SUD-related visit. EOCCO will also communicate with providers to meet the needs of members with SPMI to ensure appropriate follow up and engagement in services following an ED visit as well as meeting the goals of their IMP within 180 days. The CM team will provide close monitoring and tracking of IMPs, especially those requiring reassessments and those open longer than 180 days.

As noted in Table 1, the number of "Not Met" ED follow ups for the reason of "No Service Note Provided" is believed to contain several follow ups that were "Met" but were not communicated to the CM team. EOCCO will monitor and adjust administrative barriers impacting the tracking of follow ups to ensure that all follow ups are reported in Essette. This includes providing quarterly ED follow up lists to CMHPs for their review. Wrongly captured "Not Met" follow ups will be reviewed and changed if the provider can show that follow up did occur. Additionally, on the 15th of every month a CM staff will review open cases in Essette for 3 day follow up and reach out to providers to ensure the "Met" and "Not Met" designation is accurate.

Lastly, EOCCO will invite community partners and members to LCHP meetings to identify barriers and solutions related to SPMI to engage Hispanic and Spanish-speaking members from each county. EOCCO will also set up peer learning opportunities via office hours for clinics to build an information sharing network led by clinics who are exemplary in engaging Hispanic and Spanish speaking members who may be suffering from SPMI.

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

Activity 1 description: EOCCO will continue daily ED Rounds and improve ongoing Care Coordination with providers and members. EOCCO will also adjust the ED follow up administrative approaches to ensure tracking is timely and accurate.

☐ Short term or ☒ Long term

Monitoring measure 1.1	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)**
38% compliance for 3-day follow up post ED visit	45% compliance for 3-day follow up post ED visit	12/2023	55% compliance for 3-day follow up post ED visit	12/2024

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

☐ Short term or ☒ Long term

Monitoring measure 2.1	Monitor Essette and close IMPs timely			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
20% of the closed IMPs were within 180 days	30% of the closed IMPs were within 180 days	12/2023	35% of the closed IMPs were within 180 days	12/2024
Average days a member has an IMP initiated and closed is 183 days	Average days a member has an IMP opened and closed is 180 Days	12/2023	Average days a member has an IMP opened and closed is 175 Days	12/2024
10.7% of members with an SPMI diagnosis received a mental health service	15% of members with an SPMI diagnosis receive a mental health service	12/2023	20% of members with an SPMI diagnosis receive a mental health service	12/2024

Activity 3 description: By December 2023, EOCCO will host office hours to support peer learning between clinics regarding SMPI-related topics with an emphasis on best practices for engaging Hispanic and Spanish-speaking members in screening, assessing, and diagnosing SMPI.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Screening, assessing, and diagnosing SPMI in the Hispanic and Spanish-speaking population			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Office hours do not exist	Determine point of contact, format of the office hours and	07/2023	EOCCO will host office hours to support peer	12/2023

	cadence, and compile contacts for meeting invitation		learning between clinics to share experiences, questions, and concerns about SPMI and learn best practices for screening, assessing, diagnosing SPMI in the Hispanic and Spanish-speaking population; office hours will also serve as a time to troubleshoot any barriers that exist	

Reference:

1. A modified measurement-based care approach to improve mental health treatment engagement among racial and ethnic minoritized youth - PubMed (nih.gov)

A. **Project short title**: Frontier Veggie Rx

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

If continued, insert unique project ID from OHA: 96

B. Components addressed

i. Component 1: Social Determinants of Health
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 is a social determinants of health & equity project, which domain(s) does it address?
☒ Economic stability ☒ Education
☒ Neighborhood and build environment ☒ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

EOCCO recognizes the profound impact that social determinants of health (SDoH) have on our members and the communities served. Throughout 2022, EOCCO engaged in a range of SDoH work including the Community Benefit Initiative Reinvestment (CBIR) grants, Accountable Health Communities (AHC) Screening Project, and Connect Oregon Community Information Exchange (Unite Us) implementation. These initiatives advance health equity and promote a

member-first community-driven care model that ensures members' social needs are prioritized and addressed thoroughly.

EOCCO distributed funding to community-based SDoH programs through CBIR grants. Between June 2021-June 2022, 15 SDoH projects related to food insecurity, housing stabilization, and social isolation were funded across nine Eastern Oregon counties. This work was spearheaded by EOCCO's 12 Local Community Health Partnerships (LCHPs) and the EOCCO Community Advisory Council (CAC). The LCHP and CAC involvement in the CBIR process ensures that programs align with community health priorities and SDoH needs. Additionally, SHARE (Supporting Health for All Through REinvestment) allocated $1.5 million to 8 community health projects that addressed neighborhood and built environment, education, and economic stability.

EOCCO also engaged in the AHC Screening Project in partnership with Oregon Rural Practice-based Research Network (ORPRN). Member outreach calls were conducted to preform social needs screenings and connect high-risk members to appropriate resources. Community Health Workers (CHWs) lead the screening outreach and assisted members with navigating case management or community-based resources depending on identified needs.

Lastly, EOCCO continued the rollout of the Unite Us platform. As of the end of December 2022, 66 organizations were onboarded to the platform across the 12 Eastern Oregon counties and 415 referrals have been sent via the platform related to food assistance, housing and shelter assistance, transportation, and utility assistance.

REAL-D data was collected through the AHC Project to analyze socials needs by race, ethnicity, language, and disability. Between January 2022-December 2022, 244 members screened positive for at least one SDoH category: food, housing / shelter, transportation, safety, or utility. The top social need identified was food security, which supports the need for the continuation of the Frontier Veggie Rx project. Notably, 21% of the members who screened positive for a social need indicated Spanish as their primary language. EOCCO recognizes the significance that SOGI data yields when evaluating the Frontier Veggie Rx project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts overseen by the EOCCO DEI Committee. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

The Frontier Veggie Rx program launched in 2018 and has continued to network with more prescribers and participants every year. The program currently serves Gilliam, Harney, Sherman, Wheeler, and Lake County. Lake County was added to the program in December 2022 and enrolled 14 participants within the first month. Additionally, the program expanded its network to Safeway in Lakeview to allow participants to redeem $30 or $60 worth of produce per month depending on household size by utilizing the Safeway App. The breakdown of participants by county is shown below in Table 1.

Table 1.

Participant Household Distribution	
County	**Number of Households**
Gilliam	89
Harney	121
Sherman	72
Wheeler	47
Lake	14
Total	343

Prescribers in the Frontier Veggie Rx program have emphasized providing community connections for additional support for participants, with 45 of returning participants stating they were connected to additional supports through their Frontier Veggie Rx prescriber. The ability to connect participants with additional support is a benefit of this program that at its onset aimed to only reduce food insecurity. In 2021, participants had an average of 1.36 additional supports while in 2022 participants had an average of 1.97 out of 6 additional support categories including SNAP, WIC, OHP/EOCCO, Nutritional Program Vouchers, Farm Direct, and Food Pantry.

In addition to reducing food insecurity, the Frontier Veggie Rx program has shown to improve the overall health of participants. For example, 90.3% of returning participants feel their overall physical health has improved since enrolling in Frontier Veggie Rx and 88.8% feel their mental health has improved. Additionally, 96.3% of returning participants stated that since being in Frontier Veggie Rx “I feel my intake of fruits and vegetables has increased,” and 98.5% stated “I feel my diet has included healthier foods.” These indicators show that the program is having an overall positive outcome and participants perceive better overall physical and mental health because of the Veggie Rx program. However, goals set for the primary indicators in this project did not show the improvement EOCCO hoped to see. In 2021, 22.64% of enrolled participants reported that within the past 12 months they often worried food would run out or food did run out before they had money to purchase more, and a goal of reducing that to 18% in 2022 was not met. In 2022, 28.7% of participants stated that within the past 12 months they often worried food would run out or food did run out before they had money to purchase more. That is an increase of 6% rather than the decrease of 4% that was set for a goal.

In 2022, EOCCO hoped to grow the ability for prescribers to connect participants to additional community support via Unite Us. However, even though Unite Us was rolled out in April (upper CCO counties) and July (lower CCO counties), utilization of the platform has been slow. That said, EOCCO prescribers are becoming increasingly interested in

onboarding with the platform as they learn more about Unite Us through community meetings and the annual EOCCO Summit.

EOCCO collected some components of REAL-D data from participants including race, ethnicity, and preferred language but did not capture any disability data via the Frontier Veggie Rx enrollment form. EOCCO will add disability to the 2023 enrollment form. Only 1.7% of members who utilize the Frontier Veggie Rx program are Spanish speaking, which is a dramatic decrease from the 21% of Spanish speaking members who indicated food security as a social need via the AHC program. The EOCCO will proactively analyze the AHC data to ensure Spanish speaking members are also receiving food voucher benefits through the Veggie Rx Program. Additionally, EOCCO will create additional program materials for Spanish-speaking members and seek opportunities to outreach with community-based organizations (CBO) who work closely with the Latino population to increase engagement; for example, partnering with EUVALCREE and attending their annual events to promote the program.

EOCCO recognizes the significance that SOGI data yields when evaluating the Frontier Veggie Rx project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members. The only SOGI data that EOCCO has collected from participants is gender. EOCCO will add questions to the enrollment form that collects more SOGI data moving forward. The breakdown of participants' gender is in Table 2 below.

Table 2.

Veggie Rx Participant Gender	
Female	76.4%
Male	21.6%
Non-Binary	.6%
Preferred Not to Answer	1.4%

E. Brief narrative description: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In 2023, EOCCO will research options for transitioning the Veggie Rx program to digital voucher cards as the next step to expanding the program to other counties. EOCCO will evaluate the effectiveness of the Frontier Veggie Rx Program 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 community support programs. The program will begin capturing SOGI and disability data on the enrollment form to understand the needs of this population beyond race, ethnicity, and language moving forward. Additionally, EOCCO will onboard more providers to the Unite Us platform to encourage referrals to connect members to other community programs to address

additional social needs. Lastly, EOCCO will partner with EUVALCREE to encourage the promotion of the program and increase the participation rate of Spanish-speaking members. The program will focus on the four components of SDoH outlined below.

Economic stability: Offer vouchers to reduce the cost of food in rural settings that have high poverty rates.

Education: Develop member brochures and partner with CBOs who work closely with the Latino population to increase the rate of Spanish-speaking member participating in Frontier Veggie Rx.

Neighborhood and build environment: Frontier Veggie Rx is an intervention to limit the number of food deserts in the Eastern Oregon services area.

Social and community health: The project relies on partnerships with the LCHPs, clinics, and markets who help inform the program on social and community health needs and create a positive experience for the Veggie Rx participants. Additionally, EOCCO members connected to the Veggie Rx program will begin to experience less stress now that they know where their next meal is coming from and will also eat healthier. Eating healthier and consistently will lead to the member having more focus in their day-to-day routine (e.g., children will have more success in school).

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): EOCCO will analyze data received on the Veggie Rx enrollment form to determine if participants are increasing their consumption of fruits and vegetables and have increased their sense of food security. Additionally, Veggie Rx will transition to digital voucher cards for participating counties in preparation for expansion into other EOCCO counties.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Annual enrollment form & digital voucher cards			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
28.7% of 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	25% 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	12/2023	20% 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	12/2024
Voucher cards are not digital	Research mechanisms and apply for grant funding to	12/2023	Gilliam, Harney, Sherman, Wheeler, and Lake County	12/2024

	implement digital voucher cards in Gilliam, Harney, Sherman, Wheeler, and Lake County		implement digital voucher cards	

Activity 2 description: EOCCO will continue to roll out and train Veggie Rx prescribers to utilize the Unite Us platform to connect participants to additional community resources. EOCCO will also monitor changes to support program eligibility due to the end of the COVID 19 Public Health Emergency. EOCCO will continue to train prescribers on the existing supports available in their county and develop specific workflows to encourage increased engagement in those supports for participants.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Unite Us and community resources			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
1 prescriber currently using Unite Us to make appropriate referrals	50% of prescribers have access to the platform and are trained to make referrals	12/2023	100% of prescribers have access to the platform and are trained to make referrals	12/2024
Participants had an average of 1.97 additional formal supports out of 6 choices	Participants will average 2.25 additional formal supports	12/2023	Participants will average 2.5 additional formal supports	12/2024

Activity 3 description: EOCCO will develop educational materials in Spanish and partner with CBOs who work closely with the Latino population to increase the participation of Spanish-speaking members in the Veggie Rx Program.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Member resources and Latino community organization partnerships			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Enrollment forms and educational	Create additional educational	12/2023	Partner with EUVALCREE to	12/2024

materials are in Spanish	brochure that is translated into Spanish and review existing materials with a health equity lens for potential updates		promote the Veggie Rx program	

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: 423

B. **Components addressed**

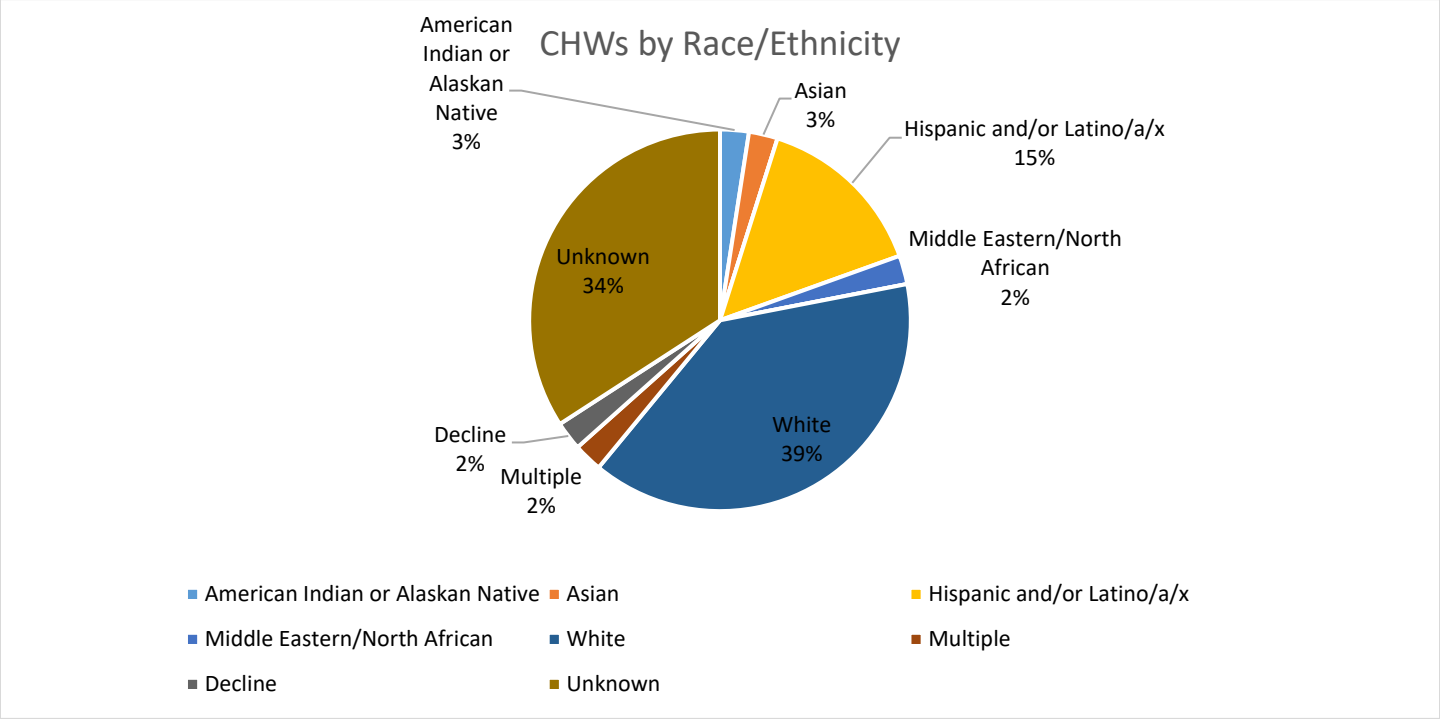
i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

As of 2023, EOCCO has signed contracts with 11 Patient-Centered Primary Care Home (PCPCH) clinics for behavioral health integration (BHI). The prior year TQS project was based on the intention to develop contracts with 10 PCPCH clinics for BHI; while the overall TQS strategy did not change with the addition of the 11th BHI clinic, the project benchmarks and milestones needed adjustment. EOCCO will continue to prioritize the innovative use of Traditional Health Workers (THWs) and Health Information Technology (HIT) into BHI PCPCH clinics, allowing for members to receive comprehensive integrated services. These projects intended to support the chronic understaffing and under-resourcing of behavioral health services in Eastern Oregon, limitations that were acknowledged in the Center for Health Systems Effectiveness' 2022 report to the OHA and Oregon Legislature. By continuing the goals of 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.

