2023 Transformation and Quality Strategy

March 2023

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Contents

Section 1: Transformation and Quality Program Details

A. **Project short title**: Medical Shelter Program

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

If continued, insert unique project ID from OHA: 410

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 project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item
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) for the component(s) selected with CCO- or region-specific data.

Advanced Health's Intensive Care Coordination (ICC) team collected referrals for approximately 420 members with Special Health Care Needs (SHCN) in 2022. The Intensive Coordination Team served 246 of the referred members. Of the 174 Members referred but not enrolled with ICC, 26 were not on Advanced Health, 64 did not respond to outreach, 22 were not interested in ICC and 14 did not need ICC services. An additional 27 were already in care management services with behavioral health or medical clinic care management.

Early in 2022, Advanced Health's ICC program worked toward streamlining the referral process into one central email where all referrals were managed. Most referral screens were received via fax and email, although referral calls continued to be accepted from emergent referral sources (hospitals). During Q1 2022 Advanced health responded to ninety-three percent of referrals within the required ICC time frames (response to referral source within one day). The other quarters of 2022 reflected similar response times, including Q2 2022, Ninety-eight percent, Q3 2022, eighty-seven percent and in Q4 2022, ninety-seven percent of referrals were responded to within the required ICC time frame.

To improve access for our SHCN members, Advanced Health has either created and/or strengthened a myriad of referral pathways and community partnerships to better meet their complex health needs. Members are identified through a variety of established CCO mechanisms and entryway points into Intensive Care Coordination services. Through Advanced Health's Customer Service department, all newly enrolled Advanced Health members are screened with a health risk assessment (HRA) and given the opportunity to self-identify special health care needs for referral to intensive care coordination services. Other pathways into ICC, in 2022, included referrals from other internal Advanced Health departments (pharmacy, medical management, claims), referrals from all local area medical clinics and Bay Area Hospital (BAH), the largest provider of hospital services in Advanced Health's network. Other hospitals, some out of area, also referred to ICC during 2022, including Southern Coos Hospital, Sacred Heart Riverbend Hospital, Oregon Health & Sciences University, Legacy Emanuel Hospital and Lower Umpqua Hospital. Other medical sources referred to ICC, including Home Health and Wound Care at BAH.

In addition, ICC received referrals for nursing support for members with Severe and Persistent Mental Illness (SPMI) via Curry County Adapt and Coos Health and Wellness, as well as from local private therapists. Substance abuse treatment

providers referred to ICC multiple times, including referrals from Crossroads Residential Treatment Center, Adapt in North Bend and Bay Area First Step. Other community partners made referrals for SCHN members to ICC, including ID/DD services (Community Living Case Management) and homeless services (Devereux Center, Curry Homeless Coalition, St. Timothy's Church, and the Gospel Mission). In 2022, ICC's partnership with DHS-APD strengthened, resulting in 40 referrals to ICC from APD during 2022. Often referrals from BAH also included a joint referral to APD, resulting in numerous partnerships with APD, via other pathways. Other referral pathways included DHS-CWS, OHA FFS Nurses, other CCOs (transition of care), Medicare Advantage plans (Dual eligible Members), OHA Ombuds Program, Advantage Dental (delegated dental network provider), Coos County Parole and Probation, and the Homeless Veterans Program. Members self-referred into ICC as well, and there were several referrals from family members who called in to Advanced Health Customer Service.

Advanced Health aims to identify SCHN Members for Intensive Care Coordination at the time of enrollment through screening protocols, through annual re-assessment or Member request. Monitoring systematically for some triggering events such as recent homelessness is challenging. Nonetheless, triggering events also serve as occasions for entry to Intensive Care Coordination. One avenue in which triggering events result in referrals to ICC is via Collective Medical's hospital event notifications (HEN). The ICC Team has built cohorts in Collective Medical which filter Special Populations including high Emergency Department (ED) Utilizers, Pregnancy identification, SPMI ED visits, inpatient or emergency department SUD diagnosis, and HEN all inpatient and ED admissions. Advanced Health's ICC Program Manager and ICC nurse staff routinely check the Collective Medical Cohorts and reach out to Members, if deemed appropriate, to screen for SCHN and a need for ICC services. Furthermore, ICC care coordinators can add themselves to the care team in Collective Medical and tag the ICC program so that the ICC team receives email notifications when enrolled (tagged) members present in the ED or are admitted to hospital, or to long term care or skilled nursing facilities.

Once referred, each ICC member is assigned a Care Coordinator (such as a Traditional Health Worker and/or Registered Nurse) as a single and consistent point of contact. Member's assigned coordinator assists the member in identifying and resolving healthcare barriers from assessment information (PRAPARE assessment), collaboration from the member, and additional information from their care team participants in case conferences such as at Bay Area Hospital, individualized complex coordination meetings and/or collaborative problem-solving monthly meetings with Aging and People with Disabilities.

Members' care plans are built by the assigned Advanced Health care coordinator, in collaboration with the Member, with an emphasis on using a comprehensive and wholistic approach. In 2022, the ICC team has continued to utilize Activate Care as the primary platform for care planning. Care plans are categorized into Medical Needs, Behavioral Health Needs, Dental Needs and Social Determinants of Health (SDOH) Needs. Care plans incorporate interdisciplinary goals, evidence of member participation, distinct roles for care team members and clear tracking of ICC time frames to help remind Advanced Health coordinators of the necessary tasks to complete enrollment, intake, and healthcare specific goals. Current length of care in the ICC program varies from short term to long term, usually spanning a time frame of 3 to 18 months. If a healthcare and/or SDOH barrier is identified by the coordinator that requires a flex fund intervention, Advanced Health has developed an internal ICC flex fund process to reduce the barriers frequently encountered by our SHCN members.

The ICC program administers the PRAPARE social needs screening tool to every member who engages in services. From this screening we can aggregate REALD data. Of the members in ICC care who received a screening during 2022, 99% speak English, with the primary race being White (86.9%) followed by American Indian/Alaskan Native (3.27%), and Hispanic/Latino (1.3%).

For members with Special Health Care Needs, who had a need for access to a specialist, the SHCN designation was composed by an ICC nurse, the ICC Director, or the ICC Program Manager. The SHCN designation includes a description of the complex medical needs, priority population status, behavioral and SUD need, ID/DD concerns, dental concerns

and confounding SDOH needs, written in a format which ties the complexity of needs together. This designation is included in the Summary Section of Activate Care, in outreach notes in Activate Care, and is included in Quantum Choice notes (for prior authorization review and determination). For Members designated to have SHCN, Advanced Health allows direct access to a specialist. The specialist should be appropriate for the member's condition and identified needs. The PCP can simply refer the member to the specialist without a prior authorization. The referring provider should notify Advanced Health of the referral. This allows the creation of a standing referral/authorization number for billing purposes. This standing authorization includes pre-approved visits (i.e.,6 visits in 6 months), allowing the member to establish care directly with the appropriate specialist.

Advanced Health's ICC team has developed strong and valuable relationships internally and externally with medical, behavioral, and social service professionals to greatly improve coordination of care and discharge planning for SHCN members. ICC staff are consistently present at weekly hospital complex case meetings, Coos and Curry behavioral health ICC sub-contractor meetings and built a new monthly partnership with DHS APD case management through an updated memorandum of understanding. Additional contracts were awarded to our unhoused population service agencies such as Brookings CORE and Nancy Devereux center to expand the reach of ICC services and provide additional support to one of the most vulnerable SHCN population groups. Through these improved collaborations, Advanced Health invested a combination of SHARE Initiative funds and Health-Related Services funds into the Coalbank Village (pallet sheltered community) operated by the Nancy Devereux center for the purposes of medical sheltering. Currently, the Advanced Health ICC team meets weekly with the Nancy Devereux Center staff to monitor the medial sheltering program which is described in detail in the subsequent sections of this report below.

The Devereux Center offers support systems and advocacy for the homeless, those suffering from mental illness, and veterans. The Devereux Center serves an average of 80 to 100 people a day. The Devereux Center is a 501(C)3 tax-exempt non-profit organization founded in 1979. The Center is a day facility that is open from 9 am to 2 pm every week on Monday, Tuesday, Wednesday, and Friday. Breakfast and lunch are served on Thursdays, but access to case management, showers and laundry is not available.

Coalbank Village is located on the South side of Coos Bay. Coalbank has 25 Pallet Shelters available, which are designed to provide temporary sheltering to homeless individuals who are seeking resolution of their homeless status. Through providing a safe environment and improved access to needed resources, sheltered individuals have improved opportunities to obtain housing. Coalbank residents share access to a full kitchen area, a restroom shelter with electricity and shower facilities, as well as a covered recreation area. Furthermore, residents have access to the Devereux Center services via provided transportation which takes Coalbank residents to the Devereux Center in the morning and returns them to Coalbank Village after lunch.

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

For a myriad of reasons, COVID-19 resulted in an increased medically complex homeless population discharging from hospital level of care back to the streets. Existing strong relationships between Advanced Health's ICC team and the Devereaux Center enhanced ICC's ability to provide direct access to Medical Sheltering to unhoused members with complex medical needs. These medically complex Members often presented with confounding behavioral health and SDOH concerns.

The homeless Members screened for, and enrolled in, ICC services, have continued to predominately fall into three main categories:

- first, the medically fragile who are newly homeless and have not been able to navigate meeting their own needs;

- second, the medically complex homeless who have been without a home for a longer timeframe and have declining health; and
- third, those with chronic health conditions, who have struggled with homelessness, and have an increased rate of alcohol and substance abuse, typically as a means of coping.

As Covid has strained resources and agency staff, the availability of services became even more limited in 2022. A discharge referral to wound care may take 2-3 weeks for an initial appointment. Primary Care offices are unable to meet the need for close follow-up post hospital discharge, due to offices being inundated with needs. Outpatient infusion, cancer treatment, dialysis providers, and home health all have had limited capacity to accept new referrals. Local and out of area Skilled Nursing Facilities (SNF), Long-term Care Facilities (LTC), and Residential Treatment Centers (RTC) have seen an increased demand for services in 2022. This has been evidenced by delayed hospital discharges due to waitlists that these facilities have. The high ratio of need verses availability allowed for these facilities to screen out those individuals deemed to be more complex with SUD and SDOH concerns. The denial of admission to SNF and LTC resulted in medically fragile Members being discharged from hospital, without the needed post-hospital care. Further contributing to this deficit in the availability of needed care is that access barrier created by these facilities. SNF and LTC facilities have increasingly denied admittance for skilled or long-term care to individuals who have substance use disorders (current or past) and to those individuals who are homeless.

As the medically complex or compromised homeless have struggled with declining health, the rate and length of hospitalization has increased. ICC has seen a steady increase in 6 population groups, over the last 12 months, all of whom need discharge shelter:

- Older individuals, post CVA, homeless, and not meeting criteria for APD services.
- Homeless individuals struggling with liver or renal disease, with either a relapse on alcohol or a worsening of alcohol or substance abuse, with recurrent episodes of acute liver related crisis (ascites, liver failure, encephalopathy) or acute renal failure.
- Homeless individuals with cellulitis, of varying origins.
- Homeless individuals who have been unable to manage diabetic needs, who are now experiencing non-healing lower extremity ulcers and, in some cases, amputations.
- Homeless individuals with respiratory illness requiring post hospital DME equipment (i.e., oxygen, C-PAP, Bi-PAP) which requires access to electricity.
- Homeless individuals recovering from surgical procedures or orthopedic injuries.

The overall availability of housing, over the past 24 months, has diminished. The cost of rentals has increased to a level that is not sustainable for many low-income or disabled individuals. Those who are newly homeless and who do have some limited resources, are unable to find affordable housing. This has resulted in:

- All resources the individual has going to motel expenses, until those resources are exhausted. Those in this category have been, in ICC's experience, older individuals post CVA or with diabetic complications, and those members with orthopedic injuries.
- Individuals living in vehicles for longer periods of time, with resources diminishing. Those in this category, again in ICC's experience, have been those with respiratory diseases (with a need for oxygen or nebulizer treatment, or a need for C-Pap or Bi-pap equipment), cellulitis or diabetic complications.
- Decreased availability of motel rooms in the area, which has driven up the cost for motel stays.

The end point in this is that those who are medically complex, fragile, or compromised, who potentially could have found housing pre-pandemic, end up on the streets and then hospitalized for a medical crisis.

E. **Brief narrative description**:

In 2022, the Advanced Health ICC team continued to work on building and improving its existing relationship with both the Bay Area Hospital nursing case managers and the Devereaux Coal Bank Village case management staff. Through

these community partnerships, Advanced Health Medically Sheltered 22 Members in 2022, who were either being discharged from the hospital or who were frequenting the ED for acute medical needs. Each member was housed for a period of one to ten weeks for medical stabilization, recovery, and transition to longer term stable housing. The Medical Sheltering goal is to medically stabilize members and assist the members with obtaining housing resources within a four-week time frame. That goal has proven unrealistic for some of the more medically complex members.

Throughout the Medical Sheltering time, Intensive Care Coordination THWs and/or RNs assisted these SHCN Members with health care related goals specific to the member's needs/concerns. Members met with the assigned ICC staff a minimum of once weekly to review and work on the identified health care goals. These goals centered around the specific medical needs, including prescribed medication access/adherence, establishing and following through with primary care appointments, following through with needed medical tests and lab work, obtaining needed Durable Medical Equipment (DME), and obtaining and following through with Specialty Care (Specialists, wound care, IV infusion, cancer treatments, diabetic education, Hospice, Home health, dialysis, etc.). In addition, Behavioral Health needs and goals were addressed, including establishment with behavioral health and substance use disorder treatments/programs/providers. Dental health needs were addressed, as well. In addition, Social Health (SDOH) needs were addressed as a vital part of overall health care outcome improvement. ICC care coordinators created goals with Medically Sheltered members specific to housing needs, the need for clothing or other basic needs items, food insecurity, employment or educational needs, financial needs (applying for disability or obtaining a rep payee), transportation needs, legal barriers/needs, and communication needs. These goals, based on the individual's specific needs, were developed into care plans in Activate Care. These care plans included specific goals with timeframes, which were carried out via collaboration between member and care coordinator.

Data collection for members participating in the Medical Shelter program has been a focus of Advanced Health since 2021. Data collected includes entry date, exit date, total days housed, member name, Medicaid ID, referral source, medical need, outcome, and ICC program status. The scope of data collection was expanded in 2022 to include pre-sheltering and post-sheltering Emergency Department utilization and inpatient hospital days for members participating in the medical shelter program, with post utilization data captured 6-months post sheltering to gauge long term impact on health outcomes. This expansion in monitoring also included housing status post-sheltering, and weekly check-ins adherence with care coordinator adherence. For 2023, Advanced Health will continue to collect data and document Member progress with the Medical Sheltering program. Ways in which to track health outcome improvement more effectively will continue to be explored. Activate Care potentially could be further utilized in this regard, not only to track weekly check-in progress and DME needs being met, but also to track adherence with PCP appointments and specialty care appointments. Furthermore, Advanced Health ICC Team will continue to work on refining the medical shelter program admission prioritizing scale, which aids in determining admission priority when there is a waitlist.

Additional benefits of Advanced Health's Medical Sheltering program are that Members with complex medical needs post discharge have a safe and clean environment to facilitate healing. Coalbank Village has 24-hour security which provides for a safety net for medically complex individuals. The Village is a clean and sober environment, which has the potential to promote abstinence in those who have medical needs and are struggling with SUD concerns. Devereux case managers, along with ICC care coordinators, have been able to closely follow Members, to ensure medical follow-up. The Devereux staff have served to remind Members to take medications, which is often forgotten when homeless. Members have had access to electricity and a kitchen space, which has assisted with needed nutrition. In 2022, the Village obtained, with funding from Advanced Health, a restroom shelter with running water, electricity, and shower facilities. The restroom shelter has promoted easy access to hygiene care. Furthermore, Village residents, including those in medical shelters, have access to a van 5 days a week to transport them to and from the Devereux Center, where hot meals, computer access and laundry facilities are provided. The community environment has provided for social needs and decreased stress levels, which are also factors in healing.

Other barriers to positive health outcomes include permanent residency, navigating the healthcare system, and having access to durable medical equipment (DME) at the time of discharge from the hospital. DME includes, but is not limited to; portable oxygen, nebulizer treatments, mobility devices, wound care supplies, incontinence supplies, ostomy and catheter supplies and diabetic supplies. The medical sheltering program has increased access to DME for those members with this need. Having an address at the time of discharge from a health care facility, significantly increases DME access and compliance. In conjunction with resources at the Coalbank village and ICC, members receiving medical sheltering have better access to DME, thus improving their short- and long-term health outcomes. Advanced health was able to build a relationship with Performance Home Medical to increase oxygen access for those members receiving medical sheltering. This relationship has allowed oxygen to be delivered directly to the Coalbank medical sheltering for those members requiring it.

The resources and supports provided at Coalbank Village, and with ICC care coordination, have served to promote a healing environment, which has allowed for needed recovery time in a sheltered environment, improved access to aftercare and needed medical services, which has resulted in decreased Emergency Department Utilization and hospital inpatient days for members utilizing medical shelter program. Improved outcomes and improved health have also been promoted via access to needed Durable Medical Equipment (DME). Members have been steered toward accessing additional community resources and services, which have had the potential for meeting housing needs. Members who have actively worked on care plan goals with the assigned ICC Care Coordinator have been able to access additional resources and care, including resources which have met behavioral health needs, SUD treatment needs, transportation needs, prescription access needs, employment needs, clothing, and basic item needs, and more.

Currently, there are two medical shelters at the Coalbank Village reserved for Advanced Health SCHN members. At times in 2022, the Devereux Center/Coalbank Village had the capacity to allow for Advanced Health to utilize additional shelter space with an additional 1-2 shelter utilization. Goals for 2023 include working with the Devereux Center/Coalbank Village to expand the number of Medical Shelters to 4 on a routine basis.

The combination of improved access to health care and community resources, improved access to needed DME, increased opportunities for housing, along with the supports provided by Coalbank Village, the Devereux Center and ICC Care Coordinators, have, as evidenced by a reduction in ED utilization and hospital inpatient days, promoted healthier outcomes for vulnerable medically complex homeless Members with special health care needs.

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

Activity 1 description: Monitoring inpatient hospital days and emergency room utilization for members post sheltering. Long term impact of medical shelter program on health outcomes.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Reduction in utilization of emergency room visits (# of visits/member for 6 months)			
# of ED visits per Member 6 months prior to Sheltering	**# of ED Visits per Member 6 months post Sheltering**	**Target met by (MM/YYYY)**	**Benchmark/future goal**	**Benchmark met by (MM/YYYY)**
65 visits/12 Members (5.4 visits/Member)	34 visits/12 Members (2.8 visits/Member)	12/2022	2 visit/member	12/2023
Monitoring measure 1.5	Reduction in utilization of hospital inpatient days (# of days/member for 6 months)			
# of inpatient days per Member 6	**# of inpatient days per Member 6**	**Target met by (MM/YYYY)**	**Benchmark/future goal**	**Benchmark met by (MM/YYYY)**

months prior to Sheltering	**months post Sheltering**			
215 days/12 Members (18 days/Member)	71 days/12 Members (5.9 days/Member)	12/2022	5 inpatient days	12/2023

Activity 2 description: Improvement in potential health outcomes via weekly care coordinator check-ins and the obtainment of housing/transitional housing.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Housing or transitional housing obtained via member engagement with Care Coordination.

Monitoring measure 2.1	**Number of members placed in housing or transitional housing after emergency shelter program**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
73% of members sheltered were placed in long term or transitional housing	80% of members sheltered were placed in long term or transitional housing	12/2023	85% of members sheltered were placed in long term or transitional housing	12/2024
Monitoring measure 2.1	**Members engaged in weekly care coordination during medical sheltering period, to work on member centered care plan goals**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
85% of members engaged with care coordination during the medical sheltering process	87% of members engaged with care coordination during the medical sheltering process	12/2023	89% of members engaged with care coordination during the medical sheltering process	12/2024

Activity 3 description: Improved access to needed Durable Medical Equipment (DME) for members receiving emergency shelter at Coalbank Village.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement:

Monitoring measure 3.1	Number of Members with identified DME needs successfully receiving DME during medical sheltering period.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
14 members with identified DME needs prior to medical sheltering (2022)	Monitor number of members in medical sheltering program with	12/2023	Monitor number of members in medical sheltering program with identified DME needs	12/2024

	identified DME needs			
86% of those members successfully receiving DME while medically sheltered	90% of members successfully receiving DME while medially sheltered	12/2023	95% of members successfully receiving DME while medically sheltered	12/2024

A. **Project short title**: South Coast Together – ACEs Training and Prevention

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

If continued, insert unique project ID from OHA: 40

B. **Components addressed**

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

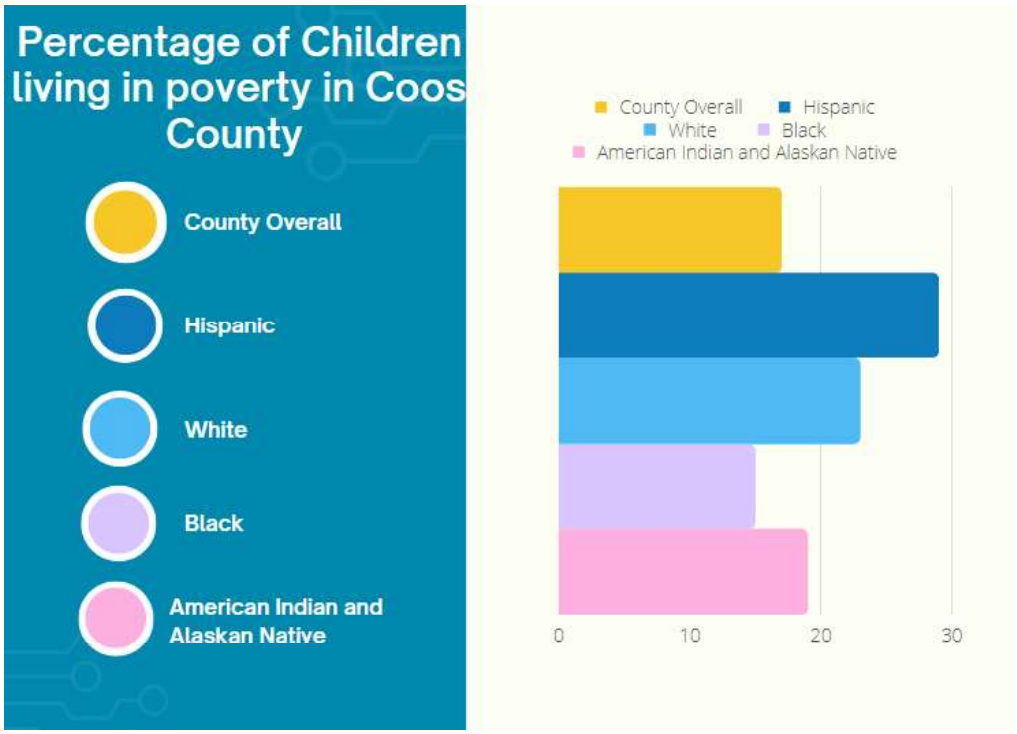
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Advanced Health aims to identify the Social Determinants of Health (SDoH) for its members with intentional interventions to improve social service networks, standardized screenings, referrals, and data collection to understand priority areas in our community. Advanced Health members are screened for Social Determinants of Health in the primary care setting, during Intensive Care Coordination enrollment, upon CCO enrollment and annually with SDoH focused questions included in the Health Risk Assessment.

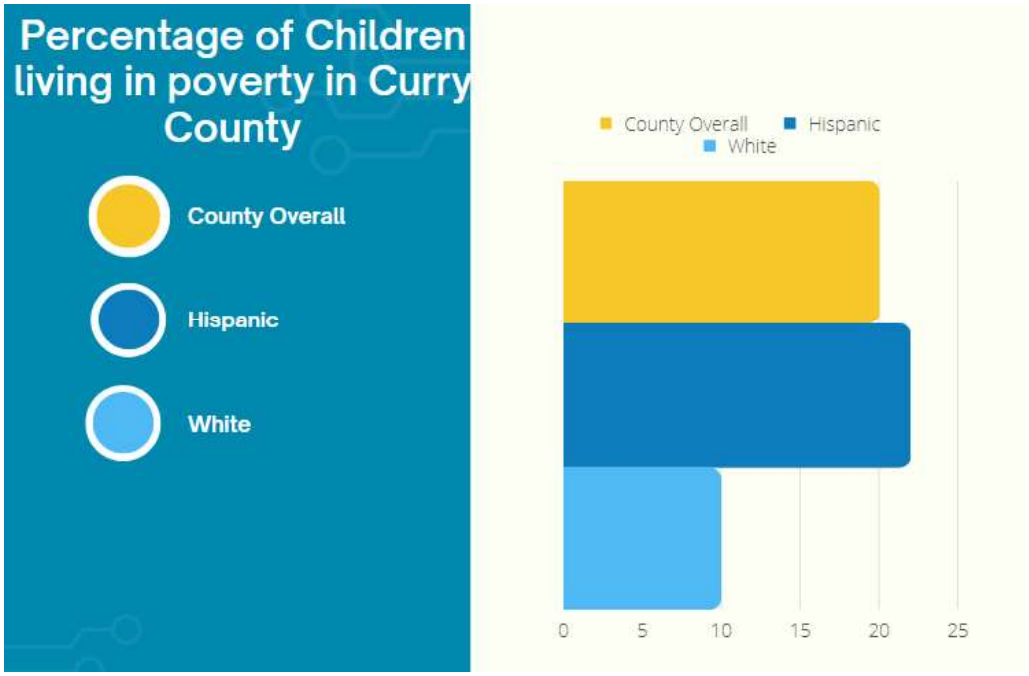
One of the ways that Advanced Health addresses the community-level social, economic, and environmental conditions that impact health, or the Social Determinants of Health, is by working upstream in developing strategies to mitigate Adverse Childhood Experiences (ACEs). The findings from the Adverse Childhood Experiences (ACE) study are the largest public health discovery of our time. The evidence linking childhood traumas to adverse health outcomes makes it clear that finding ways to mitigate and prevent trauma, as well as promoting resiliency for people impacted by ACEs, is key to improving the health of the community. The Master Training program and Self-Healing Communities Initiative from ACE Interface have been adopted in other states and are showing early evidence of improved outcomes.

Advanced Health's service area of Coos and Curry counties have some indicators of higher rates of trauma and in 2022 the percentage of children in poverty in Coos and Curry Counties was 21% which was higher than the Oregon statewide rate of 12%.

Ethnic breakouts for 2022 were not available for this report however, relying on the data from 2021 we find in Coos County shows that 29% of the population identify as Hispanic and 23% of the population identifies as White, with a higher than national average population of American Indian and Alaskan Natives at 19%. (https://www.countyhealthrankings.org/reports/children-living-in-poverty)

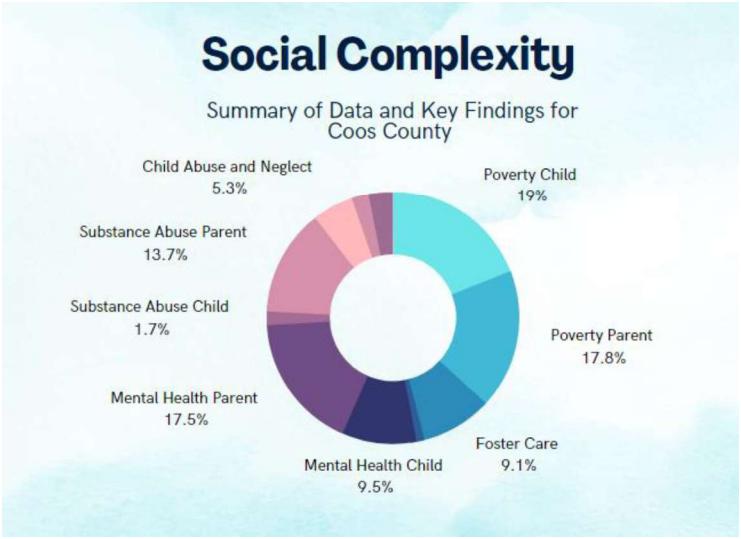


Curry County shows a slightly different story, 22% of all Hispanic children living in poverty above the county average of 20% while white Children are below the county average at 10%.

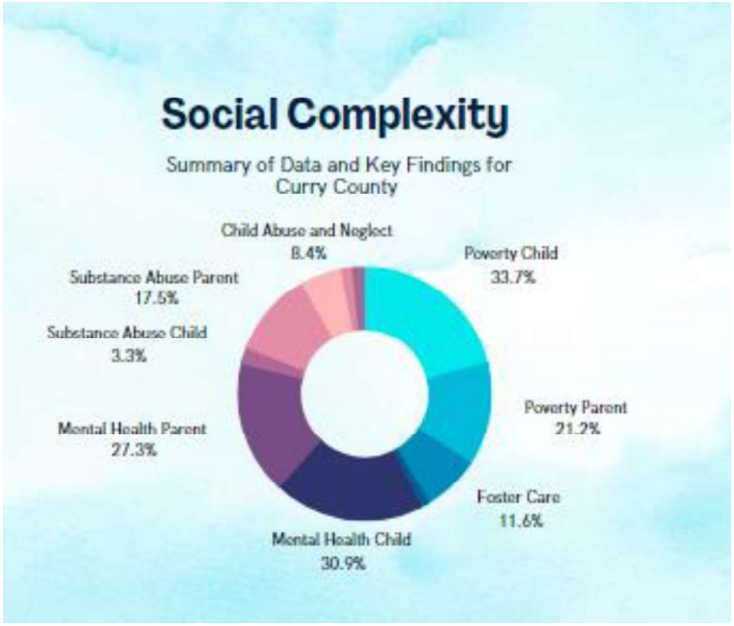


The Child Welfare Data book published in September of 2022 reflects data gathered from the Oregon Department of Human Services in 2021. Coos County reported a rate of 22.6 per 1,000 children as victims of child abuse or neglect. Curry County reported a victim rate of 20 per 1,000 children. These rates are significantly decreased from the prior year; however, Curry County showed a significant increase in the victim rate from 14.2 per 1,000 to 20 per 1,000.

The most recent Health Complexity Data, published October 2021, states 44.2% of all Coos County children have 3 or more indicators of social complexity. (https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Coos-2021-October.pdf) This is up from the 2020 report of 43.2%. The leading cause of social complexity issues is the mental health of the parent at 46.2%, followed by poverty at 41.9%



Curry County has 26.8% of all children with 3 or more Indicators of social complexity. (https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Curry-2021-October.pdf) Poverty is the leading contributor to social complexity and the mental health of the child is the number two contributor.



The social complexity indicators summarized in the Children's Health Complexity Data closely align with many indicators of trauma from the ACEs study. Social complexity indicators reported in the Children's Health Complexity Data include

poverty (child or parent), foster care, parental death, parental incarceration, mental health (child or parent), substance abuse (child or parent), child abuse and neglect, potential language barriers, and parental disability.

Supporting efforts to mitigate trauma and increase resilience are priorities of both the Coos and Curry County Community Health Improvement Plans for 2019-2024.

The COVID-19 pandemic, resulting state of emergency declaration, and protective orders issued in 2020 have likely negatively impacted many of these indicators of social complexity and adverse childhood experiences. There is still much we do not know about the long-term effects of the pandemic, but we continue to hear from our Consumer Advisory Councils, provider network, staff, care coordinators and case managers, and community partners that findings ways to mitigate and prevent trauma and build community resilience are a priority for us all.

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

Focus on Adverse Childhood Experiences aligns with the Community Health Improvement Plan (CHIP) focus area for Individuals and Families. The CHIP focus areas and priority initiatives are informed by the Community Health Assessment (CHA) and reviewed with the Consumer Advisory Council (CAC) for approval. Prior to CAC approval community and member input is gathered through communitywide surveys and listening tours. Information obtained is leveraged while developing high level strategy for Coos and Curry County CHIPs.

South Coast Together is a community collaborative focused on fostering resilience in Coos and Curry counties. Its goals are to engage community members as agents of change in preventing the accumulation of Adverse Childhood Experiences (ACEs) and to build resilience in children, adolescents, and families. The Steering Committee is a 15-person, multi-sector group, including community members. We also have a dedicated Trainers Group, currently made of up ACEs Master Trainers (5), Presenters (9), and a few others working towards becoming an ACEs Master Trainer.