As EOCCO membership continues to grow and more PCPCH clinics sign BHI contracts, the diversity of member populations served at BHI clinics grows as well. EOCCO's strategies for increasing care delivery in BHI clinics had the secondary benefit of improving health equity through care from THWs. EOCCO recognizes that THWs share socioeconomic, cultural, linguistic ties and lived experiences with members, making the expansion and integration of

THWs especially important to meet the needs of the changing member demographics. The THW worker type commonly employed in BHI clinics are CHWs. The current race/ethnicity of CHWs in the EOCCO region is below.



EOCCO recognizes the significance that SOGI data yields when evaluating Behavioral Health Integration for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

In 2022, EOCCO signed BHI contracts with 11 PCPCH clinics. Research from the Institute for Healthcare Improvement in 2022 shows that BHI improves patient care, supports population health, and reduces healthcare costs, outcomes connected with the triple aim of healthcare while providing distinct benefit to EOCCO members. BHI also increases access to behavioral health care for EOCCO members by housing services in-clinic. As acknowledged above, the Eastern Oregon region is experiencing a significant behavioral health workforce shortage; by accessing care in BHI clinics, EOCCO members are able to receive this care in spite of the shortage. The two activities to measure the success of meeting the goals of THW and HIT integration into BHI clinics were the evaluation and provision of cross-training opportunities to CHWs in BHI clinics and the onboarding of BHI clinics to the Unite Us Community Information Exchange (CIE) tool.

During 2022, EOCCO outreached to CHWs at all 11 BHI clinics to evaluate interest in CHW participation in complex systems navigation training and education. EOCCO received responses from six clinics, with five identifying a need for CHW behavioral health cross-training. As a result, EOCCO offered scholarship and navigation to eligible CHWs, and other staff interested in Family Support Specialist (FSS) certification at all 11 BHI clinics. Through ongoing CHW and FSS cross-training opportunities offered in all BHI clinics, EOCCO has met the Activity 1 2022 *Tracking of clinic providing BH*

navigation training to their CHWs goal and will retire this activity. To create a maintenance state, EOCCO will continue to offer FSS and other behavioral health cross-training opportunities to CHWs in BHI clinics on a biannual basis.

EOCCO also offered onboarding opportunities to all 11 BHI clinics to join the Unite Us network, and successfully brought six BHI clinics onto the tool. EOCCO will continue work to onboard BHI clinics onto the Unite Us tool and will transition this 2022 Activity 2 to Activity 1 of the project for 2023. Furthermore, EOCCO will utilize data tied to 2022's Activity 2 to begin a REAL-D analysis and evaluation of member access to BHI services, starting with service access in Wallowa County. EOCCO has selected Wallowa County to pilot this process as two of the 11 BHI clinics are in Wallowa County, allowing for evaluation across a variety of providers. EOCCO members living in Wallow County are predominantly White, Non-Hispanic, with top language needs including English, Spanish, and Lao. Currently, about 7% of Wallowa County EOCCO members are living with a disability. After successful evaluation of service access based on REAL-D categories in Wallowa County, EOCCO will expand the evaluation process to the other 11 counties in the service area. The goal of this evaluation is to understand how care is being accessed in BHI clinics before designing informed interventions to equitably improve BH service access.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

By the end of 2022, EOCCO signed contracts with 11 PCPCH clinics to integrate behavioral health services. By integrating these 11 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. All 12 Eastern Oregon counties have access to Unite Us as of 07/2022, allowing for providers and community-based organizations to send and receive closed-loop physical, social, oral health, and behavioral health referrals. EOCCO will continue 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 evaluate the demographics of members accessing care in BHI clinics through REAL-D categories. To begin, EOCCO's Analytics team will analyze demographics of members assigned to BHI clinics in Wallowa County as well as demographics of members routinely accessing care in Wallowa County at BHI clinics. EOCCO has selected Wallowa County to pilot this process as two of the 11 BHI clinics are in Wallowa County, allowing for evaluation across a variety of providers. As a result of this analysis, EOCCO will have quantitative data to demonstrate opportunities for improvements to BHI care access through a health equity lens. After successful REAL-D analysis and evaluation of care access in Wallowa County, EOCCO will repeat the process in the remaining 11 counties, highlighting potential gaps in access to care. EOCCO also plans to integrate SOGI variables into this analytic process as comprehensive, member-level SOGI data becomes available.

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

Activity 1 description (continue repeating until all activities included): Integrate Unite Us into BHI clinic workflows. EOCCO will support this by:

- Facilitating onboarding meetings between BHI clinics and Unite Us team members to develop workflows
- Leveraging relationships with BHI clinics and Unite Us staff to check platform onboarding and platform utilization statuses for BHI clinics
- Providing 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
- Continuing 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 measure 1.1	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)**
55% of clinics onboarded	75% of clinics onboarded	12/2023	100% of clinics onboarded	12/2024

Activity 2 description: Evaluate gaps in access to care in BHI clinics based on REAL-D and SOGI categories in all currently contracted BHI PCPCH clinics. EOCCO will work with the Analytics teams to perform REAL-D and SOGI analysis of members assigned to BHI clinics, providing comprehensive health equity data from which to develop interventions to improve BH care access gaps.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Analyze access to care gaps in BHI clinics based on REAL-D and SOGI categories			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of counties analyzed based on REAL-D categories	One county (8% of service area) analyzed	12/2023	100% of service area analyzed	12/2025
0% of counties analyzed based on SOGI categories	One county (8% of service area) analyzed	12/2024	100% of service area analyzed	12/2026

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: 424

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 is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☒ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the EOCCO Utilization Review Committee reviewed the mechanisms to detect both under- and over-utilization of services as part of the assessment and performance improvement program. These mechanisms include internal utilization management committees and case management or quality improvement teams that monitor utilization against practice guidelines and treatment planning protocols and policies. The EOCCO Quality Improvement Committee (QIC) is responsible for monitoring data related to key utilization management indicators such as over- and under-utilization and accessibility and availability of Oregon Health Authority (OHA) approved services. Reviews targeting special populations or circumstances are also conducted to cover members with Special Health Care Needs, Chronic Conditions, and Severe Persistent Mental Illness. The EOCCO Incentive Measures Workgroup includes representatives from physical, behavioral health and dental services to monitor over- and under-utilization of services data related to the OHA CCO incentive metrics. The EOCCO team develops member and provider interventions as the result of monitoring targeted aspects of member care, including over- and under- utilization of services. Decisions regarding over- and under-utilization of services are guided by evidence based clinical practice guidelines and /or policies and procedures that are reviewed on a regular basis and updated accordingly by the respective organizations.

Processes used to monitor and detect potential over- and under-utilization of services in 2022 include 1) monthly or quarterly gaps-in-care reports to identify members missing preventive screenings or tests to manage chronic disease 2) concurrent monitoring of behavioral health inpatient stays to ensure follow-up care by a behavioral health specialist or primary care provider within 7 days of discharge or within 3 days of the member being enrolled in Intensive Care Coordination (ICC) services 3) ongoing monitoring of emergency department utilization 4) monitoring of dental services utilization in both adults and children and strategize how to improve utilization at the monthly dental metrics committee meeting 5) and quarterly review of the cost and utilization dashboard that includes inpatient, outpatient, professional, mental health, dental, and pharmacy cost and utilization. Please review attachment 1 in section 3 within the optional supporting documents for a full list of monitoring processes outlined in the EOCCO Over- and Under-Utilization of Services Policy.

The respective utilization management or quality improvement committee executed the following interventions to correct utilization trends in 2022: 1) provider report cards with roster of members missing preventive screenings or tests

to manage chronic disease 2) personalized member letters regarding routine check-ups, preventive screenings or tests to manage chronic disease 3) member outreach by oral health care providers regarding following up on specialty care referral appointments 4) integrative meetings among EOCCO and community collaboratives to review high risk member reports to coordinate services 5) education to Community Mental Health Programs (CMHPs) at quarterly quality improvement forums on timely prior authorizations for inpatient behavioral health admissions and follow-up care within 7 days of discharge 6) and implementation of formalized performance improvement or quality improvement projects. Please review attachment 1 in section 3 within the optional supporting documents for a full list of monitoring processes outlined in the EOCCO Over- and Under-Utilization of Services Policy.

Using the 834 enrollment files, race, ethnicity, language, and disability data were evaluated for the diabetes utilization review population of EOCCO members with type 1 or type 2 diabetes ages 18+ assigned to Saint Alphonsus Baker City Medical Group and Saint Alphonsus Ontario Medical Group: totaling 191 members. Findings show that in 2022, 73.82% of these patients indicated difficulty with their memory, walking, dressing, completing errands, or experienced limited activity. EOCCO recognizes the significance that SOGI data yields when evaluating the Diabetes Self-Management project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community led efforts that is overseen by the EOCCO DEI Committee. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plan to better understand the needs of members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

In 2021, the MEPP dashboard reflects that diabetes accounted for $9.6 million in Adverse Actionable Events (AAE) and $2.7 million of that spending occurred in Baker and Malheur County, totaling nearly 1/3 of diabetic-related AAE in eastern Oregon. Saint Alphonsus Medical Group Baker City and Saint Alphonsus Medical Group Fruitland Health Plaza were identified as a top utilizer, with $713,608.37 in total AAE diabetic-related costs, and expressed interest in working closely with EOCCO on this project. EOCCO implemented a virtual diabetes self-management (DSM) program through the contracted vendor Livongo. Livongo offers health coaching, glucose monitoring, and data sharing with care teams within the program. After one year of implementation, EOCCO has 506 members enrolled in the Livongo DSM program, 20 of which are Saint Alphonsus patients.

In 2022, EOCCO worked with Saint Alphonsus and Livongo with the goal 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. 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 were referred to the DSM program. An EOCCO Quality Improvement Specialist (QIS) hosted monthly meetings with Saint Alphonsus Medical Group to field all questions or concerns and provided updates on their enrolled Livongo members. Additionally, Saint Alphonsus was equipped with educational materials and workflow processes to facilitate communication between the PCP and diabetic patient.

Unfortunately, the AAE spending for Saint Alphonsus increased to $730,173.66 in 2022; however, Saint Alphonsus enrolled 20 members in the Livongo DSM program, exceeding the goal of 5% enrollment by 12/2022. To account for member attrition and population changes, EOCCO will use the same population of diabetic members included in the 2022 TQS AAE calculation to determine the utilization statistic for monitoring activities moving forward: EOCCO

members ages 18-75 with type 1 or type 2 diabetes assigned to Saint Alphonsus Medical Group Baker City and Saint Alphonsus Medical Group Fruitland Health Plaza with claims between January 2021-September 2021 (191 members).

Of the 20 members enrolled in Livongo DSM, 40% have difficulty walking, 25% have limited activity, 25% have difficulty with their memory, and 15% have difficulty or are unable to run errands. The rate of functional limitations is dramatically higher amongst members enrolled in the DSM program compared to the overall EOCCO member population where only 4.55% having difficulty walking, 6.08% have limited activity, 6.07% have difficulty with their memory, and 4.48% have difficulty or are unable to run errands. Due to the high rates of functional limitations or disability amongst DSM patients, EOCCO will connect Livongo to the CIE platform Unite Us (Connect Oregon) for closed loop referral capabilities. Livongo will be able to connect and refer to Saint Alphonsus and other community-based organizations with the intent to assist patients in navigating community resources (e.g., non-emergent medical transportation). EOCCO recognizes the significance that SOGI data yields when evaluating the Diabetes Self-Management project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community led efforts that is overseen by the EOCCO DEI Committee. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plan to better understand the needs of members.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

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 Livongo DSM program. An EOCCO QIS will continue to host monthly meetings with Saint Alphonsus Medical Group to field all questions or concerns and provide updates. Saint Alphonsus will receive updated educational materials and workflow processes to facilitate communication between the PCP and patient. Additionally, Saint Alphonsus will receive a gap list of all EOCCO members ages 18-75 with type 1 or type 2 diabetes with a flag indicating who is enrolled in Livongo. The gap list will help facilitate referrals, outreach calls, and visit preparation for Saint Alphonsus staff. 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. Livongo will be onboarded with Unite Us to assist members that have been identified with functional limitations or disabilities connect to EOCCO or community-based services available to them. 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 for under- and over-utilization review.