Community wide plannings meetings were convened in 2017 with broad cross-sector representation, including CCO delegates and providers, as well as other community partners from early childhood education, K-12 education, the local community college, juvenile department, CASA, and domestic violence prevention, among others. From this convening, a steering committee and a metrics committee were seated to provide a cross-sector community infrastructure to guide the initiative and produce a comprehensive implementation and measurement plan for Coos and Curry counties.

With the winding down of the public health emergency in 2022, in person trainings resumed resulting in an increase in ACEs presentations. The 25 Level 1 ACES trainings in 2022 reached 531 individuals and the 8 Resilience trainings (part 2 of ACEs) reached 113 individuals. These individuals represented multiple sectors in our community, including social service groups, housing authority, healthcare agencies, early learning agencies and the general public. Presentations were facilitated by 10 trainers and 6 master trainers over the course of 2022.

In late 2021 through early 2022 the “Help that Helps” (HTH)guide was finished, and presentation materials finalized. The “Help That Helps” parenting guide is a project based on Brain science and is a is a tool for parents and caregivers to learn a little about the developing brain. It offers tips and practical approaches for all families to be successful. A small group of South Coast Together participants, along with consultants from Lieberman Group and Ace Interface worked on the project for nearly 2 years before completion. Parent Cafés started in March of 2022 with a presentation to a Regional Parent Advisory Council representing all 10 school districts in the region. The Spanish translation of the guide was finished in May 2022. In 2022, 11 total HTH trainings were given with 279 individuals in attendance.

The original 5,000 copies of the guide proved to be insufficient for the demand. With demand from other agencies increasing throughout the year another 27,725 guides were printed in 2022. For a grand total of 32,725 guides. The following is a breakdown of the guides and their distribution.

- 1,885 distributed to school districts, ODHS, Children's centers, and tribal councils after receiving the guide training
- 22,500 distributed to Southern Oregon Success for distribution in Josephine, Jackson, Douglas, and Klamath counties.
- 7,500 were held in reserve for direct orders from the printer.

Currently the Help that Helps guide will go through revisions from information gathered for the 2022 presentations and feedback from participants.

Advance Health's role on the steering committee was to help advise and support the South Coast Together focus training in the needed areas. In 2022, through the support of Advanced Health, South Coast Together was able to continue in its mission to build understanding and compassion for others - essential tasks made more difficult by the continuation of the pandemic. Specifically, financial and in-kind support enabled South Coast Together to:

- Provide in-person and online ACES and NEAR Science training for trainers and presenters resulting in (21) pieces of training for a total of (44) hours of presentations for CASA, Every Child Coos, the Port Orford School District staff, the regional Student Support Specialists (SSS) in each school, all (SCESD) staff, Coos Health and Wellness (CHW) staff and the staff of Advanced Health. In addition, Self-Regulation and Resiliency training was provided to the regional SSS and the CASA volunteers.
- Support a (6) hour a week administrator who served as lead trainer, grant writer, and as the backbone for the Leadership team in developing the mission and vision of SCT, monitoring the program budget, and creating agendas for our monthly Steering Committee meetings.
- Support a (5) hour a week secretary to manage online and email communications, facilitate zoom meetings, create presentations as assigned, translate documents, and coordinate the webpage design and SCT marketing.
- Finalize the Help that Helps guidebook in both Spanish and English and begin distributing the guide nationally.
- Create a curriculum to accompany the Help That Helps guidebook for those who attend Parent Cafes or other events and receives the HTH Guide.
- Conduct a spring Presenter Training for Coos, Curry, Jackson, and Douglas County.
- Begin collaboration across the South Coast with Creating Community Resilience and Southern Oregon Success to further the mission of both groups.
- Developed a Strategic Plan with goals for 2021-2023:
    - **Expanding Education/Awareness:**
        - Support trauma-informed school initiatives with ACES/NEAR to all School Districts in the region during the 2021-2022 academic year.
        - SCESD-SCT, (10) trainings estimated between July 2021 and the end of June 2022
        - Increase education, awareness, and engagement in the work of SCT over our baseline year of 2020-2021 by June 30th, 2022 by 10% with **the goal for (40) trainings this year**.
    - **Family Connections:**
        - 2022 held 11 Help that Helps parent Cafes. There were 237 individuals that attended the cafes.
        - Work with the "Mothers Of PreSchoolers" (MOPS) group to hold trainings
    - **Community Connections:**
        - Make the Help that Help Guidebook broadly available for purchase and/or free copies as funding allows to Coos and Curry communities, including AllCare, Advanced Health, health care provider offices, schools for parent cafes, CH&W, WIC, Mental Health, and other community groups.

E. **Brief narrative description**:

South Coast Together chose The Self-Healing Communities Initiative as the framework for the communities of Coos and Curry Counties to work toward building resiliency to mitigate the effects of ACEs for those who have already experienced trauma and to prevent traumas for future generations. Its goals are to engage community members as agents of change in preventing the accumulation of ACEs and to build resilience in children, adolescents, and families. Efforts to promote community awareness of ACEs, neuroscience, and resiliency practices across a broad swath of sectors, including the public, will continue, with presenters adjusting and adding to trainings in response to feedback from the community members, organizations, and service systems receiving training.

Through collaboration with the South Coast Regional Early Learning Hub (SCREL), Advanced Health will obtain access to data gathered from post Parent Café surveys. These surveys are administered by SCREL and data is deidentified and aggregated to reflect participant demographic information, specific questions aimed at understanding participant engagement, and information gained through the educational session. This data will aid Advanced Health in understanding the impact of Parent Café events on our community.

Advanced Health has committed to ongoing financial support for South Coast Together in their 2023-24 budget cycle.

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

Activity 1 description: Continue to provide ACE trainings and follow-up trainings for free to the community, across all sectors, including health care, education, law enforcement, social services, parent groups, spiritual communities, and local tribes.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of training sessions completed			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
44 Sessions held in 2022	40 sessions held in 2023	12/2023	40 sessions held in 2024	12/2024
Monitoring measure 1.2	Add new Presenters to the training team to support the training schedule and reach new audiences.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
6 presenters trained in 12/2022	5 additional presenters trained	12/2023	5 additional presenters trained	12/2024

Activity 2 description: Support trauma-informed school initiatives by presenting to all school districts in the region and providing follow-up sessions to support the implementation of trauma-informed strategies during the 2022-2023 academic year.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor the percent of school districts in the region receiving education and follow-up sessions during the 2022-2023 academic year.

Monitoring measure 2.1	Percentage of school districts in the region receiving education and follow-up sessions during the 2022-2023 academic year			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2022 100% of districts trained	Maintain 100% of school districts trained annually	6/2023	Maintain 100% of school districts trained annually	6/2024

Activity 3 description: Create and publish a "Help That Helps" parenting guide based on brain science to be used for parent trainings, presentations, and other workshops.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Complete, print, and begin using "Help that Helps" parenting guide.

Monitoring measure 3.1	**Monitor number of printed and distributed 'Help that Helps' guide**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
32,000 guides produced and distributed in 2022	Maintain demand for the Guides and distribution	12/2023	Maintain supply to meet the demand for guides and distribution	12/2024
Monitoring measure 3.2 Distribution of guide through parent cafés and or presentation				
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
11 Parent Café's held reaching 237 individuals in 2022	10 cafés and trainings	12/2023	10 cafés and Trainings	12/2024

A. **Project short title**: Member Grievance System Improvements

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

If continued, insert unique project ID from OHA: 42

B. **Components addressed**

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

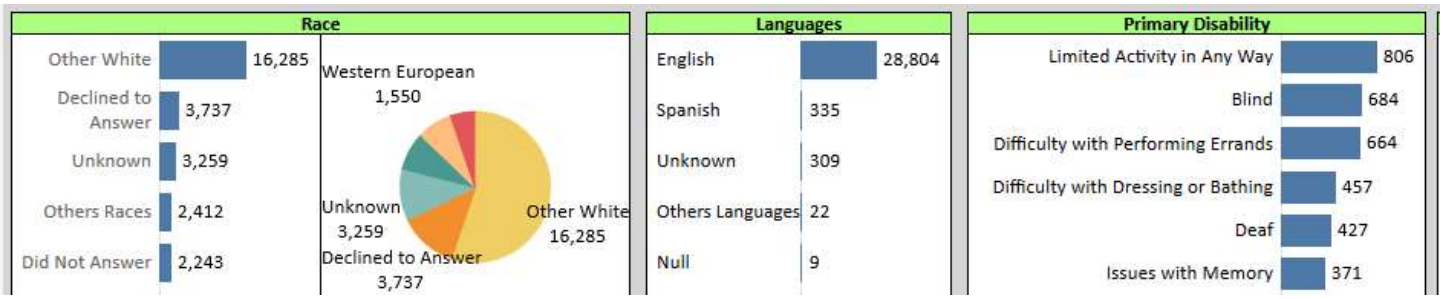
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Health Equity: Data

Advanced Health currently serves over 29,000 Oregon Health Plan Members in Coos and Curry Counties on the Southern Oregon Coast. 52% of Advanced Health Members are female, and 48% are male. 12% or, approximately 3,565 members, have one or more disabilities. A report was prepared for the Interagency Quality Meeting following Q3 2022, with the results of a focused review of complaints by members with one or more reported disabilities.

Advanced Health's primary and most complete source of data related to linguistic and cultural needs of members is the OHA 834 enrollment data. Advanced Health finds the REALD demographic data from OHA to be the most comprehensive data set available at this time. Using this REALD data, Analytics Department staff have developed a REALD demographic dashboard in Tableau to summarize the race, ethnicity, language, disabilities, and interpreter needs of Advanced Health members. The dashboard also includes a query feature to allow staff to find REALD data for a specific member. This function is used by the Grievance System Coordinator when reviewing grievance and appeal data to ensure we are offering materials in the member's language and to monitor for any trends related to equitable access to health care or the grievance system. Customer Service and other staff are able to use the feature as well.

These Tableau dashboards are updated daily to weekly, and enrollment and encounter data is updated daily.



Current demographic data identifies the following enrollee characteristics:

All Members Race and Ethnicity

American Indian or Alaskan Native	1.6%
Asian	0.6%
Black or African American	0.6%
Hispanic/Latino/Latina/Latinx	3.4%
Native Hawaiian or Pacific Islander	0.3%
White	61.4%
Other	0.7%
Declined to Answer	12.7%
Did Not Answer	7.6%
Unknown	11.1%

While there are still gaps in the race and ethnicity data set available through the 834 enrollment files, the completeness of the data improved over the course of 2022 and is continuing to improve in Q1 2023. At the beginning of 2021, nearly 41% of race and ethnicity data was not provided. As of mid-2022, 35% was unknown. And as of Q1 2023, the categories "unknown," "did not answer," and "declined to answer" account for only 31%. This is an encouraging trend in closing the gaps in available race and ethnicity data.

All Member Language Data

Unknown	1%
Other	<1%
English	97.6%
Spanish	1.1%

*Note languages reported by fewer than 20 members are suppressed from this report

Spanish is the most common non-English language spoken by Advanced Health Members, with 1.1%, or about 335 Members, indicating that their primary language is Spanish. While the language data has long been more complete than the race and ethnicity data, we have noted improvements in this data set as well in 2022 and now show only 1% of language data is listed as "unknown."

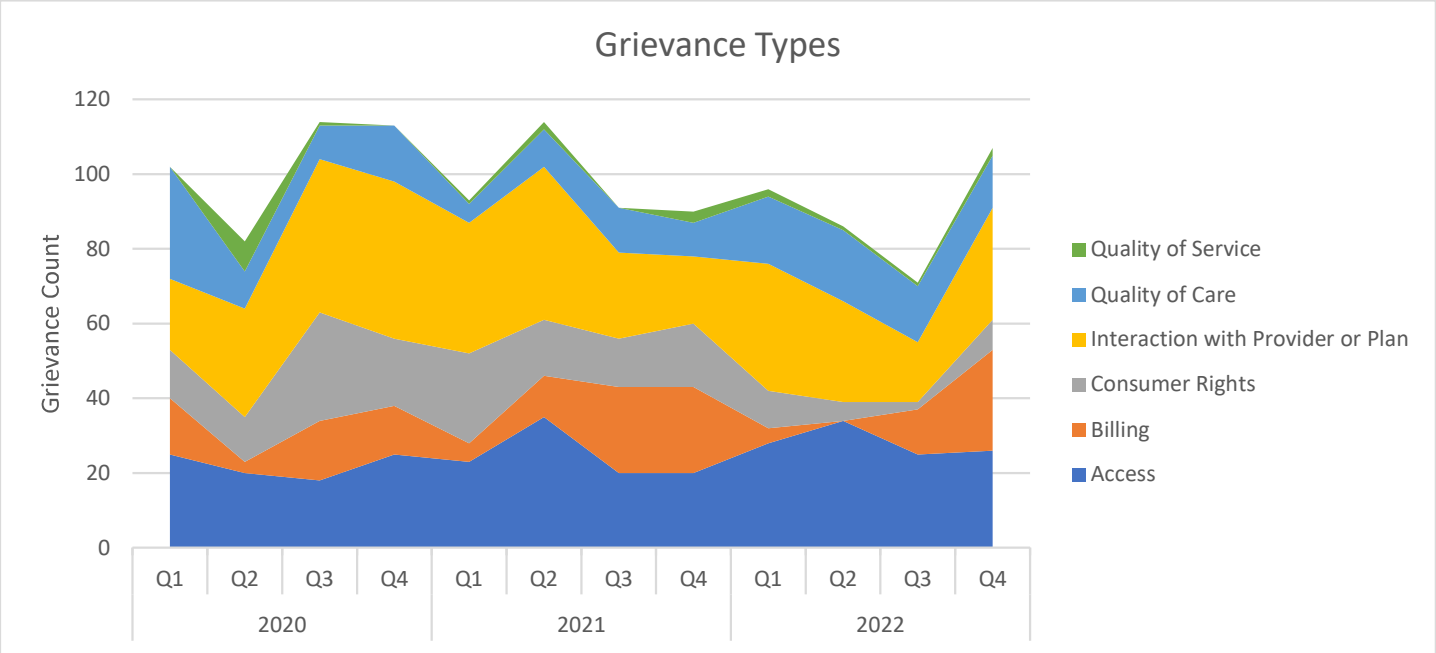
Advanced Health analytics staff have used the REALD data available in the 834 enrollment files to stratify data and reporting for quality metrics, performance improvement projects, grievance and appeals system data (including NOABDs), and improving language access. Other areas where REALD data is leveraged is in implementation of the Health Equity Plan across the eight focus areas. Examples of the REALD stratified data used to monitor the grievance and appeals system for disparities is included below in the Grievance System assessment.

In addition to the 834 enrollment REALD data, Advanced Health has other mechanisms for collecting REALD and SOGI data for some focused populations and analysis. REALD data is collected through the Health Risk Assessment process when new members enroll with the plan and annually thereafter. The Intensive Care Coordination intake process also includes REALD data collection to aid the care coordination team in identifying priority and intersectional populations in need of services. The annual CAC demographic report uses a questionnaire to collect data from CAC members and compares the membership of the CACs to the make-up of the community at large to ensure the CACs are truly representative of the communities in Advanced Health's service area. In 2022 Advanced Health began planning for an updated Community Health Assessment (CHA). The community questionnaire to be launched in 2023 includes REALD and SOGI data collection along with the health information to be included in the analysis published in the 2023 CHA. Advanced Health also has a policy and procedure for collecting REALD data from employees, subcontractors, board, and committee members. This data is analyzed and monitored for several initiatives related to the Health Equity Plan, embedding Culturally and Linguistically Appropriate Services (CLAS) standards within the organization, and for improvements to recruitment, hiring, and retention practices.

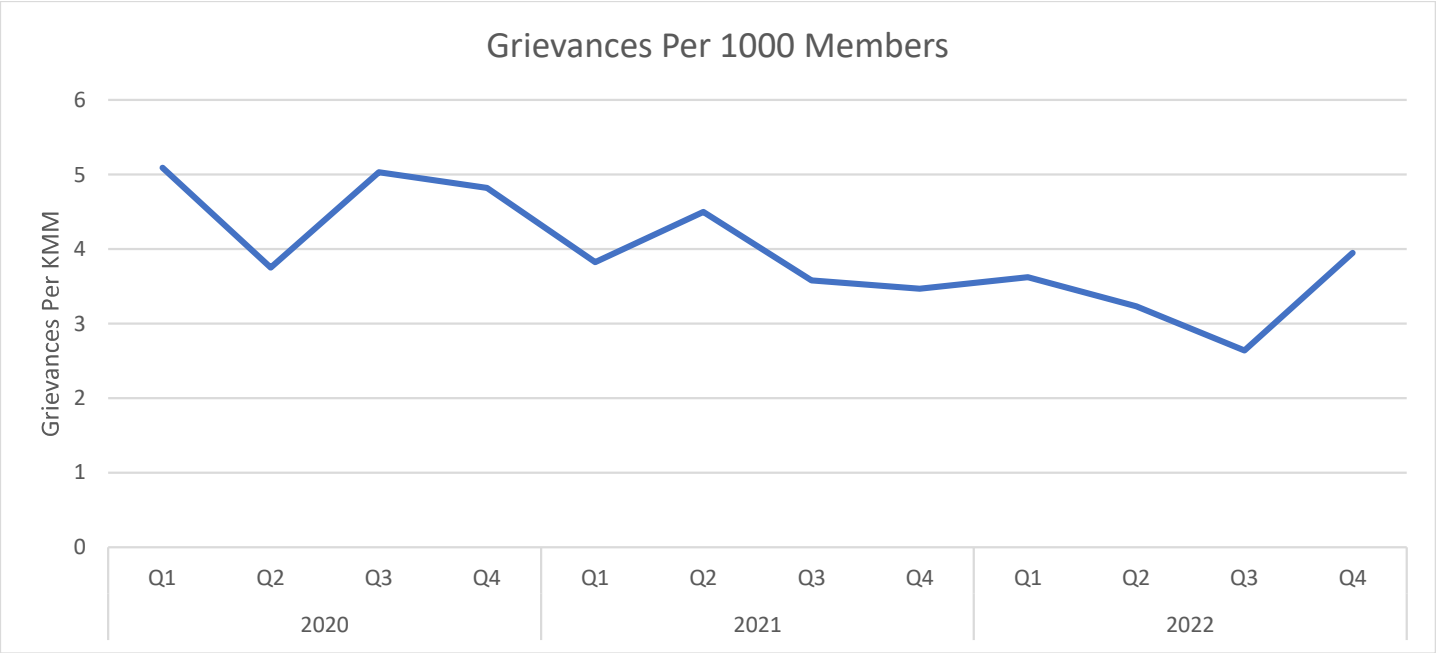
Advanced Health does not currently have a comprehensive source of SOGI (Sexual Orientation and Gender Identity) data for its full membership. In 2022, Advanced Health has supported implementation of Reliance, a health information exchange (HIE) that would allow for some visibility into the REALD and SOGI data collected by clinics and hospitals connected to the HIE. Advanced Health has also been following OHA's developments in finalizing a data set for SOGI data and the efforts to develop a REALD and SOGI data repository that will allow CCOs a comprehensive data set gathered from multiple sources throughout the agency's programs.

Grievance and Appeal System

Advanced Health monitors data from the Member Grievance System closely for trends that can be addresses through systemic quality improvement efforts.



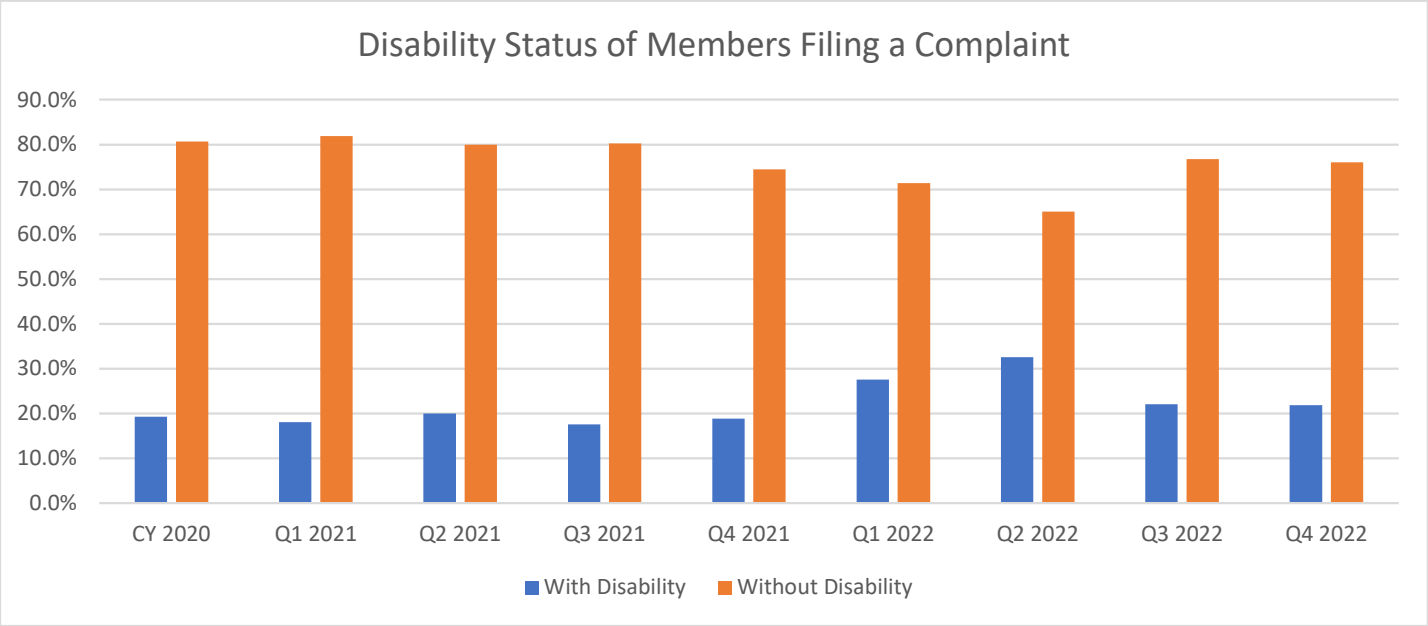
Total complaint volumes decreased slightly in 2022, despite increasing enrollment due to the suspension of the redetermination process while the public health emergency remains in effect. The rate of grievances per 1000 members declined to 3.35 in 2022, from 3.8 in 2021.



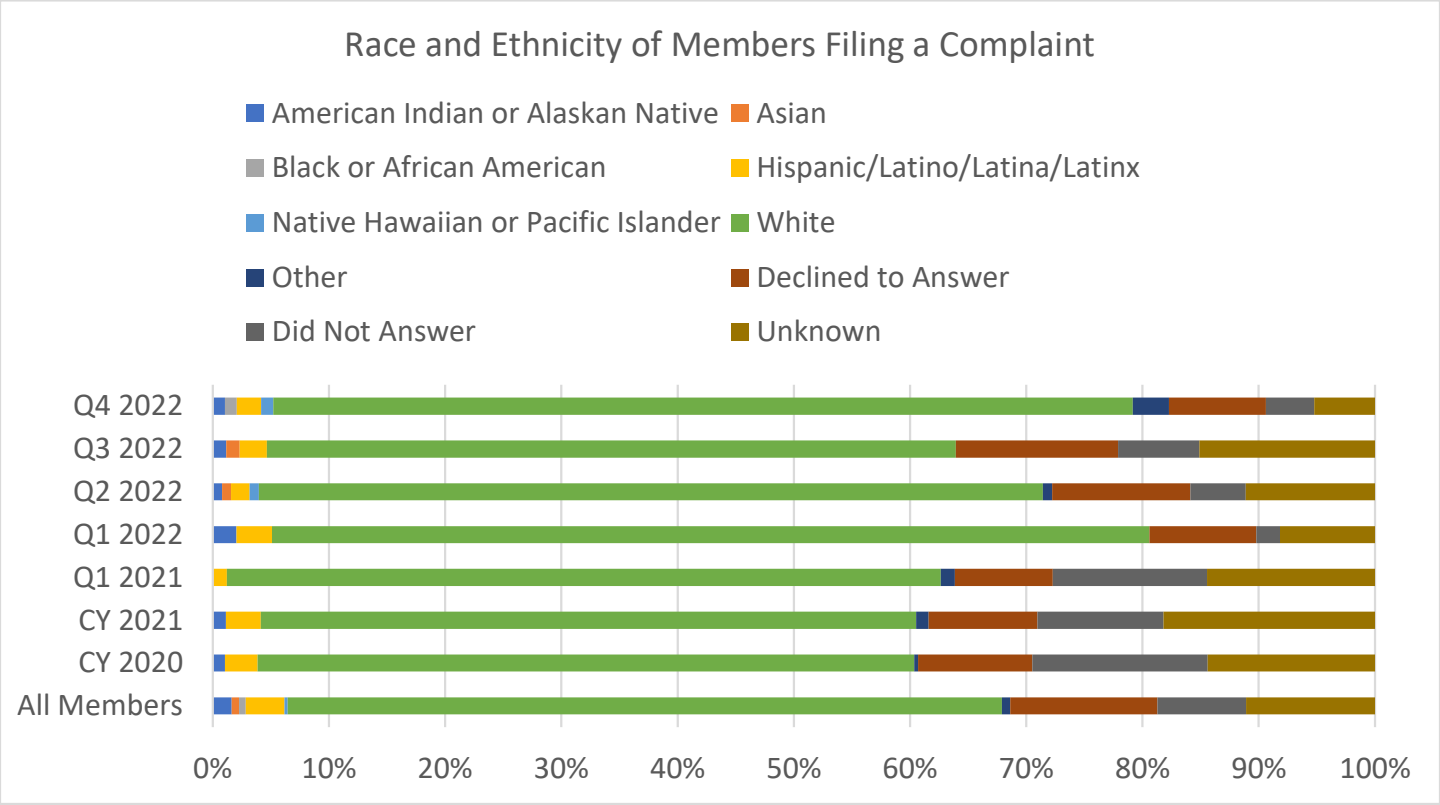
Advanced Health tracks grievances related to cultural sensitivity by both the provider and the plan. We have had no grievances related to cultural sensitivity in the past 12 quarters. We will continue to work to maintain low complaints in this category. These complaints are categorized as IP.h: Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.

With 12% of our member population experiencing disability, they represented 39% of our member complaints in Q1 2022 through Q3 2022. We had 99 complaints from members with documented disabilities. Of those 99 complaints, 12% were related to a disability, but not necessarily the disability listed in the REALD data from the enrollment files, and

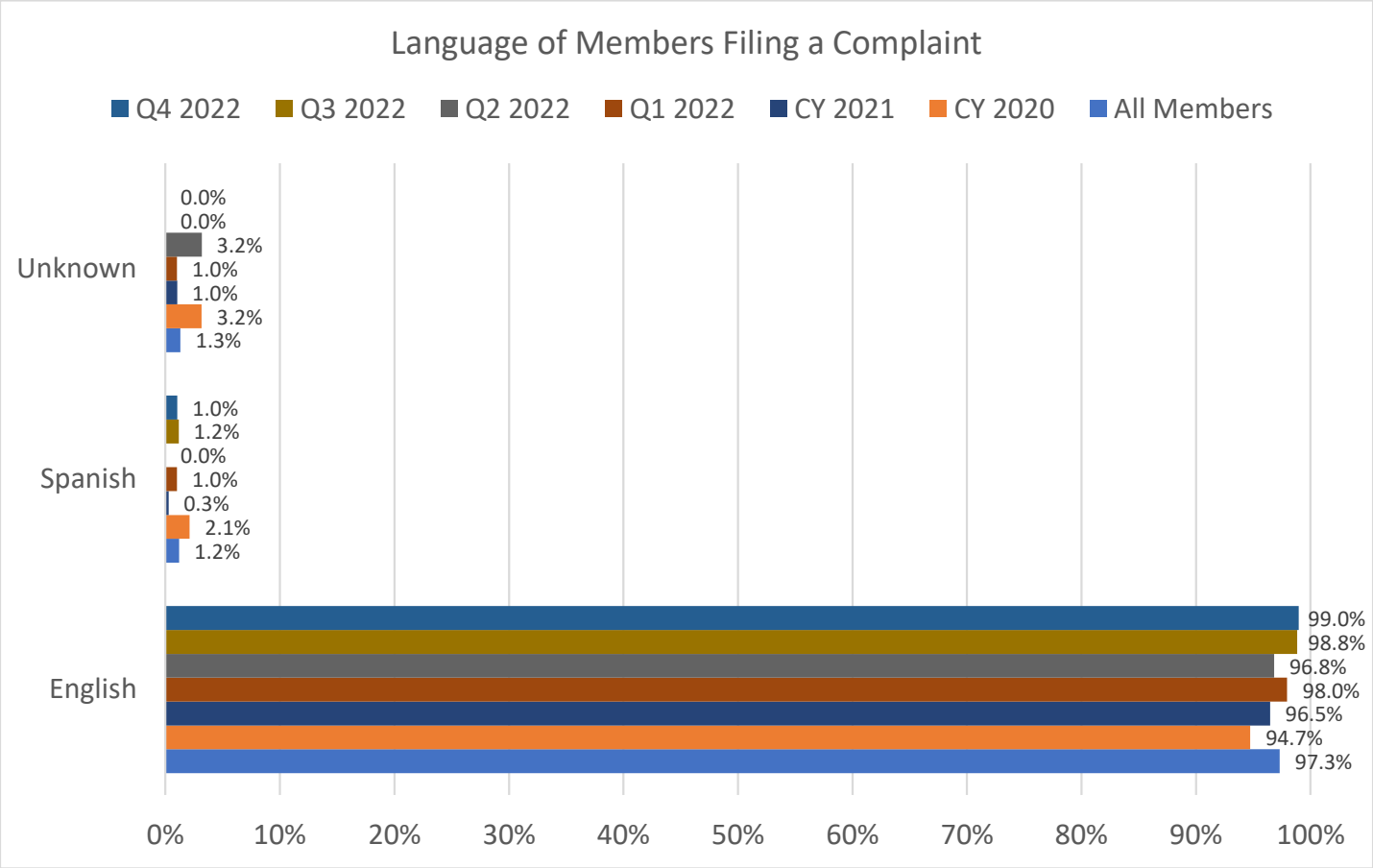
88% of those 99 total complaints were not related to the member disability. The complaint process remains accessible to our members, and we are happy that nearly 88% of those complaints were not related to their disabilities. Two complaints stood out that required corrective action or escalation, but no noted trends were identified.



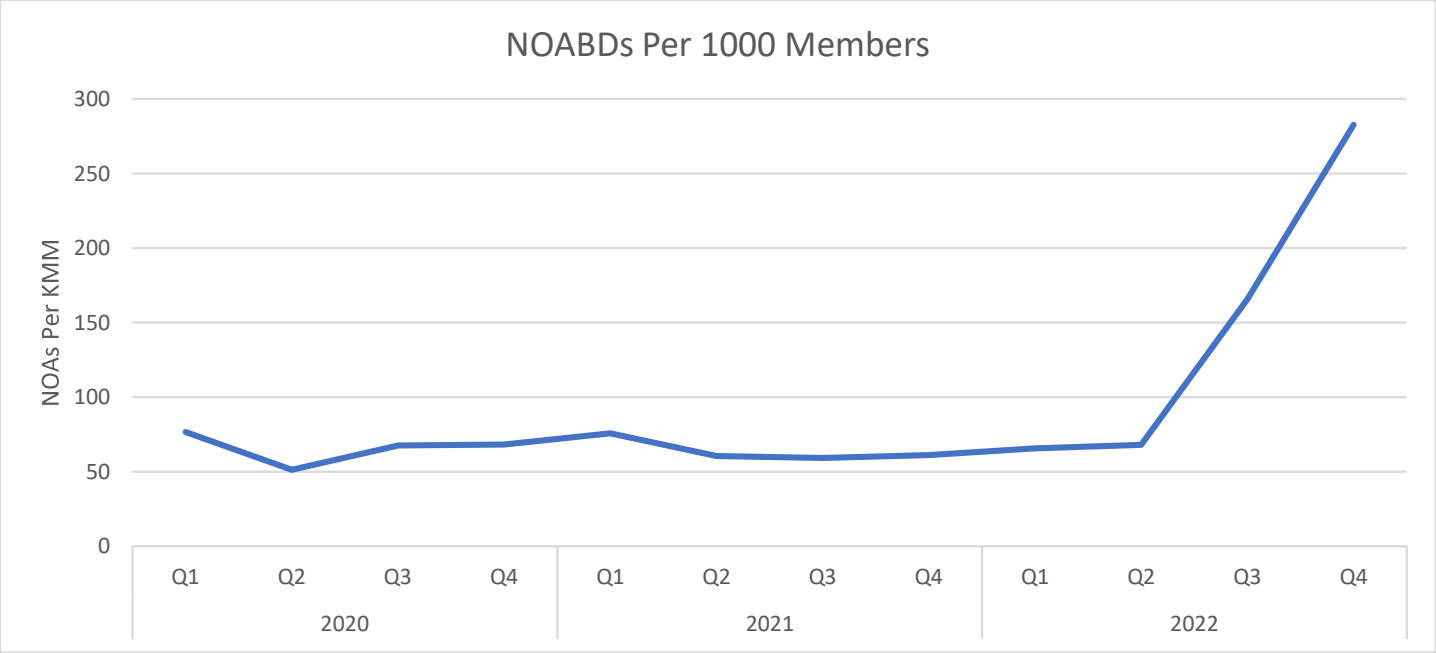
Race and ethnicity data from the 834 enrollment files is matched by member ID to data from the grievance tracking system, allowing for an analysis to better understand whether our grievance system is being accessed equitably by all members. In the chart below, we compare the data for all members to calendar year 2020 and 2021, and 2022 by quarter. We aggregate the data quarterly, so we have a large enough sample of information to give some confidence in the proportions and still have shorter-term check-ins to be able to watch for trends throughout the year. In 2021, this data analysis became part of the grievance data reviewed by the Interagency Quality Committee. There were no notable trends observed in 2022 compared to the two prior calendar years.