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

Activity 1 description (continue repeating until all activities included): By 12/31/2023, EOCCO will refer all diabetic members assigned to Saint Alphonsus to the DSM program with a goal of a 15% enrollment rate 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 20% enrollment rate 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)**
10.47% of EOCCO members ages 18-75 assigned to Saint Alphonsus are enrolled with Livongo	15% of EOCCO members ages 18-75 assigned to Saint Alphonsus enrolled with Livongo	12/2023	20% 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)**
$730,173.66 of EOCCO diabetic-related AAE at Saint Alphonsus	Decrease EOCCO diabetic-related AAE at Saint Alphonsus by 3% ($708,268.45)	12/2023	Decrease EOCCO diabetic-related AAE at Saint Alphonsus by 6% ($665,772.34)	12/2025

Activity 2 description: Onboard Livongo with the CIE platform Unite Us (Connect Oregon) to assist members that have been identified with functional limitations or disabilities connect to EOCCO or community-based services available to them by 12/31/2024.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Unite Us Onboarding			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Livongo is not onboarded with Unite Us	Train and orient Livongo to the Unite Us platform	12/2023	Livongo can send referrals to EOCCO community partners via the Unite Us platform	12/2024

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: 425

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 is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☒ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the EOCCO Utilization Review Committee reviewed the mechanisms to detect both under- and over-utilization of services as part of the assessment and performance improvement program. These mechanisms include internal utilization management committees and case management or quality improvement teams that monitor utilization against practice guidelines and treatment planning protocols and policies. The EOCCO Quality Improvement Committee (QIC) is responsible for monitoring data related to key utilization management indicators such as over- and under-utilization and accessibility and availability of Oregon Health Authority (OHA) approved services. Reviews targeting special populations or circumstances are also conducted to cover members with Special Health Care Needs, Chronic Conditions, and Severe Persistent Mental Illness. The EOCCO Incentive Measures Workgroup includes representatives from physical, behavioral health and dental services to monitor over- and under-utilization of services data related to the OHA CCO incentive metrics. The EOCCO team develops member and provider interventions as the result of monitoring targeted aspects of member care, including over- and under- utilization of services. Decisions regarding over- and under-utilization of services are guided by evidence based clinical practice guidelines and /or policies and procedures that are reviewed on a regular basis and updated accordingly by the respective organizations.

Processes used to monitor and detect potential over- and under-utilization of services in 2022 include 1) monthly or quarterly gaps-in-care reports to identify members missing preventive screenings or tests to manage chronic disease 2) concurrent monitoring of behavioral health inpatient stays to ensure follow-up care by a behavioral health specialist or primary care provider within 7 days of discharge or within 3 days of the member being enrolled in Intensive Care Coordination (ICC) services 3) ongoing monitoring of emergency department utilization 4) monitoring of dental services utilization in both adults and children and strategize how to improve utilization at the monthly dental metrics committee meeting 5) and quarterly review of the cost and utilization dashboard that includes inpatient, outpatient, professional, mental health, dental, and pharmacy cost and utilization. Please review attachment 1 in section 3 within the optional supporting documents for a full list of monitoring processes outlined in the EOCCO Over- and Under-Utilization of Services Policy.

The respective utilization management or quality improvement committee executed the following interventions to correct utilization trends in 2022: 1) provider report cards with roster of members missing preventive screenings or tests

to manage chronic disease 2) personalized member letters regarding routine check-ups, preventive screenings or tests to manage chronic disease 3) member outreach by oral health care providers regarding following up on specialty care referral appointments 4) integrative meetings among EOCCO and community collaboratives to review high risk member reports to coordinate services 5) education to Community Mental Health Programs (CMHPs) at quarterly quality improvement forums on timely prior authorizations for inpatient behavioral health admissions and follow-up care within 7 days of discharge 6) and implementation of formalized performance improvement or quality improvement projects. Please review attachment 1 in section 3 within the optional supporting documents for a full list of monitoring processes outlined in the EOCCO Over- and Under-Utilization of Services Policy.

Using the 834 enrollment files, race, ethnicity, language, and disability data were evaluated for Umatilla County EOCCO members with a diagnosis of hypertension. Findings show that these members are more likely to experience functional limitations or have a self-identified disability compared to the overall Umatilla County EOCCO member population [see Table 1 below]. Race, ethnicity, and language REAL-D components were not significantly different between the two populations analyzed. Though SOGI data collection poses challenges, EOCCO recognizes the significance that SOGI data yields when evaluating disparities in utilization trends and Adverse Actionable Events (AAEs). EOCCO plans to integrate SOGI data provided from OHA's repository flat file during 2023 into the systematic Utilization review work to better understand the care use trends and needs of members.

Table 1.

EOCCO Member Functional Limitation and Self-Identified Disability Data 2022 [READLD]							
	Blind or Difficulty Seeing	Deaf or Difficulty Hearing	Difficulty Walking or Climbing Stairs	Difficulty Dressing or Bathing	Difficulty running errands alone	Difficulty concentrating, remembering, or making decisions	Limited Activity
Umatilla County (n=26,566)	566	486	1175	649	1130	1500	1480
Percent:	2.13%	1.82%	4.42%	2.44%	4.25%	5.64%	5.57%
Umatilla County Hypertension Cohort (n=646)	47	45	138	66	93	94	119
Percent:	7.27%	6.96%	21.36%	10.21%	14.39%	14.55%	18.42%

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

Over the course of 2022, EOCCO monitored utilization trends for members with a diagnosis of hypertension. Using the OHA MEPP dashboard, it was determined that EOCCO members living in Umatilla County incurred $2,373,884 in AAE costs related to hypertension between 2019-2021. This amounts to over 1/3 of EOCCO's total AAE costs for hypertension ($6,752,973). As a result, the Umatilla Community Paramedic Program (UCPP) MEPP project launched in 2022. However, completing the necessary activities prior to UCPP initiating services, such as establishing the formal contract between EOCCO and Umatilla County Fire District #1, building out Collective Medical cohort reports, and

developing referral pathways between EOCCO case management, took longer than anticipated. This delay was largely due to the collaborative nature of the program planning and implementation process which intentionally engaged multiple stakeholders and partners across EOCCO, Collective Medical, and Umatilla County Fire District #1. UCPP paramedics began providing services to EOCCO members at the end of November 2022. EOCCO and the UCPP team engaged in an iterative program planning process that established a programmatic workflow (see Attachment 2 of section 3 within the optional supporting documents to review the Umatilla Community Paramedic Program Workflow).

Given the service-rendering delay, it's unlikely that the UCPP made a substantial impact on potentially avoidable hypertensive-related ED costs during the first year. In 2021, EOCCO used internal claims data from ED and inpatient encounters occurring between January—September 2021 in two Umatilla County hospitals to establish a potentially avoidable cost baseline of $363,489. However, review of this statistic revealed an internal data sourcing error which significantly underestimated the 2022 baseline. As a result, EOCCO recalculated a potentially avoidable hypertensive-related ED cost baseline using internal claims of Umatilla ED and inpatient encounter data between January—September 2022. The new established baseline totaled $835,072. Given this calculation error, the 2022 goal to reduce potentially avoidable hypertensive-related ED costs by 3% from baseline will be carried into 2023 and adjusted to the UCPP service start-date timeline. To account for member attrition and population changes, EOCCO will use the same population of Umatilla County members included in the 2022 baseline potentially avoidable hypertensive-related ED cost calculation (members residing in Umatilla County as of 9/30/2021) to calculate the utilization statistic for following years.

As of February 2023, 14 members have received comprehensive UCPP services and intervention. All members served were identified from the Collective Medical cohort of EOCCO members with a diagnosis of hypertension and 2 or more ED visits in the past six months. Given the time dedicated at the forefront of the program development process to implement the workflows, referral pathways, and HIT systems necessary to support UCPP service rendering, EOCCO expects to meet the program goal established last year of at least 40 hypertensive members receiving UCPP services by 06/2023.

REAL-D data indicates members served by the UCPP to date experience a higher proportion of functional limitations compared to the cohort of Umatilla County members with a diagnosis of hypertension [See Table 2]. Members served by the UCPP are more likely to identify difficulty with walking or climbing stairs (25%), difficulty with dressing or bathing (25%), difficulty with running errands alone (25%), and limited activity (25%). Additionally, 1/3 of members served by the UCPP are identified as having SHCN, defined as individuals with extensive health care needs, multiple chronic conditions, or behavioral health diagnoses and who have functional disabilities or are at risk of developing them. EOCCO is currently working to improve SOGI data collection through community-led efforts. In 2023, EOCCO plans to begin utilizing SOGI data provided from OHA's repository flat file to better understand how gender and sexual minority identities intersect with hypertension diagnoses and functional limitation or disability indicators and identify where health disparities may lie.

The UCPP was designed to help address and reduce primary care access and chronic disease management barriers that EOCCO members with a hypertension diagnosis may experience. REAL-D analysis of Umatilla County members living with hypertension and members served by the UCPP indicates that the home-visit structure of, and screening and care coordination services provided by the UCPP may particularly benefit members who experience functional limitations or disability. During 2023, EOCCO will work to amplify the potential benefit of the UCPP for our members by leveraging the CIE platform Unite Us (Connect Oregon). With Unite Us' closed loop referral capability, UCPP paramedics can input social need and health risk assessment screening results and navigate members to community resources or EOCCO case management services to help meet any identified needs. It's intended that utilizing Unite Us will expand UCPP's service

breadth, address members' health and social needs, and help meet UCPPs overarching goal of reducing hypertensive related ED encounters.

Table 2.

EOCCO Member Functional Limitation and Self-Identified Disability Data 2022 [REALD]							
Percent:	2.13%	1.82%	4.42%	2.44%	4.25%	5.64%	5.57%
Umatilla County Hypertension Cohort (n=646)	47	45	138	66	93	94	119
Percent:	7.27%	6.96%	21.36%	10.21%	14.39%	14.55%	18.42%
UCPP Cohort (n=12*)	1	0	3	3	3	2	3
Percent:	8.3%	0%	25%	25%	25%	16.6%	25%
*Lacking REALD data source for two EOCCO members served by UCPP							

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The UCPP is a partnership established in 2018 between the Umatilla County Fire District #1 and EOCCO. After a successful multi-year pilot providing direct patient care and care coordination to persons living in Umatilla County, Umatilla County Fire District decided to enroll as an EOCCO contracted provider. Under the contract established in May of 2022, the UCPP refined their scope of service to provide targeted support and care coordination to EOCCO members with a diagnosis of hypertension.

UCPP paramedics will receive care outreach lists through Collective Medical for a defined cohort of EOCCO members living in Umatilla County with a diagnosis of hypertension and two or more ED visits in six months. Paramedics will participate in EOCCO case management's daily telephonic ED rounds, as required per contract compliance, to identify additional EOCCO members for outreach. Paramedics will have initial engagement with members prior to, or within 72 hours of, hospital discharge to improve home to hospital transitions. Paramedics will then arrange for home-visit follow-up care. Depending on the member's needs, follow-up care will fall into one of four service tiers which range from an in-home lab draw to comprehensive point of care testing, social need and health risk screenings, medication review, and follow-up with the member's PCP. UCPP services may be rendered up to thirty calendar days post discharge as delineated in the contract. The UCPP team tracks EOCCO members served by the program and reports data to EOCCO's Quality Improvement Committee (QIC) for over- and under-utilization review and monitoring.

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

Activity 1 description: By supporting members through the Umatilla Community Paramedic Program, EOCCO hopes to provide timely and comprehensive follow up care to members with a diagnosis of hypertension post-discharge and reduce potentially avoidable costs associated with ED encounters. UCPP paramedics began providing services to EOCCO members in November 2022, after the following program activities were completed:

- A formal contract was established between Umatilla County Fire District #1 and EOCCO
- Referral pathways for EOCCO case management to refer members to UCPP services were finalized

- Collective Medical cohorts were established to identify priority EOCCO members for UCPP outreach and services
- EOCCO developed a data-sharing and invoicing system to track UCPP services rendered

☐ Short term or ☒ Long term

Monitoring measure 1.1	Reduce potentially avoidable costs for hypertensive related ED encounters (monitoring cohort identified between January 2021 – September 2021)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
$835,072	Reduce costs by 3% in the first year (Costs not to exceed $810,020)	11/2023	Reduce costs by 8% from baseline (Costs not to exceed $768,266)	11/2025
Monitoring measure 1.2	Increase number of members served by the Umatilla Community 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)**
14 hypertensive patients have received services	40 hypertensive patients have received services	06/2023	80 hypertensive patients have received services	06/2025

Activity 2 description: Leverage the CIE platform, Unite Us (Connect Oregon), to help conduct UCPP social need and health risk screening and referral activities. EOCCO hopes to improve care coordination provided to members with a hypertension diagnosis, especially members who may be at-risk for, or are experiencing, functional limitations or disability. The following activities will need to be completed before Unite Us can be successfully implemented and utilized as part of the UCPP program workflow:

- Provide Unite Us technical assistance to UCPP paramedics to ensure comfortability with utilizing the platform to conduct program activities
- Work with Unite Us to build UCPP social needs and health risk assessment screening tools into the platform
- Build direct referral pathways to EOCCO's case management services within Unite Us
- Enhance adoption of EOCCO's Health-Related Services (HRS) request form by UCPP paramedics, and establish workflows for navigating HRS requests to members' assigned PCP for review and submission to EOCCO
- Continue the process of integrating screening and referral data flowing from Unite Us into EOCCO's data warehouse to track referrals made through UCPP

☐ Short term or ☒ Long term

Monitoring measure 2.1	Increase the number of referrals sent through Unite Us by Umatilla Community Paramedic Program			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No referrals have been sent through Unite Us platform	20 referrals have sent through Unite Us by UCPP	12/2024	50 referrals have been sent through Unite Us by UCPP	12/2025

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: 426

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 is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☒ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the EOCCO Utilization Review Committee reviewed the mechanisms to detect both under- and over-utilization of services as part of the assessment and performance improvement program. These mechanisms include internal utilization management committees and case management or quality improvement teams that monitor utilization against practice guidelines and treatment planning protocols and policies. The EOCCO Quality Improvement Committee (QIC) is responsible for monitoring data related to key utilization management indicators such as over- and under-utilization and accessibility and availability of Oregon Health Authority (OHA) approved services. Reviews targeting special populations or circumstances are also conducted to cover members with Special Health Care Needs, Chronic Conditions, and Severe Persistent Mental Illness. The EOCCO Incentive Measures Workgroup includes representatives from physical, behavioral health and dental services to monitor data related to over- and under-utilization of services related to the OHA CCO incentive metrics. The EOCCO team develops member and provider interventions as the result of monitoring targeted aspects of member care, including over- and under- utilization of services. Decisions regarding over- and under-utilization of services are guided by evidence based clinical practice guidelines and /or policies and procedures that are reviewed on a regular basis and updated accordingly by the respective organizations.