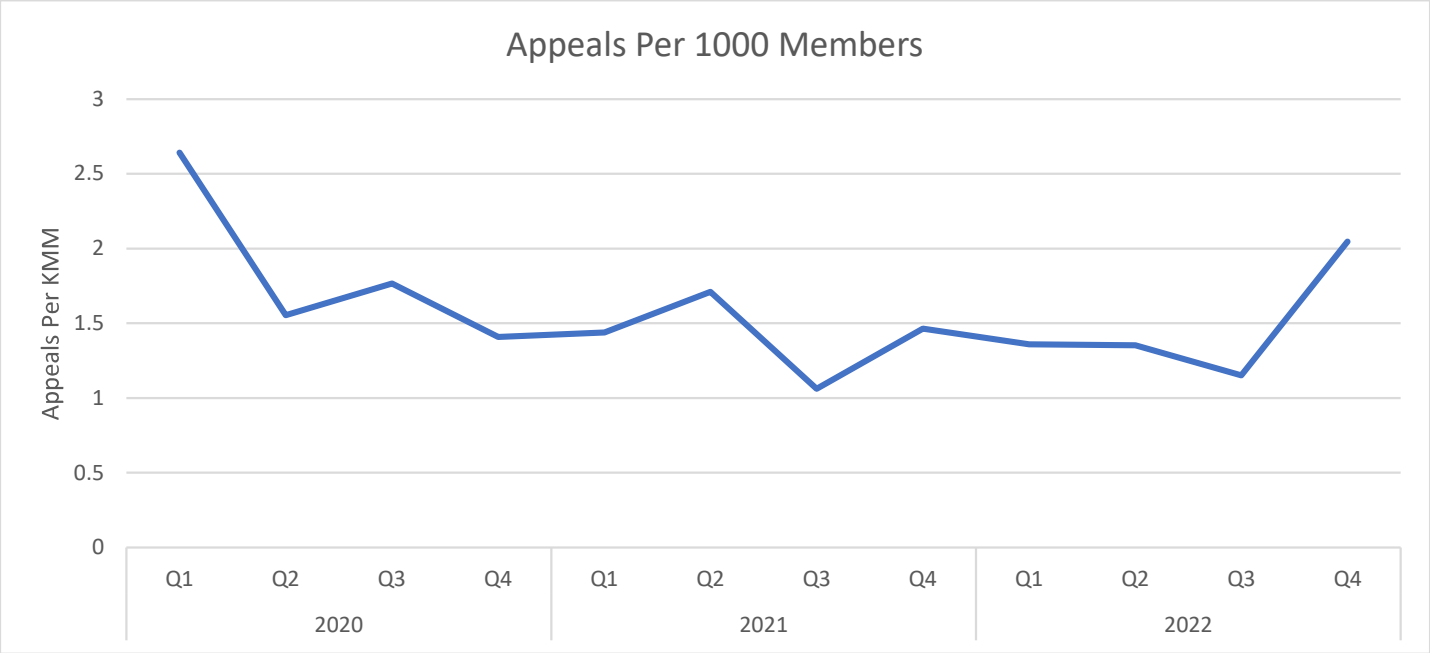
In a similar fashion as described above, the spoken language of members who filed complaints was also analyzed in 2022 and reviewed by the Interagency Quality Committee. Improving language access is an initiative at Advanced Health and it is important to use the data we have available to monitor for equitable access to health care services, but also for access to systems that support member rights, such as the grievance system. In 2021 we see only a small number of complaints from Spanish-speaking members. It is possible that we are missing an opportunity to hear from these members, or it is possible that due to small sample sizes (approximately 30 complaints per month) and the relatively small population, that we can expect to see some months with 0 complaints for Spanish-speaking members. In 2022 we observed a more expected proportion of approximately 1% of complaints coming from Spanish-speaking members. However, this is an area that will require more investigation in 2023 to ensure we identify any unknown barriers.



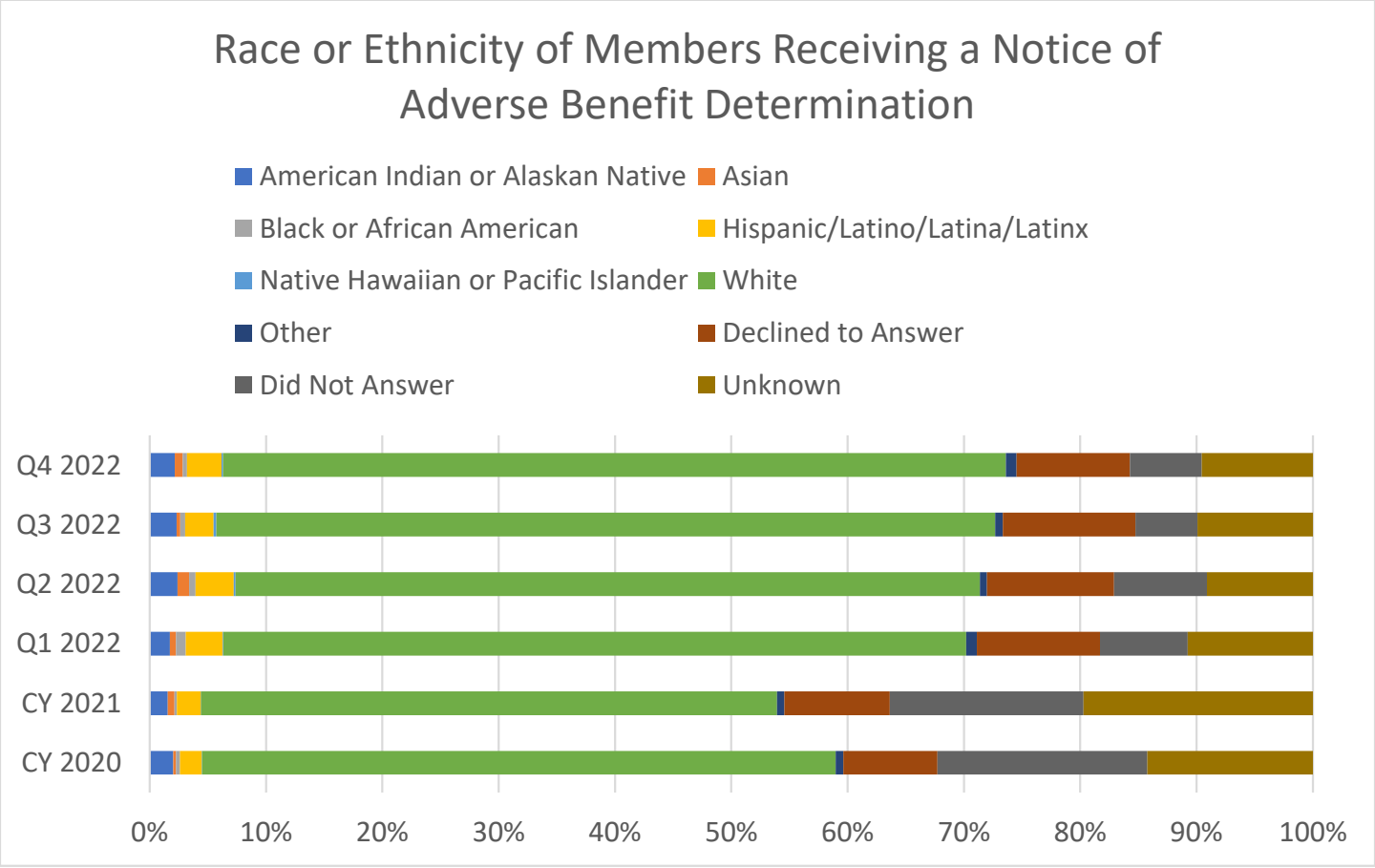
The rate of Notices of Adverse Benefit Determination (NOABDs) per 1000 Members stayed the same the first two quarters of 2022. The rate per 1000 members more than doubled the remaining two quarters with the implementation of mailing member claims NOABDs.

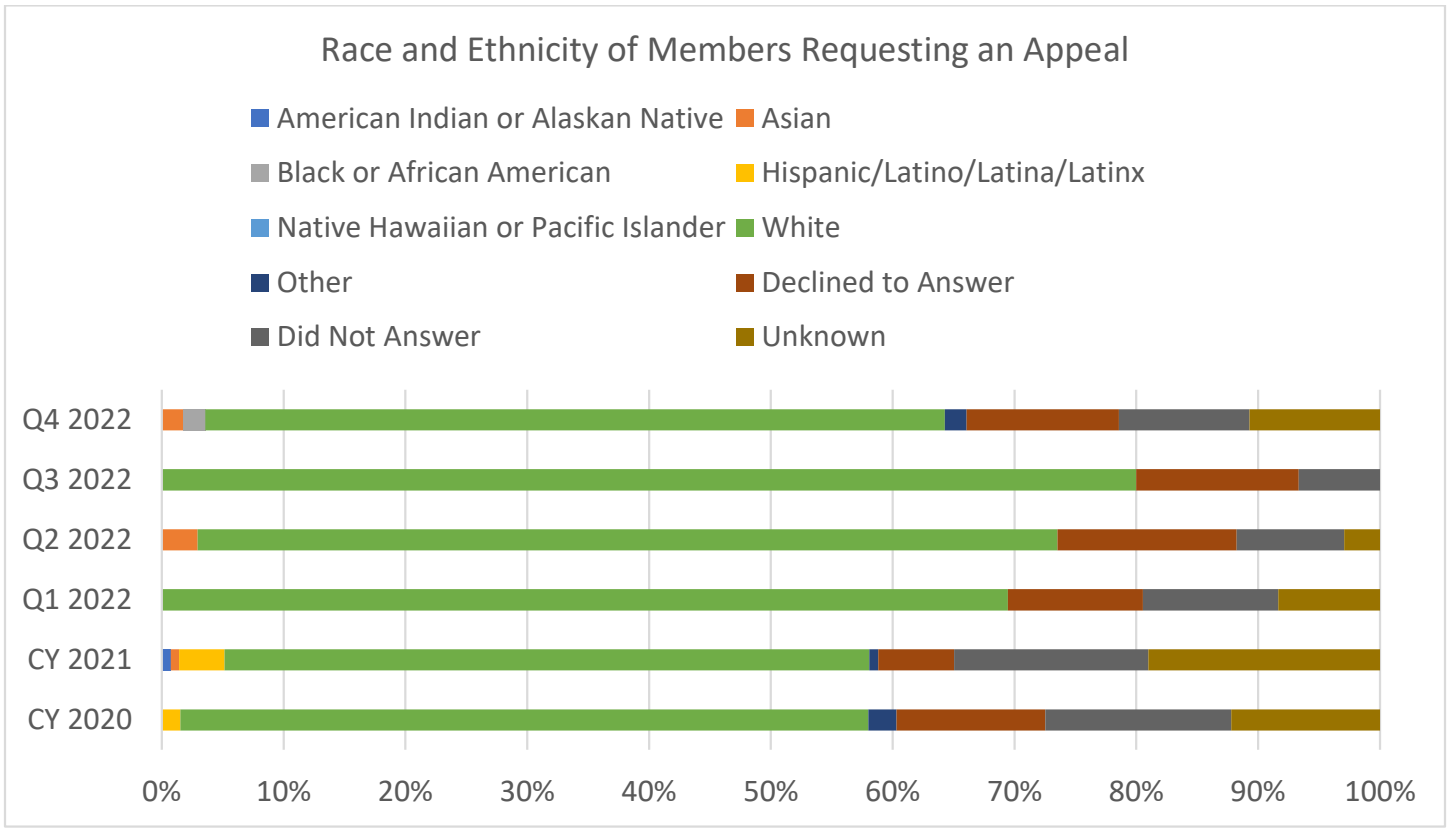


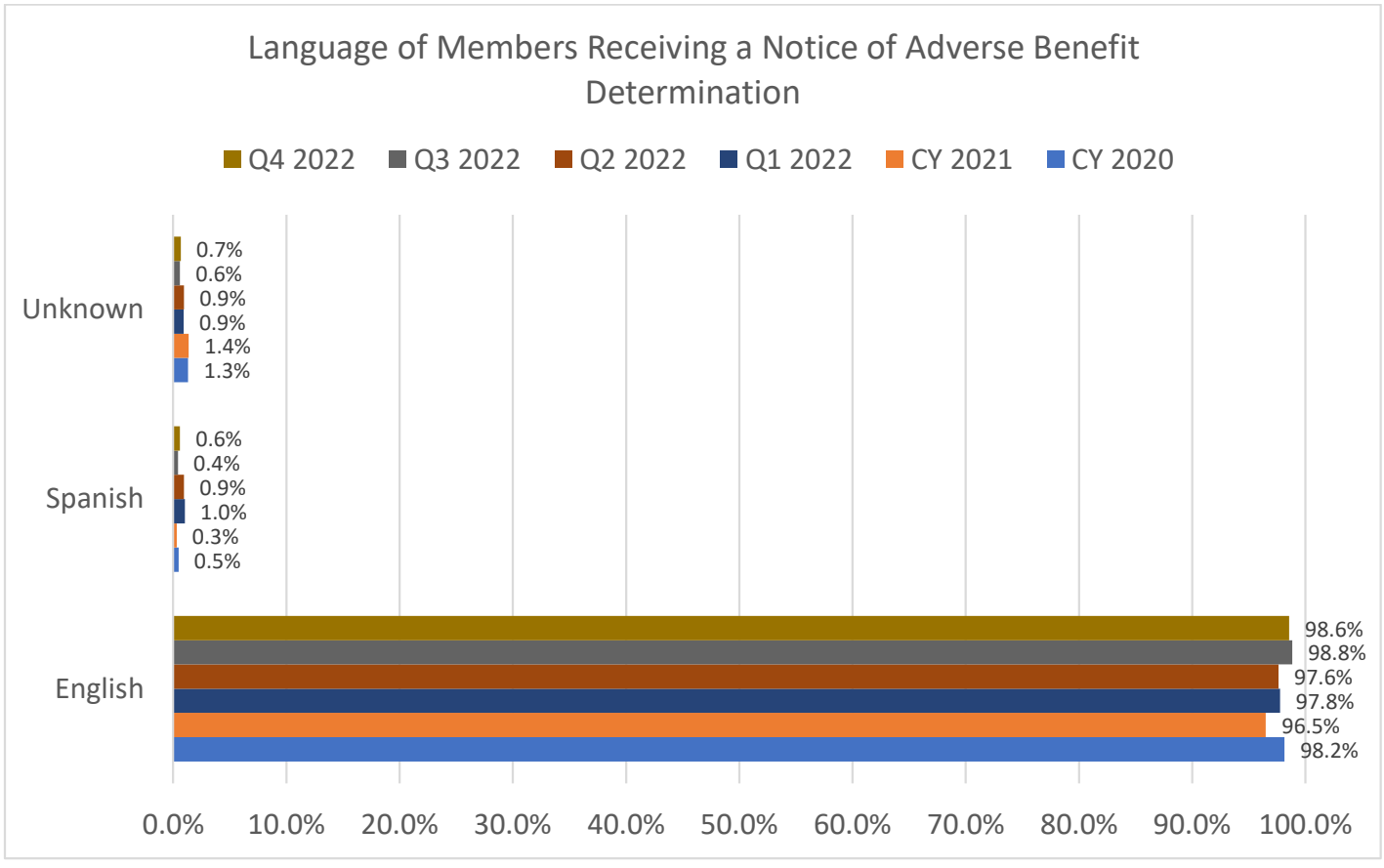
Appeals per 1000 Members increased slightly from 1.41 in 2021, to 1.48 in 2022. An increase in appeals was expected with the increase in NOABDs, but the rate per 1000 Members is still less than 1.84 per 1000 members in 2020.