Processes used to monitor and detect potential over- and under-utilization of services in 2022 include 1) monthly or quarterly gaps-in-care reports to identify members missing preventive screenings or tests to manage chronic disease 2) concurrent monitoring of behavioral health inpatient stays to ensure follow-up care by a behavioral health specialist or primary care provider within 7 days of discharge or within 3 days of the member being enrolled in Intensive Care Coordination (ICC) services 3) ongoing monitoring of emergency department utilization 4) monitoring of dental services utilization in both adults and children and strategizing on how to improve utilization at the monthly dental metrics committee meeting 5) and quarterly review of the cost and utilization dashboard that includes inpatient, outpatient, professional, mental health, dental, and pharmacy cost and utilization. Please review attachment 1 in section 3 within the optional supporting documents for a full list of monitoring processes outlined in the EOCCO Over- and Under-Utilization of Services Policy.

The respective utilization management or quality improvement committee executed the following interventions to correct utilization trends in 2022: 1) provider report cards with roster of members missing preventive screenings or tests to manage chronic disease 2) personalized member letters regarding routine check-ups, preventive screenings or tests to manage chronic disease 3) member outreach by oral health care providers regarding following up on specialty care referral appointments 4) integrative meetings among EOCCO and community collaboratives to review high risk member reports to coordinate services 5) educate Community Mental Health Programs (CMHPs) at quarterly quality improvement forums on timely prior authorizations for inpatient behavioral health admissions and follow-up care within 7 days of discharge 6) and implement formalized performance improvement or quality improvement project. Please review attachment 1 in section 3 within the optional supporting documents for a full list of monitoring processes outlined in the EOCCO Over- and Under-Utilization of Services Policy.

From January 2019 through December 2021 the MEPP dashboard reflects that EOCCO members incurred over $19.9 million in substance use disorder (SUD)-related spending, $11.2 million of which can be considered potentially avoidable or 'adverse actionable events' (AAE). The SUD episode has the highest level of AAE spending of all episodes tracked in the MEPP dashboard. The MEPP dashboard also indicates that EOCCO members with opioid use disorder (OUD) and/or methamphetamine substance use disorder (MA-SUD) diagnoses generated over $5 million in SUD-related costs, 6.8% of which were AAEs. The EOCCO Analytics team further refined this utilization review by examining internal claims data from January 2022 through September 2022 for EOCCO members with OUD and/or MA-SUD diagnoses who were also flagged for housing insecurity. Claims data revealed that this population accumulated $1.3 million in health care costs, roughly $800,000 of which (61.3%) were potentially avoidable. These analyses indicate that individuals with OUD and/or MA-SUD diagnoses and housing insecurity are likely to have much higher AAE spending than those without housing insecurity.

The Quality and Analytics teams used internal data as well as information from Oregon Health Plan (OHP) enrollment files to stratify this population by REAL-D components. The analysis of race, ethnicity, and language data did not highlight any notable disparities. The most notable difference between the population described above and full EOCCO membership is the presence of indicators of functional limitations (blindness, deafness, difficulty walking, difficulty dressing, difficulty running errands, memory challenges, and limited activity). 43.2% of EOCCO members with OUD and/or MA-SUD diagnoses with housing insecurity flags report experiencing at least one of those indicators and 14.9% report four or more. Meanwhile, only 11.6% of the full EOCCO population report at least one of those indicators and only 2.6% have four or more. This suggests a much higher burden of functional limitation for individuals with SUD diagnoses and housing insecurity. This REAL-D analysis was also performed on the cohort of members who participated in the housing support program intervention. This will be explored further in part D.

EOCCO was unable to perform a parallel analysis using SOGI data as the CCO does not currently have a SOGI data repository. EOCCO recognizes the significance that SOGI data yields when evaluating the Opioid and Stimulant Use Disorder Housing Support Program for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

This project built off a previous Statewide Opioid Response (SOR) Grant that was successfully implemented from 2019 to September 2021. The updated project was expanded to include individuals with MA-SUD as well as those with OUD and focused on meeting housing-related needs of the target population. The overall goal of this project is to reduce the total per member per month (PMPM) cost of care among EOCCO members who participate in this intervention by 3% (to $613 PMPM) by September 2024.

During the project period (October 2021 through September 2022) the grant team completed this project to fidelity and achieved two of its three short-term goals. The grant team successfully promoted the program to all twelve Community Mental Health Programs (CMHPs) in Eastern Oregon by June 2022 and vastly exceeded the referral goal by processing 240 referrals for EOCCO members. However, the final short-term goal was to disburse $250,000 in housing support funds to approved referred individuals. The grant team ultimately received $225,000 for this project rather than the originally expected amount of $250,000. Additionally, the project team distributed $233,934 during the project period, $159,234 of which was used for housing support. There was a greater than expected need for Naloxone and SUD-related medications during the grant period and the remaining $74,700 was spent on those resources.

The long-term goal for this project is to evaluate the total per member per month (PMPM) cost of care among EOCCO members who participate in this intervention. The target is to reduce the PMPM cost of care by 1.5% ($622.35 PMPM) by September 2023 and by 3% ($612.87 PMPM) by September 2024. The current state for this measure is $436.42 PMPM for the intervention population, using claims data from October – December 2022. EOCCO has also added a second long-term goal, which aims to reduce the percent of AAE care costs for the project cohort to 55.0% by September 2023 and to 45.0% by September 2024. The baseline value for monitoring measure 1.2 was retroactively calculated as 66.6% of total costs falling into the AAE category, and the current state is 30.0%. EOCCO acknowledges that the current state PMPM amount and percentage AAE cost are already well below the project's long-term goal targets. However, EOCCO does not believe these targets have been truly "met" since the current state calculations are only based on three months of claims spending for the project cohort, which is likely not a representative sample of typical costs over time. EOCCO will continue to monitor claims spending for cohort participants and expect to see average costs and percent AAE spending increase again before they decrease below the target values by September 2024.

The EOCCO Quality and Analytics teams performed a REAL-D analysis on the members included in this program cohort using Oregon Health Plan (OHP) enrollment data. The program participants have similar proportions of racial and ethnic identities and preferred languages as EOCCO's overall population. Like the population identified in part C, the program cohort had a higher percentage of individuals with disability flags than the overall CCO population.

Table 1.

Total Disability Flags	Count EOCCO Members	% EOCCO Members	Count SOR Cohort	% SOR Cohort
0	63202	88.4%	131	71.2%
1 to 3	6472	9.0%	45	24.5%
4 to 7	1844	2.6%	8	4.3%
Total	***71518***	***100.0%***	***184***	***100.0%***

As Table 1 indicates, 28.8% of the program participants reported at least one of indicator of disability (blindness, deafness, difficulty walking, difficulty dressing, difficulty running errands, memory challenges, and limited activity) and 4.3% reported four or more indicators. Meanwhile, only 11.6% of the full EOCCO population reported at least one of those indicators and 2.6% have four or more flags. As Table 2 shows, 66.3% of the SOR grant beneficiaries also fall into the Special Health Care Needs (SHCN) category, defined broadly as individuals with extensive health care needs, multiple chronic conditions, or behavioral health diagnoses and who have functional disabilities or are at risk of developing them. In comparison, only 49.3% of the full EOCCO population is designated as SHCN.

Table 2.

Special Health Care Needs (SHCN) Plan	Count EOCCO Members	% EOCCO Members	Count SOR Cohort	% SOR Cohort
yes	35223	49.3%	122	66.3%
no	36295	50.7%	62	33.7%
Total	***71518***	***100.0%***	***184***	***100.0%***

These disparities suggest a high burden of functional limitations and unique health needs among individuals who participated in this intervention. The Quality team also analyzed overall cost and AAE cost for grant participants and stratified these totals by SHCN status. As shown below in Table 3, individuals who participated in the SOR grant with SHCN designations generated lower overall per person healthcare costs in the post-intervention period (October 2022 through December 2022) than non-SHCN members but had a higher percentage of AAE costs.

Table 3.

SHCN Category	AAE Cost	Total Cost	% AAE Cost
SHCN - Total claims spend	$ 57,094.38	$ 165,954.56	34.4%
SHCN - Claims spend per member	*$ 467.99*	*$ 1,360.28*	*n/a*
Non-SHCN - Total claims spend	$ 38,007.98	$ 158,611.50	24.0%
Non-SHCN - Claims spend per member	*$ 613.03*	*$ 2,558.25*	*n/a*

The disparity in AAE spend between SHCN and non-SHCN members indicate that the increased prevalence of complex health needs could contribute to avoidable health care spending in this population. EOCCO will address this disparity by working to connect Community Mental Health Programs (CMHPs) to the community information exchange (CIE) platform Unite Us to facilitate closed loop referrals to housing services for the SOR grant cohort. More information on this activity will be provided in part E.

EOCCO was unable to perform a parallel analysis using SOGI data as the CCO does not currently have a SOGI data repository. EOCCO recognizes the significance that SOGI data yields when evaluating the Opioid and Stimulant Use Disorder Housing Support Program for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community-led efforts. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plans to better understand the needs of members.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

This project was originally based on a Statewide Opioid Response (SOR) grant program that ended on September 30, 2022. The grant funding was not extended so this intervention will be altered in the coming year to include other housing-related activities that benefit individuals in the target population of EOCCO members with housing insecurity and substance use disorder (SUD) diagnoses.

To provide continued support and care coordination services to these members, EOCCO will work to onboard all twelve of its CMHPs to the Unite Us CIE tool. As of February 2023, 13.8% of organizations onboarded to Unite Us provide housing-related services and facilitating use of the CIE tool for CMHP users could greatly increase access to these housing services for CMHP clients. Furthermore, we know that many SOR grant participants are already engaged with their local CMHPs since 47.8% of grant recipients were referred to the program by CMHP staff. Currently only one CMHP is onboarded with Unite Us, but the EOCCO team plans to increase CMHP participation by conducting individualized outreach to each site, organizing presentation opportunities for providers to learn more about the platform, and providing peer-learning opportunities for CMHPs to discuss referral use cases and workflows for their clients. Increasing CIE participation will provide more wraparound support for individuals with MA-SUD and OUD diagnoses who are also in need of housing services. Additionally, EOCCO believes that addressing social needs through Unite Us referrals will be a particularly effective strategy in reducing AAE spending for members with SHCN.

EOCCO will continue to monitor overall AAE claims spend for individuals who participated in the original SOR grant project through the benchmark date of September 2024 to track the long-term impacts of the support funds on the project cohort's utilization trends. Additionally, the EOCCO Analyst will break out claims spending for this population by those with and without SHCN flags to determine if the percent of AAE spending for members with SHCN flags reduces over time. This utilization data will ultimately be shared with the EOCCO Quality Improvement Committee for under- and over-utilization review.

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

Activity 1 description: EOCCO will reduce the total PMPM cost of care among its members served by this grant program by 3% by September 2024 by providing increased care coordination services and housing service referrals through CMHP use of the Unite Us platform.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Average per-person cost of care for EOCCO members 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)**
$436.42 PMPM[1] *(Current state of program cohort: Based on claims*	$622.35 PMPM	09/2023	$612.87 PMPM	09/2024

[1] *EOCCO acknowledges that the current state PMPM amount and percentage AAE cost are already well below the project's long-term goal targets. However, we do not believe these targets have been truly "met" since the current state calculations are only based on three months of claims spending for the project cohort, which is likely not a representative sample of typical costs. We will continue to monitor claims spending for cohort participants over time and expect to see average costs and percent AAE spending increase again before they decrease below the target values by September 2024.*

data from 10/2022 – 12/2022.) $631.83 PMPM *(Baseline for EOCCO population that met program criteria: Based on claims data from 10/2020 - 09/2021)*				
Monitoring measure 1.2	Percent of potentially avoidable (AAE) cost of care for EOCCO members served by the grant project			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
30.0%[1] *(Current state of program cohort: Based on claims data from 10/2022 – 12/2022.)* 66.6% *(Baseline for EOCCO population that met program criteria: Based on claims data from 10/2020 - 09/2021.)*	55.0%	09/2023	45.0%	09/2024
Monitoring measure 1.3	Percent of potentially avoidable (AAE) cost of care for EOCCO members with SHCN served by the grant project.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
34.4%[1] *(Current state of program cohort: Based on claims data from 10/2022 – 12/2022. 2021 baseline data is not available.)*	60.0%	09/2023	50.0%	09/2024

Activity 2 description: EOCCO will onboard all twelve CMHPs in Eastern Oregon to the Unite Us CIE tool by 12/31/2024 by providing individualized outreach to each contracted site regarding implementation and adoption of the platform, working with the Unite Us Community Engagement team and EOCCO staff to organize presentation opportunities for CMHP staff to learn more about the tool, and providing peer-learning opportunities for CMHPs to discuss referral use cases and workflows specific to their clients.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Number of CMHPs onboarded to the Unite Us platform			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
1 onboarded site *(Current state as of 01/2023)*	6 onboarded sites	12/2023	12 onboarded sites	12/2024

A. **Project short title**: Increasing Pediatric Dental Access through First Tooth Certification in the Eastern Oregon Service Area

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): Grievance and appeal system
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, EOCCO continued to strive to implement an equitable health care delivery model that seamlessly and holistically integrates physical, behavioral, and oral health. The Eastern Oregon service area has 9 oral health integrated clinics, 11 behavioral health integrated clinics, and 4 clinics that are both oral and behavioral health integrated; EOCCO continues to collaborate with primary care clinics to expand these services every year. Advantage Dental hosted dental clinics at 119 school-based health centers throughout the year where they provide oral health assessments, sealants, fluoride varnish, and education to school-aged children. Furthermore, Advantage Dental staffs 3 primary care practices, multiple Head Starts, and Pre-K programs with dental hygienists to perform oral health services throughout Eastern Oregon.

Advantage Dental and ODS Community Dental partner with EOCCO on the Incentive Measure Subcommittee, Childhood Metrics Workgroup, and DHS Metric Workgroup to ensure physical, mental, and dental care are collaborating regularly on quality initiatives. Specifically, Advantage Dental and ODS provide infant and adult toothbrush kits and dental education as part of EOCCO's Baby Care Kit that is distributed to parents when leaving the hospital after giving birth. In addition, Advantage and ODS representatives join the Local Community Health Partnerships (LCHPs) in all 12 EOCCO counties to address questions and concerns related to oral health.

Regarding the Grievance and Appeal System, the team focused their 2022 enhancements on current and new reports to include REAL-D data. The grievance and appeal data, when combined with REAL-D analytics, provided a unique view into the membership and the issues they face. While all grievances and appeals are reviewed thoroughly and each aspect of the complaint is addressed, the team created new techniques for adding an additional layer of review for grievances where the member felt discriminated against based on race, ethnicity, age, language, or disability. The team is prepping for grievances to be reviewed with a health equity lens moving into 2023. Race, ethnicity, language, and disability data were evaluated for all EOCCO members who filed a dental access grievance. Findings show that 61.04% indicated

Caucasian as their primary race, 72.73% indicated their ethnicity as not Hispanic, 100% indicated English as their primary language, and there were no significant findings around disability.