Below is an analysis of member race and ethnicity for NOABDs and for appeals. Similar to the analysis discussed above for grievance data, this information is monitored and reviewed quarterly by the Interagency Quality Committee.




Race and Ethnicity of Members Requesting an Appeal
American Indian or Alaskan Native
Asian
Black or African American
Hispanic/Latino/Latina/Latinx
Native Hawaiian or Pacific Islander
White
Other
Declined to Answer
Did Not Answer
Unknown
Q4 2022
Q3 2022
Q2 2022
Q1 2022
CY 2021
CY 2020
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Language of Members Receiving a Notice of Adverse Benefit Determination
Q4 2022
Q3 2022
Q2 2022
Q1 2022
CY 2021
CY 2020
Unknown
0.7%
0.6%
0.9%
0.9%
1.4%
1.3%
Spanish
0.6%
0.4%
0.9%
1.0%
0.3%
0.5%
English
98.6%
98.8%
97.6%
97.8%
96.5%
98.2%
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
90.0%
100.0%

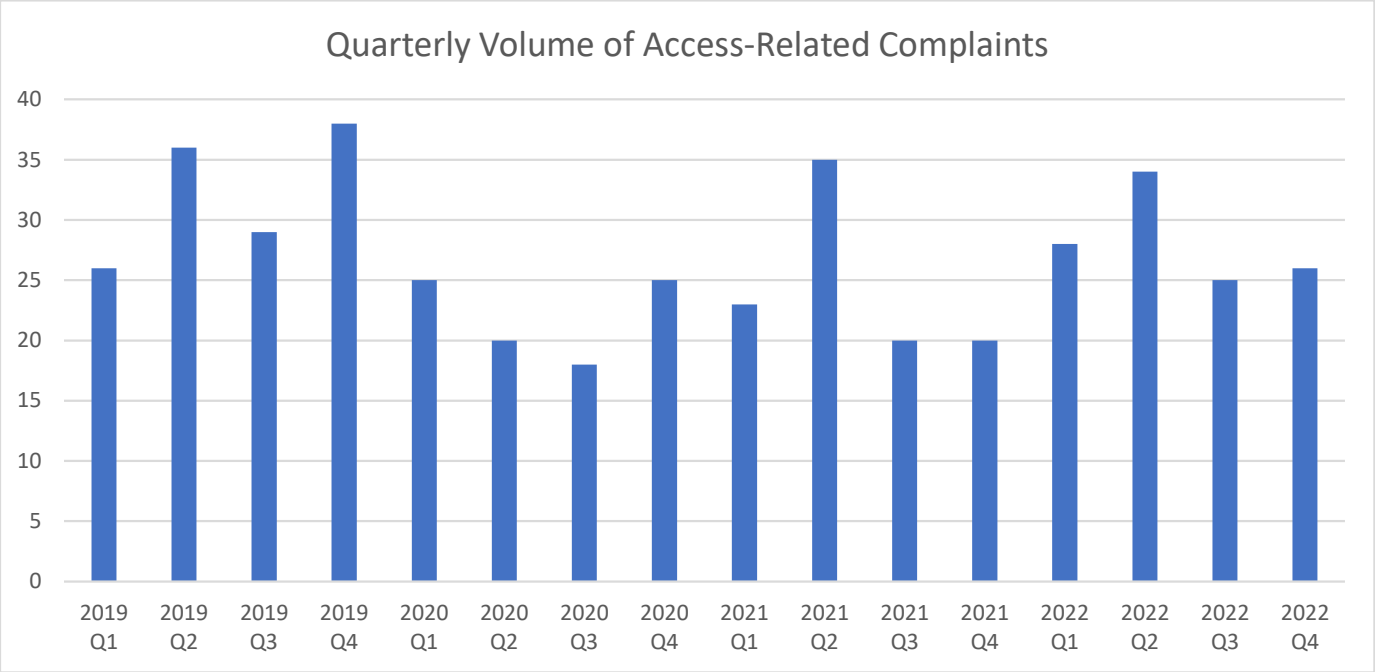
D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Advanced Health has undertaken several quality improvement efforts aimed at decreasing the rate of member complaints, especially those related to access and interactions with provider and plan.

Advanced Health has employed a dedicated staff position for the Member Grievance System since late 2016. This position is responsible to assist members in accessing the Grievance System, responding to complaints and appeals, monitoring data, presenting analysis, and implementing systemic improvements based on trends in the data. Our current Grievance System Coordinator is an experienced Traditional Health Worker and coordinated care navigator. The Grievance System Coordinator ensures our Member Grievance and Appeals System is responsive to the needs of our members. This person monitors the details of all complaints, appeals, and hearing requests for issues related to cultural considerations and health equity. She participates in the annual Grievance and Appeals audit of our contracted provider organizations.

The Grievance System Coordinator prepares our Grievance System Report and Exhibit I deliverables to OHA. This information is also presented quarterly to our Interagency Quality Committee, and bi-annually to our Clinical Advisory Panel. Any trends, and special actions taken, are discussed in the quarterly Grievance System Report submitted to OHA. The PCP Assignment Committee is an interdisciplinary team that specifically works on improving access to PCP services for Advanced Health members.

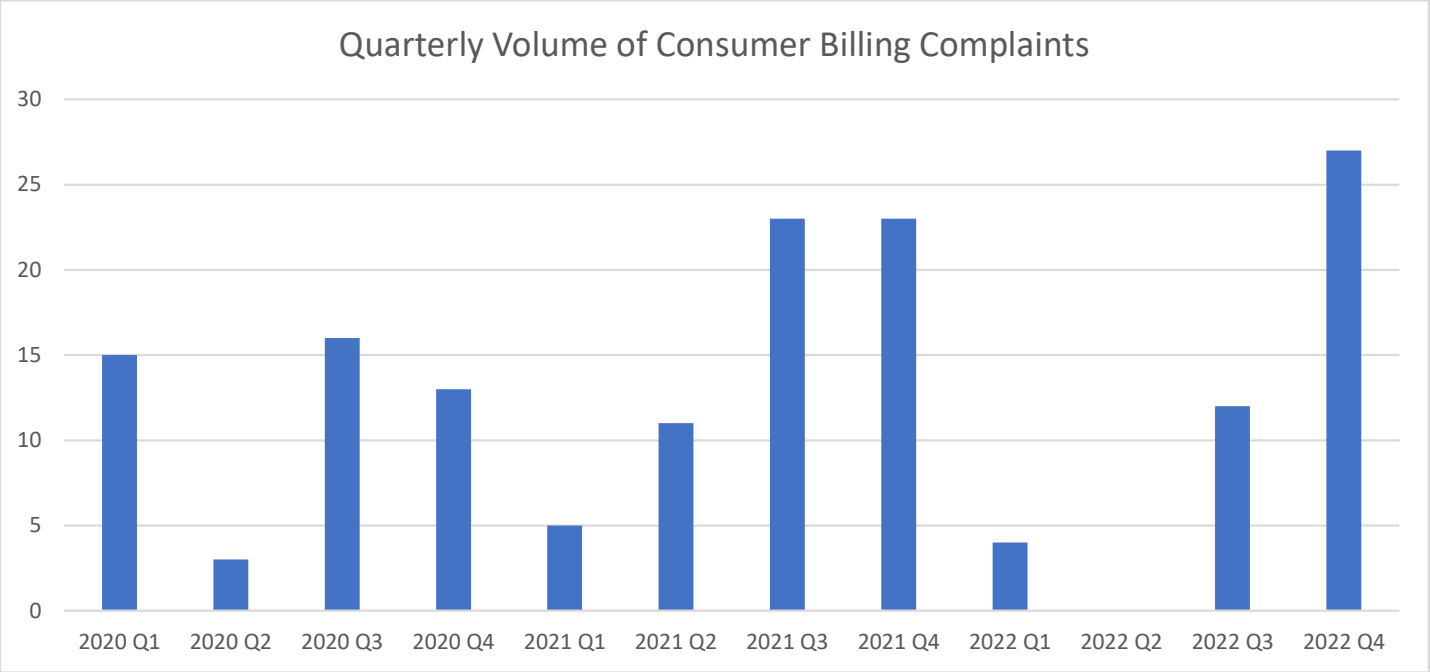
Some effects from this work are evident in the decrease of our access related complaints. PCP access is an issue affecting all patients in the region, not just Advanced Health members. In 2017, access complaints decreased by 25% compared to calendar year 2016. Access complaints decreased by a further 46% in 2018 compared to 2017. And the total decreased by an additional 18% from the 2018 total to the 2019 total. The total number of access complaints decreased again in 2020, by 32%, from 2019. However, some part of that decrease is likely driven by the stay home orders and the overall decrease in utilization pattern since the start of the COVID-19 pandemic response. In Q2 2021 we saw an increase in all complaints as well as the access category. Our region had a number of retirements, early retirements, and panel changes in that quarter compared to others. As health care utilization has risen, post-covid, and health care provider and staff shortages have continued, along with the continuing expanded Medicaid enrollment, we have seen an increase in the number of access complaints in 2022. However, the levels are still below 2019 and when normalized to enrollment, are lower still.



The Grievance System Coordinator also works with our Provider Relations Specialist to review trends and assist provider offices that are generating a high rate of complaints related to patient-provider interactions. Offices are offered evaluation, coaching, and support to improve their interactions with Members.

There was an increase in member billing complaints in 2021 and 2022, well over 2019 and 2020 levels, and the category became one of the top three for the first time. In Q2 2021 we performed an in-depth analysis of this data, but no noted trends in source or circumstance were recognized. During the 2022 calendar year, billing complaints were the complaints most often resolved outside of the 30-day timeframe. All complaints of this type were forwarded to one Customer Service Representative. A promotion led to a cross training opportunity for all customer service representatives to be trained to investigate and resolve billing complaints. The Grievance Department also performed a procedural and fact check evaluation of our internal process. We were able to identify a gap that led to untimely resolutions. These procedural changes will not likely decrease the number of billing complaints, but will result in timelier, resolutions in favor of the member.

OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health



Advanced Health will continue to monitor complaint capture and resolution processes to ensure members are able to access the system. Advanced Health will also continue to monitor data for trends and offer feedback and support to delegates, clinics, and individual providers as needed to address member concerns and drive improvements.

Complaints and appeals are monitored closely for any issues related to obtaining a second opinion, member billing, consumer rights, health equity, and fraud, waste, and abuse. In 2022, Advanced Health had a new-to-us type of complaint against the Plan. A member complained twice related to ICD 10 descriptions used in the NOABD letter. Advanced Health and OHA recognize different and more trauma-informed terms for some diagnoses than the official ICD 10 technical descriptions. During our investigation, our HIMS team relayed we could not make any changes in our Electronic Health Record definitions. They listed two primary reasons: The current code description has the benefit of being the official medical description from the CDC and WHO, and any changes to the description in our Electronic Health Record would be overwritten by quarterly updates. Our next step was to ask our analytics team for help at the time of NOABD production. However, software purchased to include plain language diagnosis and procedure definitions eliminated the need. Our EHR still indicates the CDC official definition, but the letter to member relays a more sensitive diagnosis description.

In 2020, the Grievance System Coordinator made many improvements to the Grievance System written notices to members. All letter templates were revised and standardized to eliminate potentially confusing language and improve readability and tone, as well as ensuring all required information was included. We have seen a reduction in member appeals due to the additional improvements implemented mid-2021. Our 2022 templates were approved by OHA in early January 2023, and fully implemented mid-February of 2023. These templates also include plain language descriptions of diagnosis and procedure codes. We hope these plain language descriptions and the new table format will help members better understand the denial notices.

We had a low volume of hearing requests in 2022. We believe this was due to additional information included in the NOAR, and a phone call made to the member prior to the resolution notice being mailed. Changes in workflow and capacity eliminated that phone call from non-expedited appeal requests. We saw an increase in hearing requests late in 2022, likely as a result of the change. With the addition of a new staff member to the Grievance System Department, we will resume appeal resolution phone calls, in tandem with written Appeal Resolution notices, for all members to improve communication about the process and the outcome. The phone calls offer opportunity for members to ask more

questions and for grievance system staff to make sure members are supported and offer navigation to additional options to meet the member's needs.

E. **Brief narrative description**:

Advanced Health staff will continue to stratify data in the quarterly report to the Interagency Quality Committee by REALD demographic factors to monitor for potential disparities in access or utilization of the Member Grievance System. When SOGI data sets become available for a majority of members, either from the OHA repository or through the HIE work with Reliance, the analytics team will incorporate the data into current metric and performance dashboards, including the monitoring dashboards and reports for the Grievance System. The combined REALD and SOGI data analysis of the Grievance System data will be presented to the Interagency Quality Committee for oversight and monitoring for potential disparities in access.

In 2023 the complaint process will be reviewed for potential underutilization by Spanish-speaking members and other LEP members.

In 2022, Advanced Health implemented a cross-training plan to train quality department staff to support the Grievance Systems Coordinator and ensure full coverage for time off. This improved the capacity and continuity of the member grievance system during staff vacation time. An additional staff person was added to the Grievance System Department in Q4 2022. This will provide the additional administrative support needed to fully implement reporting, analyis activities, and further process improvements..The new Grievance Support Specialist monitors the details of all complaints twice weekly along with the lead Member Services staff and is working to streamline the process of providing oversight of complaint and resolution information from subcontracted entities. One area of process improvement is the timely resolution of billing complaints discussed in the section above.