Using the 834 enrollment files, race, ethnicity, language, and disability data were evaluated for the oral health integration population of EOCCO members ages 1-14: totaling 21,339 members. Findings show that in 2022, 529 EOCCO members ages 1-14 indicated American Indian or Alaska Native as their primary race. Dental utilization for American Indian or Alaska Native members was 42.49% compared to 54.46% for all other members ages 1-14. Additionally, while 15% of all EOCCO members ages 1-14 indicated Spanish as their primary language, only 6.93% requested interpreter services. There were no significant findings around disability.

EOCCO recognizes the significance that SOGI data yields when evaluating the Increasing Pediatric Dental Access through First Tooth Certification in the Eastern Oregon Service Area project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community led efforts overseen by the EOCCO DEI Committee. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plan to better understand the needs of members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

The Centers for Disease Control and Prevention (CDC) states that the most common childhood chronic disease in the United States are cavities.[1] Children 5-19 in low-income households are two times more likely to have cavities compared to children from higher-income families.[1] Cavities that go untreated can cause a child pain or lead to infection which can ultimately hinder eating, speaking, playing, and learning.[1] Fortunately, cavities are a preventable disease and fluoride varnish can limit the chances of a childhood cavity by 33%.[1]

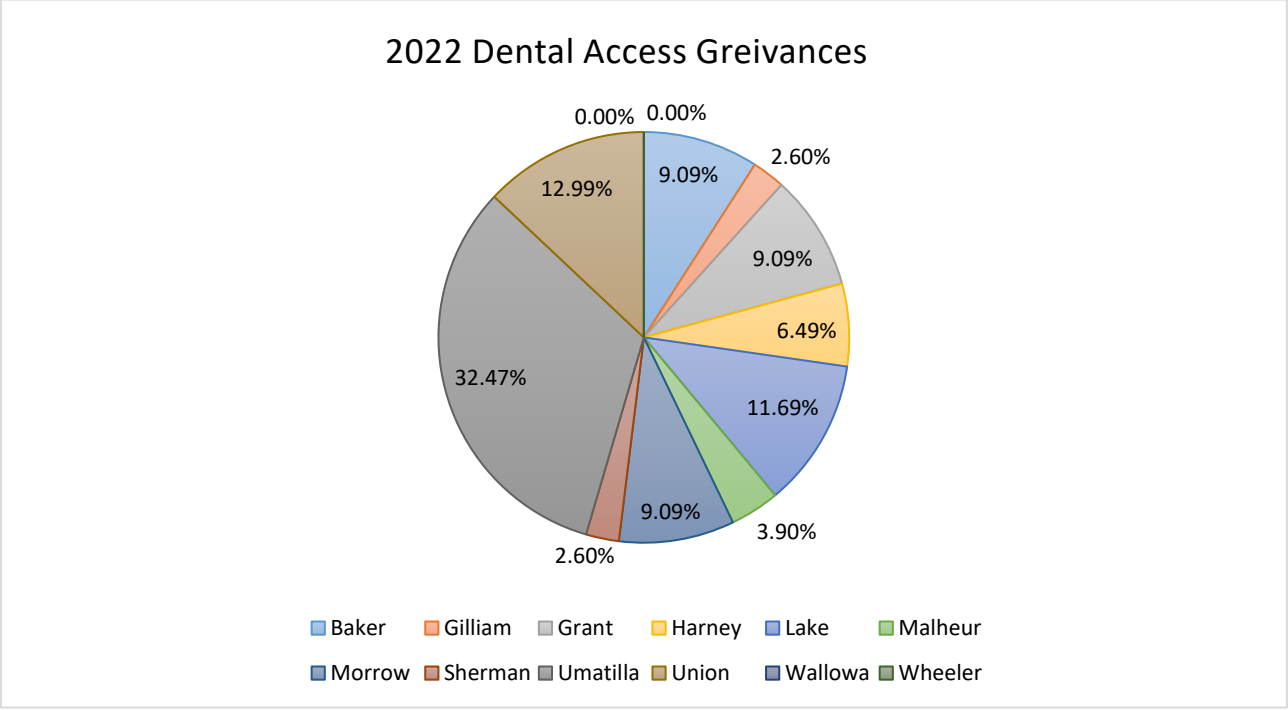
In 2022, there have been a total of 77 grievances filed by EOCCO members regarding limited access to a dental provider and nearly 1/3 of the grievances originated from Umatilla County (refer to graph 1 below). EOCCO members have more accessibility and contact with their primary care providers (PCP) versus their dentists for numerous reasons. For example, many patients grasp the importance of physical health (but fail to see the importance of dental health), patients may have a fear of dentistry, and there are simply more PCPs than dentists in Eastern Oregon. Additionally, since there are limited dentist offices in each community there are long waitlists for a dental appointment (sometimes up to 6-months) causing frustration for a patient because they must wait or travel long distances for the next availability. Therefore, it is pertinent that PCPs are addressing preventive dental during well child visits to limit the access burden for pediatric patients. EOCCO, in partnership with Advantage Dental, will train Umatilla PCP offices in First Tooth and implement oral health evaluations and fluoride varnish into clinic workflows to increase dental access and utilization for EOCCO members ages 1-14. Upon successful implementation, the project will expand to Union, Lake, Grant, Baker, Morrow, and Harney County who also received higher volumes of dental access grievances.

The project will have an increased focus on the American Indian/Alaska Native population in Umatilla where 66.73% of the Eastern Oregon American Indian/Alaska Native population resides and 19% requested interpreter services. 2022 claims data reveals that 39.94% of members ages 1-14 in Umatilla County who identify as American Indian or Alaska Native utilized dental services compared to 58.48% of all other members 1-14 in Umatilla County who utilized dental services. These findings show a drop in dental utilization rates for American Indian/Native Alaskan members in Umatilla County compared to overall EOCCO rates, while the total 1–14-member population in Umatilla had a 4% increase compared to overall EOCCO rates. Accessibility to interpreter services and culturally competent care will enhance a provider's understanding of the patient's beliefs about health, disease, diet, and hygiene. Receiving oral health

recommendations with the patient in mind creates a positive experience for the patient to return for dental services again; therefore, increasing dental utilization. Additionally, the number of dental access grievances filed were overwhelming made by Caucasian, non-Hispanic, English-speaking members. Increased member education about the processes for filing grievances will enhance EOCCO's understanding of who and why members experience dental access barriers so those issues can be addressed thoroughly. Umatilla County is home to the Confederated Tribes of Umatilla Indian Reservation (CTUIR), a federally recognized tribe, and Yellowhawk Tribal Center. Over the years, EOCCO has made concerted efforts to partner with Yellowhawk, however EOCCO is still building this relationship. Within this project EOCCO hopes to provide support to all clinics in Umatilla County who see pediatric members, including, but not limited to Yellowhawk.

EOCCO recognizes the significance that SOGI data yields when evaluating the Increasing Pediatric Dental Access through First Tooth Certification in the Eastern Oregon Service Area project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community led efforts that is overseen by the EOCCO DEI Committee. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plan to better understand the needs of members.

Graph 1.



E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The target population of the project is EOCCO members ages 1-14 residing in Umatilla County to increase dental access; additional attention will be diverted to EOCCO members ages 1-14 residing in Umatilla County who identify as American Indian or Alaska Native. Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic, and Yellowhawk Tribal Health Center will be recruited to become First Tooth certified. The certification training is a 1-hour live virtual session hosted by a dental hygienist from Advantage Dental. Topics covered during the training will

include the prevalence and impact of oral disease, prevention, risk assessment, fluoride varnish application, implementation, workflow tips, billing, and access to dental care and a dental home. By the conclusion of the training, providers will be able to conduct an oral health evaluation (D0191) and providers, physician assistants, nurses, and medical assistants will be able to apply fluoride varnish (CPT 99188) during a well child visit and bill for those services. Advantage Dental will be available to clinics for technical assistance while they are implementing the First Tooth curriculum into their workflows. A separate cultural competency training will be provided to participating clinics prior to workflow implementation. Additionally, EOCCO will create a language access roster that will compile data of members who have requested interpreter services to be shared with the clinics. Cultural competency training and language access data will assist clinics with providing holistic care with the patient's beliefs about health, disease, diet, and hygiene in mind. Further research must be complete to determine the dental and PCP offices' electronic health records (EHR) capabilities to share member information. In the meantime, to open pathways for sharing member health information between dentists and PCPs, the EOCCO will provide a monthly gap list with participating clinics indicating which patients ages 1-14 have not had preventive oral health services anytime during the calendar year to allow clinics to conduct outreach attempts.

Additionally, EOCCO will create a *Quick Start Guide* for members explaining how to access CCO services. This guide will underscore the importance of sharing grievances with the CCO so their concerns can be addressed. EOCCO staff will share the *Quick Start Guide* with the EOCCO Community Advisory Council (CAC) and Local Community Health Partnerships (LCHP) outlining the importance of sharing grievances and the process of contacting EOCCO. Sharing this information with the CAC and LCHPs is an important step since many EOCCO members attend those meetings. Lastly, to address an improvement in the grievance and appeals system, the EOCCO Grievance and Appeals team will notify members of their opportunity to have dental services completed at their PCP should a member between the ages of 1-14 residing in Umatilla files a grievance about dental access. The EOCCO Grievance and Appeals team will also notify the PCP so the clinic can conduct their own outreach to the patient to schedule them for an oral evaluation and fluoride varnish.

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

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

EOCCO, in partnership with Advantage Dental, will certify Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic, and Yellowhawk Tribal Health Center to conduct oral health evaluations (D0191) and apply fluoride varnish (CPT 99188) during a well child visit to increase the Umatilla County childhood dental utilization by 3.0% by 12/31/2027. EOCCO will provide cultural competency training and share language access data with participating clinics to increase American Indian/Alaska Native dental utilization rates by 5.0% by 12/31/2027.

☐ Short term or ☒ Long term

Monitoring measure 1.1	First Tooth certification			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic, and	Good Shepherd Medical Center and Pediatric Specialist of Pendleton will have clinic teams certified in First Tooth	6/2023	Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic, and	12/2023

Yellowhawk Tribal Health Center do not have a clinic team certified in First Tooth			Yellowhawk Tribal Health Center will have clinic teams certified in First Tooth	
Monitoring measure 1.2	Cultural competency training and language access roster			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic and Yellowhawk Tribal Health Center have not been offered cultural competency training in the integrated oral health field	EOCCO will research appropriate cultural competency trainings to offer Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic and Yellowhawk Tribal Health Center	6/2023	Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic and Yellowhawk Tribal Health Center will participate in cultural competency training prior to seeing patients for oral health	12/2024
Interpreter access roster has not been created	Build an interpreter access roster indicating which patients have previously requested interpreter services and research other data points to include on the data file	12/2023	Interpreter access roster is live and shared quarterly with Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic and Yellowhawk Tribal Health Center	12/2024
Monitoring measure 1.3	First Tooth integration and billing for services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic, and Yellowhawk Tribal Health Center do not conduct oral health evaluations or apply fluoride varnish and,	One clinic will fully integrate oral health evaluations and fluoride varnish workflows within well child visits and bill for services	12/2024	Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic, and Yellowhawk Tribal Health Center will fully integrate oral health evaluations and fluoride varnish workflows within	12/2026

therefore, do not bill for services			well child visits and bill for services	

Monitoring measure 1.4	Dental Utilization			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
EOCCO members ages 1-14 residing in Umatilla County have a dental utilization rate of 57.71%	Increase dental utilization by 1.5% for EOCCO members ages 1-14 residing in Umatilla County (59.21%)	12/2025	Increase dental utilization by 3% for EOCCO members ages 1-14 residing in Umatilla County (60.71%)	12/2027
EOCCO members ages 1-14 residing in Umatilla County who indicated their primary race as American Indian/Alaska Native have a dental utilization rate of 39.94%	Increase dental utilization by 2.5% for EOCCO members ages 1-14 residing in Umatilla County who indicated their primary race as American Indian/Alaska Native (42.44%)	12/2025	Increase dental utilization by 5% for EOCCO members ages 1-14 residing in Umatilla County who indicated their primary race as American Indian/Alaska Native (44.94%)	12/2027

Activity 2 description:

By 6/30/2024, EOCCO will distribute a *Quick Start Guide* to members, clinics, and community-based organizations explaining the importance of the grievance and appeals system and will present this information at the EOCCO CAC and LCHPs. By 12/31/2026, the EOCCO Grievance and Appeals team will notify EOCCO members ages 1-14 who reside in Umatilla filing a dental access grievance that they can visit their PCP offices to complete their preventive oral evaluations and fluoride varnish treatments.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Member education and grievance and appeals system change			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The *Quick Start Guide* has been drafted	Finalize the *Quick Start Guide*	12/2023	Distribute *Quick Start Guide* to all EOCCO members, clinics, and community-based organizations and present the information to the EOCCO CAC and LCHPs	6/2024

The EOCCO Grievance and Appeals team does not notify members of PCP offices who can see patients for oral health services	Draft verbiage and orient the Grievance and Appeals team to notifying eligible members about PCP offices who conduct oral evaluations and apply fluoride varnish (members ages 1-14 who file a grievance about dental access in Umatilla County)	6/2024	The Grievance and Appeals team will notify eligible members about PCP offices who conduct oral evaluations and apply fluoride varnish (members ages 1-14 who file a grievance about dental access in Umatilla County)	6/2026
Monitoring measure 2.1	Dental access			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
EOCCO members residing in Umatilla County filed 25 dental access grievances in 2022	20% reduction in dental access grievances from Umatilla County members	12/2025	40% reduction in dental access grievances from Umatilla County members	12/2027

Activity 3 description: By June 2024, research will be completed to determine the dental and PCP offices' electronic health records (EHR) capabilities to share member information between each discipline.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Data sharing between oral and physical health			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The EHR capabilities between the dental and physical health partners in Umatilla County are unknown	Conduct an assessment across Umatilla County clinics to determine current EHR capabilities between oral and physical health providers via survey and/or scheduled meetings; additionally, bring discussion to incentive measure workgroup meetings to explore potential	12/2023	Compile information from the Umatilla County provider and DCO assessment to determine next steps for how data will be shared between oral and physical health providers; reassess targets and benchmarks of monitoring measure 3.1 upon information discovered	06/2024

	solutions with the DCOs			

Reference:

1. https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html

A. **Project short title**: Improve Health Outcomes of Full Benefit Dual Eligible Patients with Chronic Kidney Disease

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

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

B. **Components addressed**

i. Component 1: SHCN: Full benefit dual eligible
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

EOCCO and Summit Health Medicare Advantage collaborated to align policies and procedures for the special health care needs (SHCN) population and agreed to follow the processes outlined in the EOCCO SHCN Policy and Procedures. In 2022, EOCCO and Summit Health continued processes outlined in the SHCN policy and procedure for dual-enrolled EOCCO patients. Specifically, members with SHCN were identified via the enrollment file from the Oregon Health Authority (OHA). Next, EOCCO Health Services assessed SHCN members to identify ongoing special conditions that require a course of treatment or regular care monitoring (must be completed within 90 days of the SHCN identification). Then, a Health Risk Assessment (HRA) was completed by a qualified staff member to identify physical, oral, behavioral, cognitive, developmental, functional, educational, cultural, social, spiritual, and financial needs of the member. The assessment includes a utilization review of claims and grievances and appeals. Data was evaluated via monthly reports to identify and assess the members with complex needs to establish referrals to additional services (reports include high risk list, APD LTSS list, Collective notifications, and claims data).