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

Activity 1 description: Grievance System Coordinator will provide quarterly Grievance System reports to the Interagency Quality Committee. Reports will include both quantitative data from the Grievance System and qualitative data from member feedback and observations about the changes to the Member letter templates after they are implemented. The quarterly report to the Interagency Quality Committee will also include data stratified by demographic characteristics including race and ethnicity, language, and disability. Additional data analysis related to SOGI will be included when the data set becomes available.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Quarterly trend reports, including data stratified by demographic characteristics, and results of focused reviews, delivered to Interagency Quality Committee.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
4 Quarterly data reports in 2022, stratified by REALD	4 quarterly reports in 2023 stratified REALD data	12/2023	2 reports in 2023 stratified by SOGI data	12/2023
Completed focused review and report of complaints by members with one or more disabilities	Continue to monitor complaints by members with disability	6/2023	Determine need for additional focused review reports based on SOGI stratified quarterly data reports	09/2023
Monitoring measure 1.2	Maintain current performance or better on the quarterly rate of member complaints per 1000 member months. (Total number of complaints for the calendar quarter divided by			

	the average monthly enrollment for the quarter times 1000.) This is the complaint rate reported by all CCOs in the quarterly grievance system report.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current: 3.35 complaints per 1000 members in Q4 2022	<4.0 grievances per 1000 members	12/2023 (Q4 2023 rate to be reported in 2/2024)	<4.0 grievances per 1000 members	12/2024 (Q4 2024 rate to be reported in 2/2025)
Monitoring measure 1.3	Monitor Appeal rates per 1000 members for changes.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
1.48 Average Appeal Requests per 1000 members in 2022 2.05 Appeal requests in Q4 2022	<2.0 Appeal Requests per 1000 members	12/2023 (Q4 2023 rate to be reported in 2/2024)	<2.0 Appeal Requests per 1000 members	12/2024 (Q4 2024 rate to be reported in 2/2025)

Activity 2 description: Advanced Health hired a new Grievance Support Specialist in Q4 2022. This position will ensure full coverage for time off, and administrative support needed to fully implement reporting, analyis activities, and further process improvements, including related to timely resolution of billing complaints. We have verbal and written language access improvement plans to be implemented based on REALD Grievance and Appeal data.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Develop and implement language accessibility process improvements for Grievance System.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Brainstorming	Language Accessibility plan related to Grievance System developed and mutually agreed upon across overlapping departments	06/2023	Language accessibility plan implemented and complete	3/2024
Monitoring measure 2.2	Timely (30 days or less) resolution for all member billing complaints			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Billing complaints resolved outside 30 day maximum timeframe	100% of Billing complaints resolved in time frame in Q2 2023 after process improvement implementation	06/2023	100% of Billing complaints resolved timely in Q3 and Q4, showing sustained improvement.	12/2023

A. **Project short title**: Oral Health Integration for Members with Diabetes

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

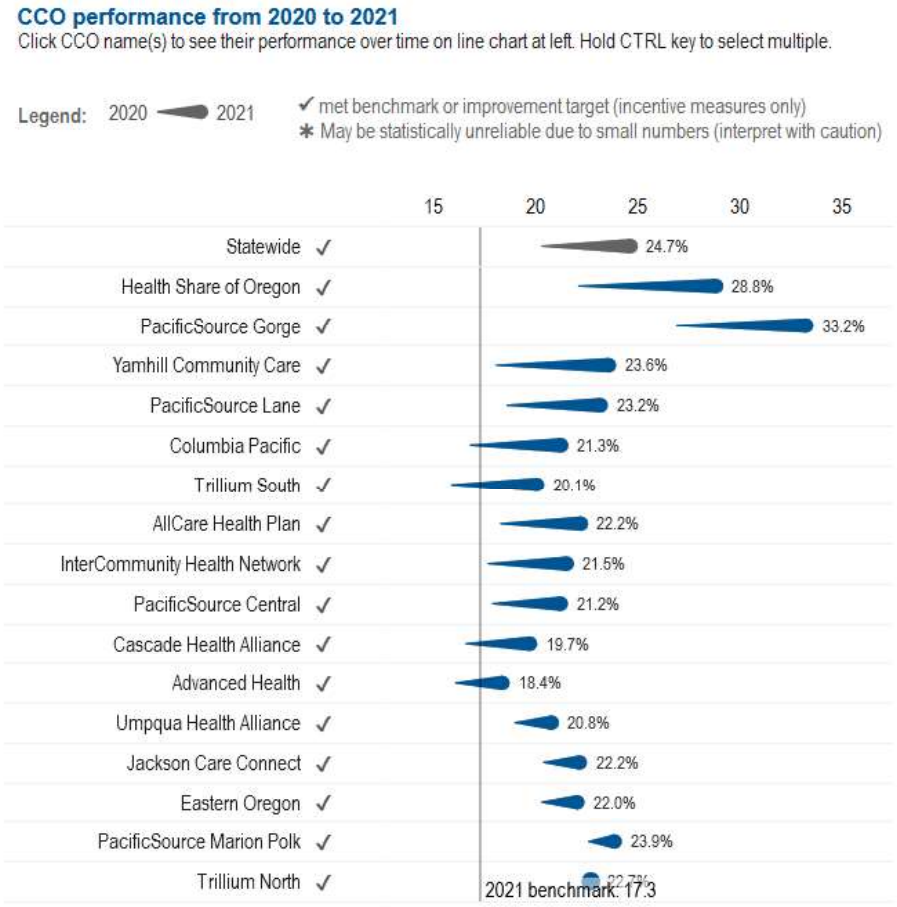
If continued, insert unique project ID from OHA: 43

B. Components addressed

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

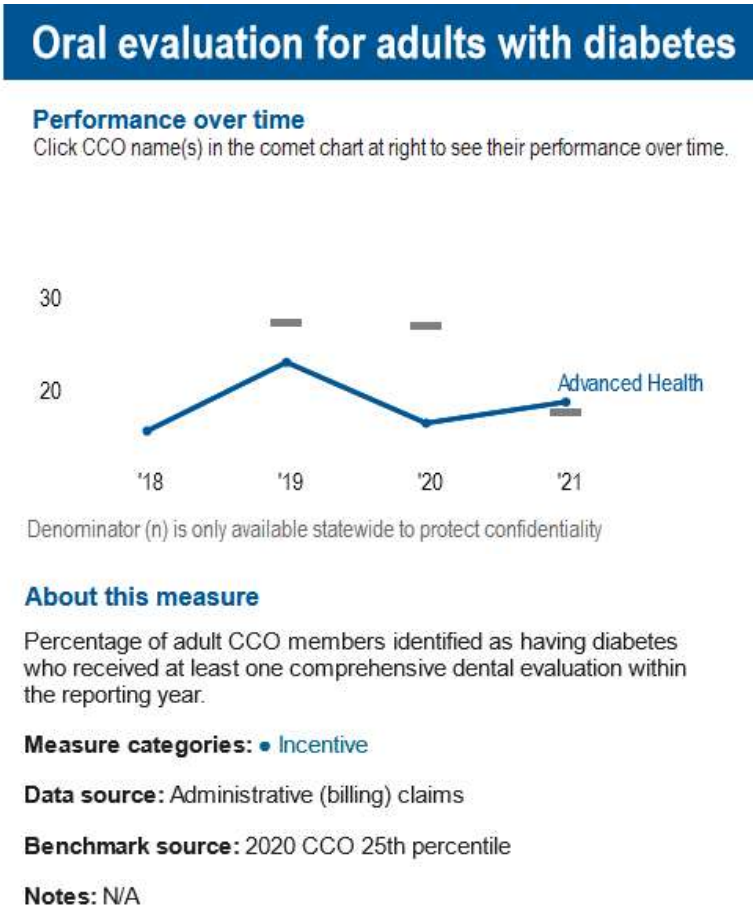
C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In 2022, Advanced Health continued to have a relatively low rate of oral health assessments for adult members over the age of 18 years with a diagnosis of diabetes not stratified by poor control, compared to the Oregon State average for CCOs. The difference has decreased significantly in 2022 based on the most recent OHA CCO Metrics Dashboard dated January 2023 (with a rolling period of 1/10/2021-9/30/2022). Of note, the state-wide benchmark for this measure in 2022 was reduced to 20.4%, which is 6.4% less than the 2021 state-wide benchmark of 26.8%. This said, although closing the gap, we are still behind the state CCO average rate by 2.6% for 2022, based on our most recent dashboard results.



OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health

Due to a community wide EHR conversion to Epic at our largest primary care clinics, as well as Advanced Health implementation of a new internal claims processing system and subsequent need for all internal reports to be re-written, internal preliminary data was not available to us for part of 2021 and for almost all of 2022. However, the most recent data available from the OHA 12 Month Rolling Dashboard for January 2023, with a rolling period of 1/10/2021-9/30/2022, shows a rate of 21.3% which is an encouraging increase of 2.9% over the 2021 final performance rate of 18.4%.



Utilization of services, which was curtailed in 2020 and into 2021, due to the COVID-19 pandemic response, especially dental services as many dental offices closed to all but emergencies in March 2020, slowly increased over 2021 and continued to increase over 2022. Thankfully, Advantage Dental confirmed in 4th Quarter of 2022, they are now back to pre-pandemic level utilization of services within Coos and Curry counties, and Advanced Health anticipates appropriate level of service utilization for oral health assessments for adult members with a diagnosis of diabetes for 2023.

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

Evidence shows patients with diabetes who have good oral health care have improved HbA1c blood sugar control. In turn, diabetic patients with better controlled HbA1c levels have better outcomes for their oral health care. Periodontal disease outcomes and diabetic health outcomes are linked. Through analysis of historical performance of the Oral Health Evaluation for members with diabetes, and in collaboration with the Interagency Quality and Accountability Committee, Advanced Health identified members 18 years of age or older with diabetes as a priority population for improvement efforts.

State Current Average CCO Rate (OHA CCO Metrics Dashboard, Jan 2023 rolling period 1/10/2021 - 9/30/2022)	State Average CCO 2021 Rate (OHA CCO Metrics Dashboard)	State Average CCO 2020 Rate (OHA CCO Metrics Dashboard)	State Average CCO 2019 Rate (OHA CCO Metrics Dashboard)
23.9%	24.7%	20.3%	30.7%
Advanced Health Current Rate (OHA CCO Metrics Dashboard, Jan 2023 rolling period 1/10/2021 - 9/30/2022)	Advanced Health 2021 Rate (OHA CCO Metrics Dashboard)	Advanced Health 2020 Rate (OHA CCO Metrics Dashboard)	Advanced Health 2019 Rate (OHA CCO Metrics Dashboard)
21.3%	18.4%	16.1%	22.7%
Difference between State Average CCO Rate and Advanced Health Current Rate	Difference between State Average CCO Rate and Advanced Health 2021 Rate	Difference between State Average CCO Rate and Advanced Health 2020 Rate	Difference between State Average CCO Rate and Advanced Health 2019 Rate
2.6%	6.3%	4.2%	8%

Advanced Health's performance on this metric has slowly regained some ground since the onset of the Covid-19 Pandemic in 2020. Advanced Health's performance has consistently been below the statewide average although it appears that 2022 performance could be very close.

Through this collaboration Advanced Health was able to outline multiple interventions for improvement including, member education, integration of oral health into the primary care setting, the use of care management for scheduled oral health visits, and gap list management.

Member education materials were developed to outline the importance of oral health and the link to diabetes disease management. Integrated Oral Health "dental days" were established at our largest primary care clinics as effort to leverage the patient-provider trust relationship and the primary care space. When scheduling during a "dental day" is not possible, primary care case management teams work directly with members to navigate the oral health visit scheduling process.

Utilization of gap list reports is the primary way that Advanced Health shares member health information with primary care providers. To a lesser degree, Activate Care is used to share care plans for members in ICC care between primary care, care management and Behavioral Health Providers. Advanced Health's gap list development has taken many iterations historically with the main goal being a comprehensive provider-based list of members who meet denominator inclusion criteria but have not received numerator services in the calendar year. Internal data analytics challenges in 2022 prevented the dissemination of these gap lists for the majority of the year, however other reports were used to attempt to get at the same outcome. In late 2022, these reports were back up and running and distributed to primary care and Advantage Dental (DCO) monthly. Outreach done by Advantage Dental via telephone and mailed letter (see example letter below) proved to be effective in 2022. Additional points of integration in the Behavioral Health setting were considered, developed but due to provider recruitment were not successful.

E. **Brief narrative description**:

Advanced Health will continue to work with Advantage Dental, the primary care provider network, and as primary care providers, to create pathways for better information sharing, care coordination and integration for shared patients with diabetes. This means that both PCP clinics and Advantage Dental will continue to receive reports and gaps lists of

diabetic members in need of dental appointments. PCP clinics will work directly with Advantage Dental Care Coordinators, who can be reached by calling a single number, to schedule patients in real time during their PCP visits. With the more complete dental visit information available to PCP offices, they will be able to coordinate appointments such as diabetic oral health exams, annual checkups and cleanings, urgent dental needs, and sealants for pediatric patients more effectively.

The Advanced Health Interagency Quality Committee (AHIQC) continued to work together in 2022 as capacity allowed, to reinforce their processes for scheduling members identified as needing appointments with their dental providers and clinic specific processes for working the gap lists. We recognized during 2022 how ongoing staffing shortages continued to impact clinic workflows, including their ability to conduct warm hand offs to Advantage Dental, but based on recent updates from AHIQC members the staff shortages for positions impacting these workflows are stabilizing and our larger primary care clinics anticipate increased capacity to conduct warm hand-offs to Advantage Dental in 2023.

Staffing shortages also impeded our larger primary care clinics from working directly with Advantage Dental to create an effective workflow to close the referral loop and ensure patients/members with a diabetic diagnosis, have indeed been seen in a timely fashion and their PCPs are aware of the outcomes. Several times clinic managers could not attend scheduled meetings to work on a solution because they were covering for various staff positions and often for extended periods of time. Bringing the assigned AHQIC sub-committee members together continued to be a challenge throughout 2022, and despite meeting several times to work on a viable solution, the explored options ended up not being feasible. This said, we are committed to finding a solution and will continue to work towards this goal over 2023.

The intervention to integrate oral health care in the primary care setting continued in 2022 with the successful integration of an Advantage Dental advanced practice hygienist at a total of six of our Primary Care Clinics. This integration included two of the largest clinics, with both onsite basic dental services and telehealth services with a dentist being offered at all participating sites which includes the following: Bay Clinic, North Bend Medical Clinic (NBMC), Waterfall Clinic, Coos Health & Wellness, and both Coast Community Health's Bandon and Port Orford clinic sites. The Advantage Dental expanded practice dental hygienist also helps patients in need of further dental services get connected with their primary dental care home and Advantage Dental case management services as needed. The successful advancement of integrated services at these sites has greatly improved access to our members and there has been a concerted effort to schedule diabetic patients/members onsite by their care teams, as well as offering diabetic health fair or other outreaches in which the advanced practice hygienist is available to see diabetic patients/members in attendance.

In 2022, Advantage Dental advanced practice hygienists saw a total of 326 diabetic patients in the primary care setting, up from 88 members served in 2021. In Coos county, 191 members were seen at Bay Clinic, 8 were seen at Coos Health & Wellness, 65 at North Bend Medical Center, 31 at Waterfall Community Health Center and in Curry County; 21 members were seen at Curry Family Medical and 10 were seen at Wally's House. Participating clinics and Advantage Dental will continue to work to increase utilization in 2023 with adult diabetic members being a priority, as well as addressing any barriers as they arise. Review of the individual clinic data reveals Bay Clinic as the front runner for scheduling diabetic members to receive oral health assessments in the primary care setting. There are deficiencies in smaller clinics and with our Coos Health and Wellness providers. The focus in 2023 will be in increasing the number of scheduled appointments for "dental days" at low performing clinics.

As an ongoing long-term strategy, Advanced Health continues to work with Advantage Dental and local dental providers to offer educational materials, to all local primary care providers with the consistent messaging on the benefits of regular oral health evaluations to patients with chronic diseases, especially diabetes. Co-branded member educational materials targeting diabetic members was developed by Advanced Health and Advantage Dental and successfully distributed to 49 individual primary care clinics in late 2021 and early 2022.

Consistent educational messaging continues to be an important strategy in reaching our diabetic members regarding the importance of their oral health and fully supported and promoted by all our primary care clinics. In 2023 Advanced Health plans to distribute more member focused co-branded materials and continue to track the number of distributed materials per clinic.

In 2023 Advanced Health plans to promote Integrated Oral Health "dental day" utilization at clinics with low utilization. In addition, we hope to onboard at least one more primary care office to offer "dental days", including an additional provider in Curry County. Optimization of existing dental days through max scheduling via member outreach in the primary care setting and adding dental days to clinics with high utilization will be a focus of Advanced Health and primary care providers in 2023. Goals below have been developed in collaboration with Advantage Dental, to account for their access and availability to offer integrated services.

In partnership with our primary care clinics and Advantage Dental, and despite some setbacks, we have managed to move forward and continue to believe our core strategies are working. In 2023 Advanced Health plans on reinforcing these core strategies, improving and expanding them where we can, and once we are confident they are truly hardwired explore new strategies which can advance this work most effectively. At this time our clinical partners are still walking out of the negative impact from the pandemic and dealing with ongoing staff shortages as well as both provider and staff burn out. We do not believe implementing additional new strategies at this time would be effective.

In 2023, Advanced Health we will continue to explore expanding the number of dental days of the advanced practice hygienists within our main primary care clinics and have the clinics work on improving and hardwiring their warm hand-off workflow processes with the use of the monthly gap lists. Advanced Health will continue to explore additional opportunities to integrate care, especially for vulnerable populations such as those with serious and persistent mental illness, and plan to continue to analyze available data and monitor throughout the course of the year performance improvement projects for potential health disparities which need to be addressed through additional or modified intervention.