Once a patient was identified as having SHCN, then EOCCO/Summit Health would notify the patient's PCP and share the member's needs assessment. At the completion of an assessment, the member developed a treatment plan with a care coordinator and/or the care coordinator referred the member to an EOCCO or Summit Health program (behavioral health care management, physical health care management, oral health case management, aging and people with disabilities case management, multidisciplinary team, health coaching). All treatment plans were developed in

participation with the member, member's family, or the member's representative. Additionally, the treatment plans addressed additional services available for a member, incorporates the treatment, recommendations, or plan of other agencies or providers, accords with state quality assurance and utilization reviews, and is evaluated or revised every 12 months at a minimum. Lastly, EOCCO and Summit Health monitored the care that SHCN patients received via chart reviews, authorization requests, electronic health records, and notifications by providers or members to ensure patients' are receiving appropriate care.

Furthermore, EOCCO and Summit Health contracted with Livongo and Strive Health in 2022 to better support patients with complex health conditions through specialized care management. Livongo offers diabetes self-management to patients with type 1 or type 2 diabetes ages 18+, and equips eligible patients with unlimited strips & lancets, ships refills directly to patients, provides patients with easy-to-use blood glucose meters (readings are uploaded to patient's private account), and patients receive support and guidance with health coaching. Additionally, EOCCO and Summit Health contracted with Strive Health to offer specialized care management services to EOCCO patients ages 18+ with chronic kidney disease (CKD) and end stage renal disease (ESRD). Overall, contracting with Livongo and Strive Health assisted with providing dual enrolled EOCCO members with targeted care management for SHCN.

Using the 834 enrollment files, race, ethnicity, language, and disability data were evaluated for the dual-enrolled SHCN population: totaling 3,430 members. Findings show that in 2022, 39.83% of members have difficulty walking, 36.53% experienced limited activity, 34.66% have difficulty or cannot run errands, 31.63% have difficulties with their memory, and 24.17% have difficulty dressing themselves. EOCCO and Summit Health recognizes the significance that SOGI data yields when evaluating the Improve Health Outcomes of Full Benefit Dual Eligible Patients with Chronic Kidney Disease project for health disparities. Though SOGI data collection poses challenges, EOCCO and Summit Health will continue to look for new ways to improve this collection through community led efforts that is overseen by the EOCCO DEI Committee. Additionally, EOCCO and Summit Health plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plan to better understand the needs of dual-enrolled members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

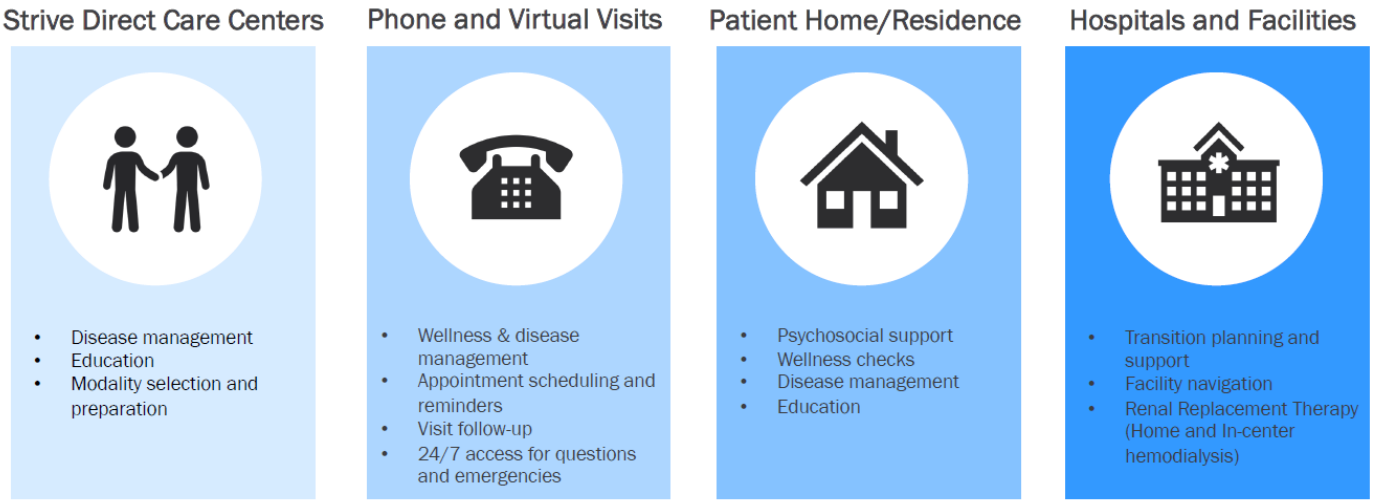
According to the Centers for Disease Control and Prevention (CDC), CKD is a leading cause of death in the United States with an estimated 37 million American adults with CKD.[1] Additionally, treating Medicare beneficiaries with CKD costs $87.2 billion and treating Medicare beneficiaries with ESRD accounted for 7% of the Medicare paid claims costs, totaling $37.3 billion.[1] Furthermore, 40% of patients with limited kidney function are undiagnosed, and 3 out of 4 new kidney failure cases are attributed to uncontrolled diabetes and high blood pressure.[1] There are varying levels of seriousness with CKD and the disease tends to worsen over time; however, not all patients progress to kidney failure and there are preventive measures that can be taken to lower the risk of kidney failure through lifestyle changes, and medication and medical appointment adherence.[1]

Recognizing the impact CKD has on patient health outcomes and healthcare costs, Summit Health Medicare Advantage has implemented a case management program specifically for CKD and ESRD patients through the contracted vendor Strive Health. Other lines of business in Eastern Oregon that are part of the Moda family have contracted with Strive Health and implemented case management services for their members (e.g., OEBB/PEBB and EOCCO). Additionally, Summit Health received clinical buy-in from the Summit Health Clinical Advisory Panel (CAP) justifying the implementation of the case management program for Summit Health-EOCCO members. The Summit Health CAP and Stars Oversight and Advancement Responsibility (SOAR) Team will have continued oversight on the workflows and

progress of the target population to ensure dual-enrolled EOCCO/Summit Health members are receiving quality care from both lines of business. Strive Health will focus on early identification, slowing of disease progression, and the prevention of unplanned crashes into dialysis. Summit Health identified early identification and engagement into case management to avoid quick progression of the disease, and comprehensive coordinated care between Strive Health, providers, EOCCO/Summit Health, and community-based organizations as the end goals for this program. Specifically, CKD patients will develop and maintain treatment plans with a registered nurse every 8-9 weeks and will discuss a wide range of topics including medication adherence, mental health, and lifestyle changes. The treatment plan will be shared with the patient's PCP, insurer, and any other provider/specialist that is required for quality care. See Table 1 for additional details on services offered.

To date, 102 EOCCO members are dual enrolled in Summit Health Medicare Advantage and 13.33% have difficulty walking, 24.44% have difficulty with their memory, and 34.44% are unable to complete errands and have limited activity. While these rates are lower than the overall dual-enrolled rates mentioned in part C, they are significantly higher compared to non-dual enrolled patients and initiatives will be implemented to address this disparity. Due to the high rates of functional limitations or disability, EOCCO and Summit Health will add a disability flag on the eligibility files sent to Strive Health. This additional context on the members will assist case managers with creating treatment plans specific to the patient. EOCCO and Summit Health recognize the significance that SOGI data yields when evaluating the Improve Health Outcomes of Full Benefit Dual Eligible Patients with Chronic Kidney Disease project for health disparities. Though SOGI data collection poses challenges, EOCCO and Summit Health will continue to look for new ways to improve this collection through community led efforts that is overseen by the EOCCO DEI Committee. Additionally, EOCCO and Summit Health plan to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plan to better understand the needs of dual enrolled members.

Table 1.



E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

Dual-enrolled EOCCO/Summit Health Medicare Advantage members 18+ with CKD or ESRD will be connected to Strive Health via provider referral, EOCCO case management referral, member mailings, and phone outreach from Strive. More specifically, Strive Health will create and maintain treatment plans alongside the patient every 8-9 weeks and share these plans with patient's PCP, insurer, and any other provider/specialist that is required for quality care. Treatment

plan can include services such as social determinants of health screenings and mental health support. Additionally, Strive Health will be onboarded with the Unite Us Community Information Exchange platform to conduct closed-loop referrals between EOCCO/Summit Health, providers, and community-based organizations to connect the patient to additional resources outside the medical scope. Strive Health case managers will be asked to stress the importance of monitoring blood pressure and HbA1c levels and encourage lifestyle changes for hypertensive and diabetic patients. Information on additional EOCCO/Summit Health programs, such as Livongo Diabetes Self-Management Program, will be provided to Strive Health for referral purposes. Implementing check-ins on blood pressure and A1c will help to achieve the health outcome goals of controlling a patients glomerular filtration rate (GFR) and lowering the rate of disease progression. To ensure this is being completed, Summit Health will track the number of treatment plans that have blood pressure and A1 check-ins incorporated for diabetic and hypertensive patients with CKD bi-annually.

The EOCCO/Summit Health Quality Improvement Specialists (QIS) will host monthly meetings with clinics to field all questions or concerns and provide updates related to the program. Additionally, a Strive Health representative will connect with all Summit Health providers to offer learning sessions and engage the providers in the case management process. Providers will also be equipped with educational materials and workflow processes to facilitate communication between each party. Furthermore, Summit Health will provide an eligibility file with the addition of a functional limitations or disability flag to Strive Health of all CKD and ESRD patients to conduct outreach and referrals. The results and findings related to the proposed project will be tracked using Strive Health enrollment reports and claims data. The data will be shared with the Summit Health CAP and SOAR Team for continued oversight on the workflows and progress to ensure dual-enrolled EOCCO/Summit Health members are receiving quality care from both lines of business.

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

Activity 1 description (continue repeating until all activities included): By 12/31/2023, 25% of diabetic or hypertensive patients with CKD will have A1c or blood pressure check-ins incorporated in their treatment plans and by 06/30/2024, 50% of diabetic or hypertensive patients with CKD have A1c or blood pressure check-ins incorporated in their treatment plans. EOCCO will track the number of treatment plans that have blood pressure and A1 check-ins incorporated for diabetic and hypertensive patients with CKD bi-annually.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Treatment plan			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of diabetic patients with CKD have A1c check-ins incorporated in their treatment plans	25% of diabetic patients with CKD have A1c check-ins incorporated in their treatment plans	12/2023	50% of diabetic patients with CKD have A1c check-ins incorporated in their treatment plans	06/2024
0% of hypertensive patients with CKD have blood pressure check-ins incorporated in their treatment plans	25% of hypertensive patients with CKD have blood pressure check-ins incorporated in their treatment plans	12/2023	50% of hypertensive patients with CKD have blood pressure check-ins incorporated in their treatment plans	06/2024

Activity 2 description (continue repeating until all activities included): By 12/31/2023, 5% of patients enrolled in Strive Health will have controlled blood pressure, HbA1c rates, and GFR, and 75% of patients will not progress in their disease. By 12/31/2024, 10% of patients enrolled in Strive Health will have controlled blood pressure, HbA1c rates, and GFR, and 78% of patients will not progress in their disease.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Controlled blood pressure (approx. 35.8% of stage 1, 48.1% of stage 2, 59.9% of stage 3, and 84.1% of stage 4-5 CKD patients have high blood pressure[2])			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% patients enrolled in Strive Health monitored for blood pressure with a recorded reading of 140/90 mmHg or below	5% patients enrolled in Strive Health monitored for blood pressure with a recorded reading of 140/90 mmHg or below	12/2023	10% patients enrolled in Strive Health monitored for blood pressure with a recorded reading of 140/90 mmHg or below	12/2024
Monitoring measure 2.2	Controlled HbA1c rate (approx. 33% of diabetic patients have CKD[3])			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of patients enrolled in Strive Health monitored for A1c with a recorded reading below 9%	5% of patients enrolled in Strive Health monitored for A1c with a recorded reading below 9%	12/2023	10% of patients enrolled in Strive Health monitored for A1c with a recorded reading below 9%	12/2024
Monitoring measure 2.3	Controlled glomerular filtration rate (GFR)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of patients enrolled in Strive Health monitored for GFR with a recorded reading of 60 or above	5% of patients enrolled in Strive Health monitored for GFR with a recorded reading of 60 or above	12/2023	10% of patients enrolled in Strive Health monitored for GFR with a recorded reading of 60 or above	12/2024
Monitoring measure 2.4	Monitor disease progression (approx. 23% of patients with diabetes progress in their disease[4])			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of patients enrolled in Strive Health have been monitored for disease progression	75% of patients enrolled in Strive Health have *not* progressed in their disease	12/2023	78% of patients enrolled in Strive Health have *not* progressed in their disease	12/2024

Activity 3 description: By 6/30/2023, EOCCO will submit a request to the EOCCO/Summit Health Analytics team to include a functional limitations or disabilities flag to the Strive Health eligibility file. By 12/31/2023, the Analytics team will have completed the request and Strive Health will begin incorporating this knowledge into building treatment plans.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Functional limitations or disability flag on eligibility file			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Functional limitations or disabilities flag is not included	EOCCO/Summit Health's Health Equity Administrator will determine what other indicators may be helpful to include on the eligibility file and submit the request to Analytics	06/2023	The Analytics team has completed adding the limitations or disabilities flag to the eligibility file and is now being sent to Strive Health to begin incorporating this knowledge into their treatment plan building	12/2023

References

1. Chronic Kidney Disease Basics | Chronic Kidney Disease Initiative | CDC
2. Hypertension in Chronic Kidney Disease: Navigating the Evidence - PMC (nih.gov)
3. Diabetes and Chronic Kidney Disease | CDC
4. Contemporary rates and predictors of fast progression of chronic kidney disease in adults with and without diabetes mellitus | BMC Nephrology | Full Text (biomedcentral.com)

A. **Project short title**: Improve Health Outcomes of Non-dual Medicaid Patients with Chronic Kidney Disease

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

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

B. **Components addressed**

i. Component 1: SHCN: Non-duals Medicaid
ii. Component 2 (if applicable): 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 is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which standard does it primarily address? Choose an item
vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. **Component prior year assessment:** Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, the EOCCO continued processes outlined in the Special Health Care Needs (SHCN) Policy and Procedure. Specifically, members with SHCN were identified via the enrollment file from the Oregon Health Authority (OHA). Next, EOCCO Health Services assessed SHCN members to identify ongoing special conditions that require a course of treatment or regular care monitoring (must be completed within 90 days of the SHCN identification). Then, a Health Risk Assessment (HRA) was completed by a qualified staff member to identify physical, oral, behavioral, cognitive, developmental, functional, educational, cultural, social, spiritual, and financial needs of the member. The assessment includes a utilization review of claims and grievances and appeals. Data was evaluated via monthly reports to identify and assess the members with complex needs to establish referrals to additional services (reports include High Risk List, APD LTSS list, Collective notifications, and claims data).

Once a patient was identified as having SHCN, then EOCCO would notify the patients' PCP and share the member's needs assessment. At the completion of an assessment, the member developed a treatment plan with a care coordinator and/or the care coordinator referred the member to an EOCCO program (behavioral health care management, physical health care management, oral health case management, aging and people with disabilities case management, multidisciplinary team, health coaching). All treatment plans were developed in participation with the member, member's family, or the member's representative. Additionally, the treatment plans address additional services available for a member, incorporates the treatment, recommendations, or plan of other agencies or providers, accords with state quality assurance and utilization reviews, and are evaluated or revised every 12 months at a minimum. Lastly, EOCCO monitored the care that SHCN patients received via chart reviews, authorization requests, electronic health records, and notifications by providers or members to ensure patients are receiving appropriate care.

EOCCO contracted with Livongo and Strive Health in 2022 to better support patients with complex health conditions through specialized care management. Livongo offers diabetes self-management to patients with type 1 or type 2 diabetes ages 18+, and equips eligible patients with unlimited strips & lancets, ships refills directly to patients, provides patients with easy-to-use blood glucose meters (readings are uploaded to patient's private account), and patients receive support and guidance with health coaching. Additionally, EOCCO contracted with Strive Health to offer

specialized care management services to EOCCO patients ages 18+ with chronic kidney disease (CKD) and end stage renal disease (ESRD). Overall, contracting with Livongo and Strive Health assisted with providing EOCCO members with targeted care management for SHCN.

Using the 834 enrollment files, race, ethnicity, language, and disability data were evaluated for the non-dual SHCN Medicaid population: totaling 35,223 members. Findings show that in 2022, 12.24% experience limited activity, 12.10% have difficulty with their memory, 9.18% have difficulty walking, and 8.95% have difficulty completing errands. EOCCO recognizes the significance that SOGI data yields when evaluating the Improve Health Outcomes of Non-dual Medicaid Patients with Chronic Kidney Disease project for health disparities. Though SOGI data collection poses challenges, EOCCO will continue to look for new ways to improve this collection through community led efforts overseen by the EOCCO DEI Committee. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plan to better understand the needs of members.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

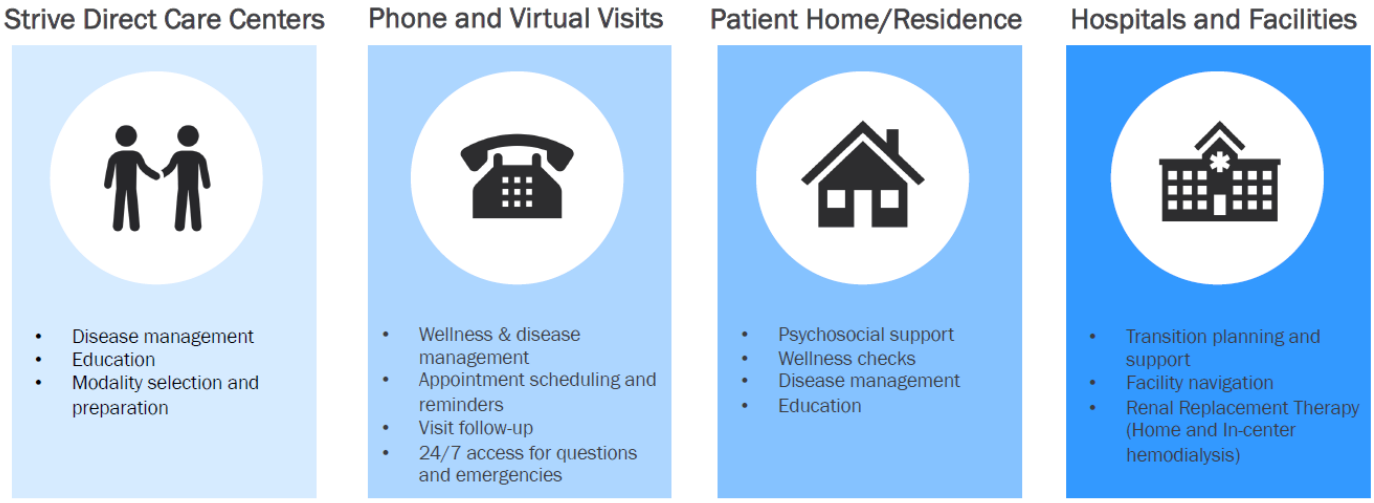
According to the Centers for Disease Control and Prevention (CDC), CKD is the leading cause of death in the United States with an estimated 37 million American adults with CKD.[1] Additionally, treating Medicaid beneficiaries with CKD cost on average $24,017 per patient per year (costs vary depending on the progression of disease).[2] Furthermore, 40% of patients with limited kidney function are undiagnosed, and 3 out of 4 new kidney failure cases are attributed to uncontrolled diabetes and high blood pressure.[1] There are varying levels of seriousness with CKD and the disease tends to worsen over time; however, not all patients progress to kidney failure and there are preventive measures that can be taken to lower the risk of kidney failure through lifestyle changes, and medication and medical appointment adherence.[1]

Recognizing the impact CKD has on patient health outcomes and healthcare costs, EOCCO is in the process of implementing a case management program specifically for CKD and ESRD patients through the contracted vendor Strive Health. Other lines of business in Eastern Oregon that are part of the Moda family have contracted with Strive Health and implemented case management services for their members (e.g., OEBB/PEBB and Summit Health). Additionally, EOCCO received clinical buy-in from the EOCCO Clinical Advisory Panel (CAP) justifying the implementation of the case management program for EOCCO members. Strive Health will focus on early identification, slowing of disease progression, and the prevention of unplanned crashes into dialysis. The end goals are early identification and engagement into case management to avoid quick progression of the disease, and comprehensive coordinated care between Strive Health, providers, EOCCO, and community-based organizations. Specifically, CKD patients will develop and maintain treatment plans with a registered nurse every 8-9 weeks. Strive Health will discuss a wide range of topics with the patient including medication adherence, mental health, and lifestyle changes, and the treatment plan will be shared with the patient's PCP, insurer, and any other provider/specialist that is required for quality care. See Table 1 for additional details on services offered.

To date, 343 EOCCO members with CKD are eligible to participate in Strive Health case management, 23.62% have difficulty walking, 20.12% have limited activity, 15.45% are unable to complete errands, and 13.70% have difficulty with their memory. Due to the high rates of functional limitations or disability compared to the overall SHCN population rates mentioned in part C, EOCCO will add a disability flag on the eligibility files sent to Strive Health. This additional information on the members will assist case managers with creating treatments plans specific to the patient. EOCCO recognizes the significance that SOGI data yields when evaluating the Improve Health Outcomes of Non-dual Medicaid Patients with Chronic Kidney Disease project for health disparities. Though SOGI data collection poses challenges,

EOCCO will continue to look for new ways to improve this collection through community led efforts that is overseen by the EOCCO DEI Committee. Additionally, EOCCO plans to integrate SOGI data provided from OHA's repository flat file in 2023 into the TQS plan to better understand the needs of members.

Table 1.



E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

EOCCO members 18+ with CKD or ESRD will be connected to Strive Health via provider referral, EOCCO case management referral, member mailings resulting in a self-referral, and phone outreach from Strive. More specifically, Strive Health will create and maintain treatment plans alongside the patient every 8-9 weeks and share these plans with patient's PCP, insurer, and any other provider/specialist that is required for quality care. Treatment plan can include services such as social determinants of health screenings and mental health support. Additionally, Strive Health will be onboarded with the Unite Us Community Information Exchange platform to conduct closed-loop referrals between EOCCO, providers, and community-based organizations to connect the patient to additional resources outside the medical scope. Strive Health case managers will be asked to stress the importance of monitoring blood pressure and HbA1c levels and encourage lifestyle changes for hypertensive and diabetic patients. Information on additional EOCCO programs, such as Livongo Diabetes Self-Management Program, will be provided to Strive Health for referral purposes. Implementing check-ins on blood pressure and A1c will help to achieve the health outcome goals of controlling a patients glomerular filtration rate (GFR) and lowering the rate of disease progression. To ensure this is being completed, EOCCO will track the number of treatment plans that have blood pressure and A1 check-ins incorporated for diabetic and hypertensive patients with CKD bi-annually.

The EOCCO Quality Improvement Specialists (QIS) will host monthly meetings with clinics to field all questions or concerns and provide updates related to the program. Additionally, a Strive Health representative will connect with all EOCCO providers to offer learning sessions and engage the providers in the case management process. Providers will also be equipped with educational materials and workflow processes to facilitate communication between each party. Furthermore, EOCCO will provide an eligibility file with the addition of a functional limitations or disability flag to Strive Health of all CKD and ESRD patients to conduct outreach and referrals.

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

Activity 1 description (continue repeating until all activities included): By 12/31/2023, 25% of diabetic or hypertensive patients with CKD will have A1c or blood pressure check-ins incorporated in their treatment plans and by 06/30/2024, 50% of diabetic or hypertensive patients with CKD have A1c or blood pressure check-ins incorporated in their treatment plans. EOCCO will track the number of treatment plans that have blood pressure and A1 check-ins incorporated for diabetic and hypertensive patients with CKD bi-annually.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Treatment plan			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of diabetic patients with CKD have A1c check-ins incorporated in their treatment plans	25% of diabetic patients with CKD have A1c check-ins incorporated in their treatment plans	12/2023	50% of diabetic patients with CKD have A1c check-ins incorporated in their treatment plans	06/2024
0% of hypertensive patients with CKD have blood pressure check-ins incorporated in their treatment plans	25% of hypertensive patients with CKD have blood pressure check-ins incorporated in their treatment plans	12/2023	50% of hypertensive patients with CKD have blood pressure check-ins incorporated in their treatment plans	06/2024

Activity 2 description (continue repeating until all activities included): By 12/31/2023, 5% of patients enrolled in Strive Health will have controlled blood pressure, HbA1c rates, and GFR, and 75% of patients will not progress in their disease. By 12/31/2024, 10% of patients enrolled in Strive Health will have controlled blood pressure, HbA1c rates, and GFR, and 78% of patients will not progress in their disease.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Controlled blood pressure (approx. 35.8% of stage 1, 48.1% of stage 2, 59.9% of stage 3, and 84.1% of stage 4-5 CKD patients have high blood pressure[3])			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of patients enrolled in Strive Health monitored for blood pressure with a recorded reading of 140/90 mmHg or below	5% of patients enrolled in Strive Health monitored for blood pressure with a recorded reading of 140/90 mmHg or below	12/2023	10% of patients enrolled in Strive Health monitored for blood pressure with a recorded reading of 140/90 mmHg or below	12/2024
Monitoring measure 2.2	Controlled HbA1c rate (approx. 33% of diabetic patients have CKD[4])			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of patients enrolled in Strive	5% of patients enrolled in Strive	12/2023	10% of patients enrolled in Strive	12/2024

Health monitored for A1c with a recorded reading below 9%	Health monitored for A1c with a recorded reading below 9%		Health monitored for A1c with a recorded reading below 9%	
Monitoring measure 2.3	Controlled glomerular filtration rate (GFR)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of patients enrolled in Strive Health monitored for GFR with a recorded reading of 60 or above	5% of patients enrolled in Strive Health monitored for GFR with a recorded reading of 60 or above	12/2023	10% of patients enrolled in Strive Health monitored for GFR with a recorded reading of 60 or above	12/2024
Monitoring measure 2.4	Monitor disease progression (approx. 23% of patients with diabetes progress in their disease[5])			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of patients enrolled in Strive Health have been monitored for disease progression	75% of patients enrolled in Strive Health have *not* progressed in their disease	12/2023	78% of patients enrolled in Strive Health have *not* progressed in their disease	12/2024

Activity 3 description: By 6/30/2023, EOCCO will submit a request to the EOCCO Analytics team to include a functional limitations or disabilities flag to the Strive Health eligibility file. By 12/31/2023, the Analytics team will have completed the request and Strive Health will begin incorporating this knowledge into building treatment plans.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Functional limitations or disability flag on eligibility file			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Functional limitations or disabilities flag is not included	EOCCO's Health Equity Administrator will determine what other indicators may be helpful to include on the eligibility file and submit the request to Analytics	06/2023	The Analytics team has completed adding the limitations or disabilities flag to the eligibility file and is now being sent to Strive Health to begin incorporating this knowledge into building treatment plans	12/2023

References:

1. Chronic Kidney Disease Basics | Chronic Kidney Disease Initiative | CDC

2. Annual Data Report | USRDS (nih.gov)
3. Hypertension in Chronic Kidney Disease: Navigating the Evidence - PMC (nih.gov)
4. Diabetes and Chronic Kidney Disease | CDC
5. Contemporary rates and predictors of fast progression of chronic kidney disease in adults with and without diabetes mellitus | BMC Nephrology | Full Text (biomedcentral.com)

Section 2: Discontinued Project(s) Closeout

A. **Project short title:** Enhancing Language Services for Spanish-Speaking Members
B. Project unique ID (as provided by OHA): 88
C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): EOCCO will continue the work of this project outside of the TQS submission. Instead, EOCCO has chosen to limit the number of CLAS projects to better focus our efforts on the current work taking place as recommended in the TQS FAQ guide. Updates on this project will be included in the 2023 DSN Narrative.

A. **Project short title:** Impacting Acute Incidents Resulting from Negative Member Outcomes through Care Coordination
B. Project unique ID (as provided by OHA): 98
C. Criteria for project discontinuation: Project fails to meet TQS requirements for the chosen component(s) based on OHA feedback and/or written assessment
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):
The project failed to meet the TQS requirements for the SHCN Full Benefit Dual Eligible and Utilization Review components. EOCCO will reprioritize efforts to a new project that will meet the requirements of the SHCN component and has chosen to limit the number of Utilization Review projects to better focus our efforts on the current work taking place.

A. **Project short title:** Increase Testing and Improving Accessibility of Hepatitis C Care
B. Project unique ID (as provided by OHA): 99
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):
The project failed to meet expected outcomes for the Grievance and Appeals and Utilization Review components. EOCCO will reprioritize efforts to a new project that will meet the requirements of the Grievance and Appeals component and has chosen to limit the number of Utilization Review projects to better focus our efforts on the current work taking place. The Access: Quality and Adequacy of Services component will continue to be monitored via the DSN deliverable.

A. **Project short title:** Additional Support and Care Coordination for Members with Special Healthcare Needs
B. Project unique ID (as provided by OHA): 370
C. Criteria for project discontinuation: Project fails to meet TQS requirements for the chosen component(s) based on OHA feedback and/or written assessment
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):

The project failed to meet the TQS requirements for the SHCN Non-Duals and CLAS Standards components. EOCCO will reprioritize efforts to a new project that will meet the requirements of the SHCN component and has chosen to limit the number of CLAS Standards projects to better focus our efforts on the current work taking place.

Section 3: Required Transformation and Quality Program Attachments

REQUIRED

Quality Assurance and Performance Improvement (QAPI) Workplan

Work Plan Approval: EOCCO approves the work plan annually during the December Quality Improvement Committee meeting. The work plan acts as a guide to Quality Improvement work intended to be completed during the following calendar year. The plan can be amended based upon data availability and adjustments in project timelines.

Quality Improvement Sub Committee Overview: EOCCO maintains subcommittees to oversee core Quality Improvement efforts in an efficient and effective manner. This structure allows for subject matter experts to engage in an ongoing manner and report progress to the full Quality Improvement Committee on a recurring basis. Each subcommittee has a charter that guides their activities. Each subcommittee is led by 3 co-chairs representing Med/Surg, Behavioral Health, and Dental services. 2022 Quality Improvement Subcommittees include:

- Policy Oversight
- Health Information Technology (HIT)
- Diversity Equity and Inclusion (DEI)
- Incentive Measures
- Member Engagement
- Network Management
- Utilization Review Committee (New)

Transformation and Quality Strategy: 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.

Projects as described in the TQS will be coordinated by Audrey Egan and Sam Shea and led by subject matter experts. Project updates are provided on an ongoing basis at the Quality Improvement Committee.

Quality Improvement Committee: EOCCO will hold a Quality Improvement Committee (QIC) on a bimonthly basis. The QIC will be led by Sam Shea (Quality Improvement Coordinator), with support from the subcommittee co-chairs. The

Chief Medical Officers representing both Physical and Behavioral Health services are key members who will be given time at each meeting to discuss critical emergent or ongoing topics.

Meeting Dates

- February 27, 2023
- April 24, 2023
- June 26. 2023
- August 28, 2023
- October 23, 2023
- December 19 (Observed Holiday Dec 26)

Standard Agenda Items

- Approval of Meeting Minutes
- TQS Project Updates
- Subcommittee Updates
- TQS Project Updates
- PIP Progress Updates
- Adverse Incidents
- Field Team (Community Engagement Update)
- CMO Update

Periodic Agenda Items		
Agenda Topic	**Responsible Person(s)**	**Intended Meeting Date(s)**
Crisis Intervention Team and Sequential Intercept Model Annual Overview (2022)	Chris Thomas	● **February**
Appeals and Grievances (Cultural and Linguistic Specific, Interpreter Specific, Rights and Responsibilities Specific, Second Opinions, NOABD, OHA Resolutions)	Sue Lee and Beth Graham	● April Q3 and Q4 2023 ● October Q1 & Q2 2023
REAL-D Data Overview		
Annual Network Management Network Analysis	Melissa Strong Lindsay Gordon	● August
Out of Network Claims	Matt Byrne (Bx Health) Mina Zarnegin (Physical Health)	● February Q3 2022 ● April Q4 2022 ● June Q1 2023 ● October Q2 2023 ● December Q3 2023
Member Survey Reviews (June) (Released in April 2021)	Sam Shea	● June 2023
Credentialing Activities Summary	Hillary Parks	● February (Q4 2022)

		● April (Q1 2023) ● August (Q2 2023) ● October (Q3 2023)
Practice Guidelines (Annual)	Kristi Swank Kathleen Madore	● December
Delegation Audit Outcomes (Annual)	Hillary Parks	● April
Eligibility Files (Annual)	Mina Zarnegin	● December
Disenrollment Data Overview (Annual)	Kayla Jones	● October
Inappropriate Medication Override (Quarterly)	Dr Chandragiri	● April ● August ● October ● December
Health Related Services (Bi-annual)	Kristi Swank	● April ● October

HRA Response Rates, Trends, and Services (Quarterly)	Kristi Swank	● February ● June ● August ● October
Medication Management Program Evaluation Report (Annually)	Kristi Swank	February (2022 Overview)
Utilization Management Indicators (Annually)		● February (2021 Review)

QAPI Impact Analysis

Project Title	Project ID	Component(s)	Did the project meet the 2022 goals?	Are there formal policies & procedures for the component?	Did the project increase the number of members who can navigate services?	What are the primary health outcomes the project aims to achieve for members?	What are the potential consequences of implementing this project and how are they being addressed?
Improvement and Stratification of Health Equity Data	91	CLAS Standards Health Equity: Data	Partially. While EOCCO did not meet the goal of reducing members with 'unknown' listed as their race/ethnicity by 1.5%, EOCCO did make tremendous progress developing our data collection capabilities.	Yes: EOCCO Cultural Competence Policy	Unknown. EOCCO has not tracked the number of members who can navigate services because of this project since it is not a member facing project. Moving forward, EOCCO will identify monitoring activities that track the number of members navigating services because of this project.	Access to higher quality data will help EOCCO plan, evaluate, and design member-facing programs based on the needs of our members. Additionally, updated member data will ensure that EOCCO has the correct information to provide members with culturally specific resources to meet their needs.	Consequences relating to the collection of data may include members who are unwilling provide personal information as they are unsure how this information will be used. Additionally, members have expressed concerns with how much time the AHC and REALD screenings currently consume. EOCCO hopes to mitigate these concerns by providing members with transparent information prior to starting the screen. Consequences relating to the

							integration of data into the data warehouse may include reconciling conflicting sources of data. This could update the member's demographic data to categories or parent groups the member is unfamiliar with or based on an internal logic pattern written by the analytics team to help code complex data. EOCCO will maintain records of which data sources are currently displayed in each member's profile as the source of truth and when they were last updated.
Culturally Responsive Services by Community Health Workers	92	CLAS Standards Health Equity: Cultural Responsiveness	Partially. All goals were met except for the percentage of clinics billing for CHW services.	Yes: EOCCO Community Health Workers Policy	Unknown. EOCCO has not tracked the number of members who can navigate services because of this project since it is not a	Members will receive culturally and linguistically appropriate care from providers, improving satisfaction with care and	Patients in COFA and HOP populations may be inundated with outreach from multiple partners including EOCCO and community-based organizations leading to confusion. EOCCO has established

					member facing project. Moving forward, EOCCO will identify monitoring activities that track the number of members navigating services because of this project.	health outcomes.	relationships with community-based organizations working with these member populations and will work to co-brand projects rather than duplicating communications.
Technical Assistance for PCPCHs	94	PCPCH: Member Enrollment PCPCH: Tier Advancement	Yes	Yes: EOCCO PCP Assignments	Unknown. EOCCO has not tracked the number of members who can navigate services because of this project since it is not a member facing project. Moving forward, EOCCO will identify monitoring activities that track the number of members	Members will receive advanced care via assignment to higher tiered PCPCH clinics and via the growth in percentage of Tier 4 or 5 Star PCPCH clinics	Members may be reassigned to higher tier PCPCH clinics through the auto-assignment process, even if they've been seeing a lower-tier provider who they like. EOCCO will educate members on how to select and/or change their PCP to mitigate some of these unanticipated transitions of primary care providers.

					navigating services as a result of this project.		
Strive Health-Duals	NEW	Special Health Care Needs - Full benefit Dual Eligible	New Project	Yes: EOCCO Special Health Care Needs Policy	New Project	Dual-enrolled patients will show controlled blood pressure and A1c rates leading to lower GFR rates and slower/no progression in their disease.	Patients may be inundated with outreach from multiple entities (provider, insurer, Strive Health, etc.). Strive Health has established communication pathways with Moda Health Case Management and EOCCO/Summit Health providers to help limit the duplication of outreach efforts.
Strive Health-Non duals	NEW	Special Health Care Needs - Non duals	New Project	Yes: EOCCO Special Health Care Needs Policy	New Project	Medicaid patients will show controlled blood pressure and A1c rates leading to lower GFR rates and slower/no progression in their disease.	Patients may be inundated with outreach from multiple entities (provider, insurer, Strive Health, etc.). Strive Health has established communication pathways with Moda Health Case Management and

							EOCCO providers to help limit the duplication of outreach efforts.
Increasing Pediatric Dental Access through First Tooth Certification in the Eastern Oregon Service Area	NEW	Oral Health Integration Grievances and Appeals	New Project	Yes: EOCCO Medicaid Member Grievances and Appeals Policy	New Project	EOCCO members ages 1-14 residing in Umatilla County will have increased access and utilization of dental services and lower rates of cavities.	Patients may opt to only see their PCP for dental services and decline to schedule with their dentist. The PCPs will remind patients the importance of visiting their dentist and explaining that an oral evaluation and fluoride varnish at the PCP is not a replacement for visiting their dentist.
Expansion of Behavioral Health Integration Using THWs and HIT	423	Behavioral Health Integration	Yes	Yes: EOCCO Traditional Health Worker Integration Policy	Unknown. EOCCO has not tracked the number of members who can navigate services as a result of this project since it is not a member facing project. Moving forward, EOCCO will identify	By receiving care at a BHI clinic, members will have better behavioral health outcomes.	Members may think that their only options for behavioral health care is through their BHI PCPCH. EOCCO will continue to direct members to the BH provider search tool and provide information about other contracted providers so members know they are able to seek care outside of the primary setting.

					monitoring activities that track the number of members navigating services as a result of this project.		
Diabetes Self-Management Program	424	Utilization Review	Partially. EOCCO met the Livongo enroll goal but did not meet AAE spending goal.	Yes: EOCCO Over- and Under-Utilization of Services Policy	Yes. 20 members from Saint Alphonsus are utilizing Livongo DSM services.	By engaging in a DSM program, members will control their diabetes and limit their visits to the hospital	Members enrolled in the DSM program may think DSM replaces visiting the doctor. EOCCO/Livongo will incorporate education about the importance of scheduling regular checkups with a PCP and will share enrollment information and progress reports to clinics of their assigned patients. Additionally, members may feel deterred to participate in a digital program due to not having a smartphone or computer. To address this, EOCCO will use health-related services funds to

							equip members with a phone or computer so they can participate in the program.
Umatilla Community Paramedics Program	425	Utilization Review	No. EOCCO experienced a data sourcing error for calculating AAE and did not meet the spending or enrollment goals.	Yes: EOCCO Over- and Under-Utilization of Services Policy	Yes. 14 members have received Umatilla Paramedic Program services.	By receiving Umatilla Paramedic Program Services, EOCCO members with a diagnosis of hypertension living in Umatilla County will have enhanced chronic condition management support and increased PCP access and utilization. This will ultimately reduce ED utilization for hypertension or chronic disease management.	Members may think UCPP services can be received in lieu of visiting their PCP. UCPP paramedics will address this by ensuring that members understand the scope of their services, and by providing education surrounding the importance of scheduling and attending PCP appointments for chronic condition management and general preventive care and wellness. If need-be, UCPP paramedics will refer members to EOCCO case management for additional care navigation and coordination support

							post hospital discharge.
Opioid and Stimulant Use Disorder Housing Support Program	426	Utilization Review	Partially. The grant team successfully promoted the program to all twelve CMHPs and processed 240 referrals for EOCCO members. The goal of distributing $250,000 in housing support funding was not achieved, but the grant team did received $225,000 for this project.	Yes: 1) EOCCO Access to Substance Use Disorder Services Policy 2) EOCCO Over- and Under-Utilization of Services Policy	Yes. The 240 individuals who received housing support funds were also connected to SUD and non-SUD-related services. Many individuals in this intervention received SUD medications such as Naloxone that they may not have received otherwise.	Reduced avoidable spending for individuals with OUD and/or MA-SUD diagnoses and housing insecurity flags. Indirectly, we hope that increased housing security will lead to lower avoidable spend such as ED visits and ambulance trips.	A potential consequence of this project is that members may not be able to maintain their housing after the initial support funds are disbursed. The project team attempts to keep participating members engaged with their care team to encourage employment and SUD treatment so members can maintain their housing stability. Additionally, care teams help with education and enrollment into available housing programs and connect members with appropriate EOCCO programs or community-based services.

3-day Follow-up Post Emergency Department (ED) Visit	95	Serious and Persistent Mental Illness (SPMI)	No. Adjusted goals to be more achievable 2023 target/benchmarks.	Yes: EOCCO ED Utilization for Behavioral Health Policy	Yes. The 714 members who received follow up were connected to care coordination and EOCCO programs as appropriate.	Follow up with SPMI members who visited the ED to assist with immediate and long term needs by connecting them with appropriate EOCCO programs or community-based services, improving their mental health and decreasing their utilization of the ED.	Members may feel they should avoid the ED during a true emergency. EOCCO will include education on when to seek care at the ED, urgent care, and PCP.
Improving the Utilization and Impact of Frontier Veggie Rx	96	Social Determinants of Health & Equity (SDOH-E)	Partially. One prescriber is utilizing Unite Us, but EOCCO still needs to onboard the rest of the prescribers to Unite Us, increase the # of additional community support services, and decrease the rate at which members worry about	No: The Veggie Rx policy and procedure is outdated. EOCCO will update to reflect current procedure.	Yes. The 343 members enrolled with Veggie Rx are also connected to other community programs and can easily be directed to EOCCO customer services for additional	Members connected to the Veggie Rx program will begin to experience less stress now that they know where their next meal is coming from and will also eat healthier. Eating healthier and consistently	Members may not be able to maintain food security should they move to an Eastern Oregon county that does not offer Veggie Rx. The member will be connected to EOCCO case management to determine what community services exist and how health-related services can be distributed to

			running out of food.		navigational assistance.	will lead to the member having more focus in their day-to-day routine (e.g., children will have more success in school).	support the member and their family.

OPTIONAL

Attachment 1: EOCCO Over- and Under-Utilization of Services Policy

Click here to review EOCCO's Over- and Under-Utilization of Services Policy

Attachment 2: Umatilla Community Paramedic Program Workflow