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

Activity 1 description: Create, validate, and disseminate reports and educational materials as requested by the Interagency Quality Committee

☒ Short term or ☐ Long term

Monitoring measure 1.1	Create, validate, and disseminate gap reports and educational materials as requested by the Interagency Quality Committee.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Pause in the creation and distribution of monthly gap lists	Provide Oral Evaluation status to PCPs for all members meeting the denominator criteria of the Oral Health Evaluations quality measure monthly	04/2023	Continue to provide Oral Evaluation status to PCPs for all members meeting the denominator criteria of the Oral Health Evaluations quality measure monthly	12/2024
Co-branded member education documents developed and disseminated in 2022 to 49 primary care	10% increase in number of provider offices who obtained these documents	12/2023	10% increase in number of provider offices who obtained these documents	12/2024

providers in our network				

Activity 2 description: Monitor utilization of oral health evaluations for adults with Diabetes using the Oral Health for member with Diabetes incentive measure.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Monitor performance on the Oral Evaluations for Adults with Diabetes quality measure with a goal of returning to 2019 performance in CY 2022.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
18.4% of adults with diabetes receiving an oral evaluation (2021 performance)	18.6% CCO improvement target (2022)	12/2023	23.0% of adults with diabetes receiving an oral health evaluation	12/2024

Activity 3 description: Monitor utilization of integrated Oral Health

☐ Short term or ☒ Long term

Monitoring measure 3	Monitor Integrated Oral Health "dental day" utilization			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
326 members scheduled for oral health integration "dental days" at primary care clinics (2022)	10% increase in number of members scheduled for oral health integration "dental days" at primary care clinics	12/2023	10% increase in number of members scheduled for oral health integration "dental days" at primary care clinics	12/2024
72 integrated oral health "dental days" scheduled at primary care clinics (2022)	96 integrated oral health "dental days" scheduled at primary care clinics (based on 2022)	12/2023	108 integrated oral health "dental days" scheduled at primary care clinics	12/2024
6 Primary care clinics participating in integrated oral health "dental days". (2022)	7 primary care clinics participating in integrated oral health "dental days".	12/2023	8 primary care clinics participating in integrated oral health "dental days"	12/2024

A. **Project short title**: Community Collaborative – Initiation and Engagement in SUD Treatment

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

If continued, insert unique project ID from OHA: 44

B. Components addressed

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

Behavioral Health Integration

Historically, Advanced Health has worked alongside our provider network to identify and mitigate delivery service network deficiencies and barriers to care. This included service expansion, the expansion of our internal Behavioral Health staff, and taking time to understand the perspective of our network of Behavioral Health providers to hear and mitigate barriers. The service expansion in previous years created foundational changes to services including:

- New contracts with local mental health providers allowing a broader network for Members to choose from.
- Greater accountability for mental health programs including more fee-for-service encounters, incentivizing agencies to increase services to Members.
- Integrated services for mental health services within medical clinics.
- Care coordination for high-risk members with Serious and Persistent Mental Illness.

Integrated healthcare is a collaborative approach to patient care that combines the physical, mental, and behavioral aspects of healthcare. This has been the main goal of the Patient Centered Primary Care Home model since its conception in 2009. Patient-Centered Primary Care Homes are health care practices that have been recognized by the Oregon Health Authority for their commitment to providing high quality, patient-centered care. This model of care fosters strong relationships with patients and their families to better care for the whole person. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention and wellness, and managing chronic conditions. The core attributes of the PCPCH model includes “coordinated” which specifies that care is integrated, and practices help patients navigate the health care system to get the care they need in a safe and timely way. Advanced Health contracts with community clinics who are PCPCH recognized with our largest providers being 5-Star clinics. In 2022, 53% of our population was empaneled at a 5-star clinic with 90% empaneled at a PCPCH of any tier or star rating.

Integrated Behavioral Health continues to be established in the largest clinics in our provider network serving approximately 80% of Advanced Health members and providers members and PCPs quick access to mental health consults. Integrated behavioral specialists are trained in referrals to specialty programs. These well-established programs aim to strengthening the alliance of the physical wellbeing with mental health. Our local primary care providers lean heavily on our behavioral health teams to meet the needs of our members swiftly, seamlessly, and effectively.

The integrated model of care for behavioral health reduces stigma associated with seeking mental health services and leverages the trust-based patient provider relationship of primary care. This model often allows primary care providers, patients, and mental health providers to seize the opportunity to shepherd a patient from diagnosis to treatment in a timely manner by reducing barriers related to access and transportation. Through the equity lens, integration of mental

and physical health is often built to allow for all patients to access care, and services are not rendered based on race/ethnicity, gender, disability, insurance, or ability to pay.

The use of the community wide Electronic Health Record (EHR) Epic during 2022 revealed some unanticipated challenges to data collection in the areas of data reliability during the screening process, as well as accuracy in capturing the work that clinicians are completing. Clinic data mangers continue to work with the electronic health record reporting capabilities to understand the structured data and determine how best to modify reporting to capture value added data points. Creating standardized workflows was the focus of 2022 which aims to improve timeliness of referral processing and loop closure.

Utilization Review

Utilization review is the process of reviewing, evaluating and ensuring appropriate use of medical resources and services. The review encompasses quality, quantity and appropriateness of medical care to achieve the most effective and economic use of health care services.

Utilization of care is directly linked to quality of care in the way that is indicates proper management of chronic conditions, preventive services, access to care and promotes improved health outcomes. Advanced Health promotes utilization of services in many ways; reduction of barriers to accessing care, a robust provider network, and continuous monitoring of claims data for utilization trends. Advanced Health also pairs with Milliman analytics to better understand our member population, the services they utilize, and the chronic conditions they manage through analysis and predictive analytics.

Advanced Health's Interagency Quality and Accountability Committee serves as evidence of the collaboration and coordination between Advanced Health's leadership, contracted organizations, and community partners in monitoring the quality, accountability, and utilization review activities of the entire CCO. In addition to continuous monitoring of incentive measure dashboards which provide analysis of utilization of preventive services, Advanced Health captures data on our referral process, including approved, denied or cancelled authorizations to further reduce barriers to access to specialists and second opinions for our member population. It was thorough review of these dashboards that unintended barriers were identified and mitigated through changes to the prior authorization process. The same is true for pharmacy benefits and our formulary.

Advanced Health maintains and monitors internal claims driven dashboards which are used in the analysis of utilization including both under-utilization and over-utilization of services. These dashboards are reviewed internally quarterly and with the IQAC at least annually. Advanced Health has continued to incorporate REALD data for claims driven dashboards which allows for analysis of utilization trends and the detection of disparities. SOGI data will be incorporated when available.

In 2022 overall utilization for preventive services for the 0-18 population is slowly recovering since the onset of the Covid-19 pandemic. Performance on the Adolescent Well Care Visits for ages 3-6 dropped dramatically in 2020, with a slight increase in 2021. Final performance on this measure for 2022 is not yet determined, however our internal claims-based dashboards reflect the efforts to improve utilization of preventive services for this age group with a rate that is more aligned with pre-pandemic performance.

Our internal dashboards are also stratified by REALD data, which allows for the identification of disparities. For Children 3-6 years old who meet denominator criteria for the Adolescent Well Care visits incentive measure, 69% identify as Hispanic. In addition, this race/ethnic group generate 63% of the numerator compliant visits. This supports the open access to preventive services for this age group regardless of race/ethnicity, language, or disability.

In addition to the utilization of preventive services, Advanced Health also monitors the use of Emergency Department Utilization. This allows our internal teams to monitor and build interventions to address over utilization. In 2022, Emergency Department Utilization remained low at 46.7/1,000mm as per the most recent OHA rolling dashboard. This is in line with performance since 2020.

Emergency Department utilization for Advanced Health members identified as having Spanish as their primary language was minimal during 2022. On average, 10 claims a month with increased utilization in November and December for reasons like chest pain, fever, and cough.

Monitoring outpatient utilization can be an indicator for the level of access within our provider network, Advanced Health does this by reviewing the OHA rolling dashboard, which calculates the rate of Outpatient utilization of services. The most recent OHA rolling dashboard has outpatient utilization at 248.7/1,000 which continues the downward trend since 2019 (317.1/1000). This steady decline in utilization of services is mainly attributed to the public health messaging to avoid preventive care that coincided with the pandemic.

Advanced Health continues to consider ways to monitor utilization of Behavioral Health and Oral Health services with advancements in our internal dashboards. In addition, our internal teams are focused on identifying utilization trends for sub-populations within our membership, like those needing Long Term Supports and Services (LTSS), those with Severe and Persistent Mental Illness (SPMI) and incorporating SOGI data when available.

Initiation and Engagement in SUD Treatment Measure Performance Discussion (utilization review)

Initiation and Engagement of Alcohol or Other Drug Treatment was a new Coordinated Care Organization Quality Incentive Measure in 2020 that is comprised of two components ensuring access to care for initiating and engaging in treatment. Historically, Advanced Health has had a low performance rate compared to statewide performance:

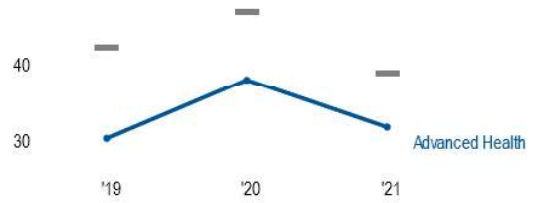
Initiation: The statewide benchmark for initiation in 2021 was 38.8% Advanced Health's performance was short at 31.6%. In 2021 the statewide rate for Initiation was 39.3% and Advanced Health's performance has decreased significantly from 37.8% in 2020 to 31.6% in 2021. The results from the 2021 CCO Quality Measures report is included below. This is the most recent year for which full performance data is available.

OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health

Initiation and engagement of alcohol and other drug treatment (Initiation phase)

Performance over time

Click CCO name(s) in the comet chart at right to see their performance over time.



Denominator (n) is only available statewide to protect confidentiality

About this measure

Percentage of adult members newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of the initial diagnosis.

Measure categories: • Incentive • CMS Core

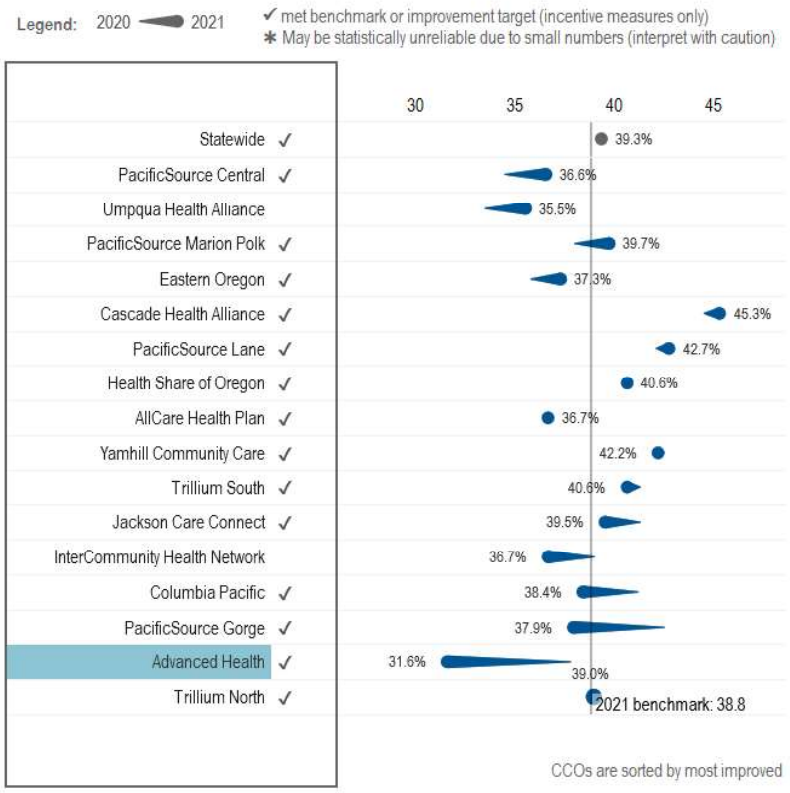
Data source: Administrative (billing) claims

Benchmark source: 2019 national Medicaid 25th percentile

Notes: Due to specification changes from the measurement steward and refinements in OHA's calculation for 2020, the 2019 results have been revised using the latest calculation and are not comparable with prior reports. Click the button below to view additional breakouts of this measure (by age group and cohort).

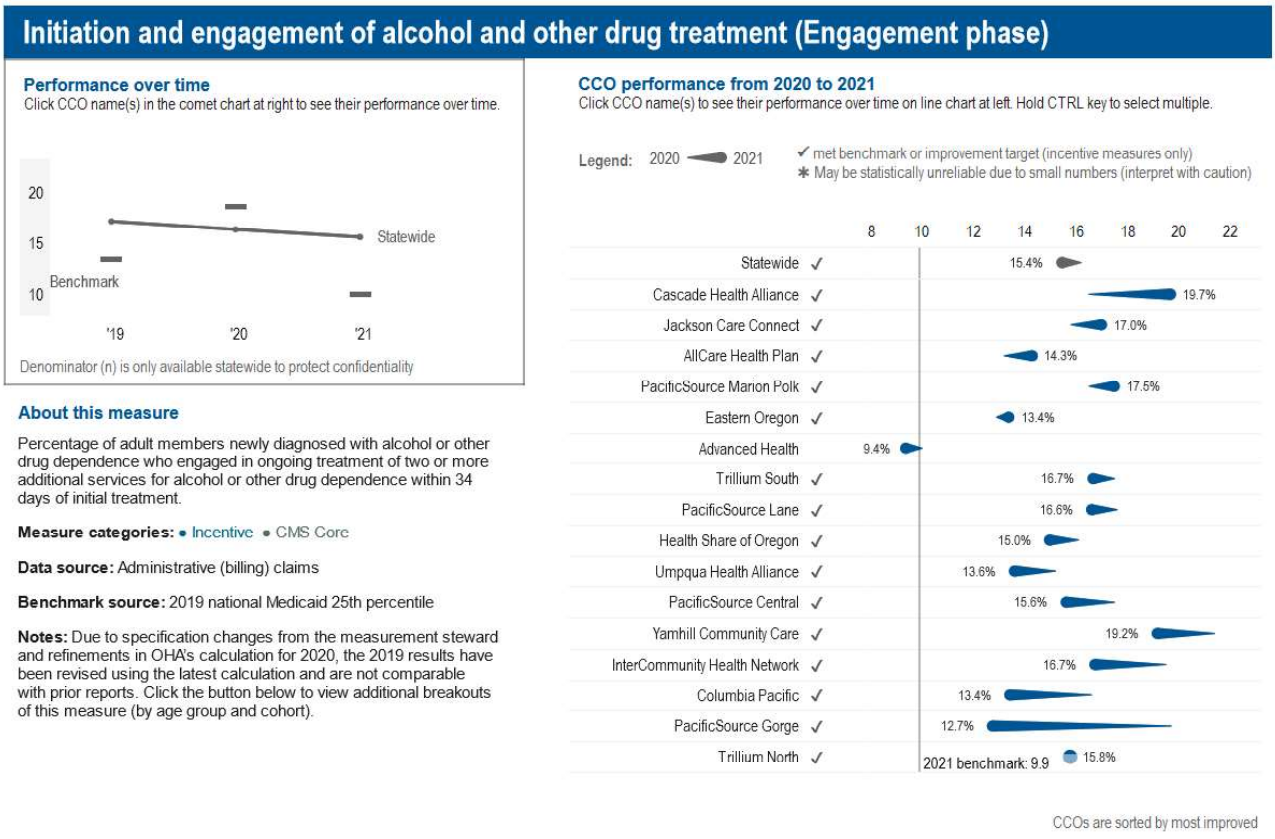
CCO performance from 2020 to 2021

Click CCO name(s) to see their performance over time on line chart at left. Hold CTRL key to select multiple.



Engagement: The statewide benchmark for engagement in 2021 was 9.9% with a statewide average performance at 15.4%. Advanced Health's performance declined from 10.0% in 2020 to 9.4% in 2021. The results from the 2021 CCO Quality Measures report is included below.

OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health



Annual report data reveals that both the rate of initiation and engagement are down compared to previous years, and both are below the statewide average and benchmark. Advanced Health's role continues to focus on improving processes that ease member navigation through the system, build lasting relationships with peer supports and other caregivers and use motivational interviewing to help alleviate barriers increasing the likelihood of members success.

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

Advanced Health's low performance rate for the Initiation and Engagement in Alcohol and Other Drug Treatment quality measure, has been an ongoing concern for the Advanced Health Interagency Quality Committee. The Interagency Quality Committee includes representatives from Behavioral Health, Non-Emergent Medical Transportation, Oral Health, Physical Health (Adult and Pediatric), and Substance Use Treatment provider organizations. All four clinics with integrated behavioral health services are represented on the Interagency Quality Committee.

The point of concern identified by the Interagency Quality Committee around timeliness regarding Initiation and Engagement in Alcohol and Drug Treatment (IET) was due to low performance on the quality measure despite all the work that had been done in the past several years around screening, referral lop closure and network adequacy in Coos and Curry counties. Previous efforts to address referral loop closure barriers and gaps in care were met with privacy requirement challenges leaving the group to re-evaluate the direction of interventions for improvement. The group understands that relying on claims data to identify members who have initiated treatment is untimely for the management of engagement in treatment.

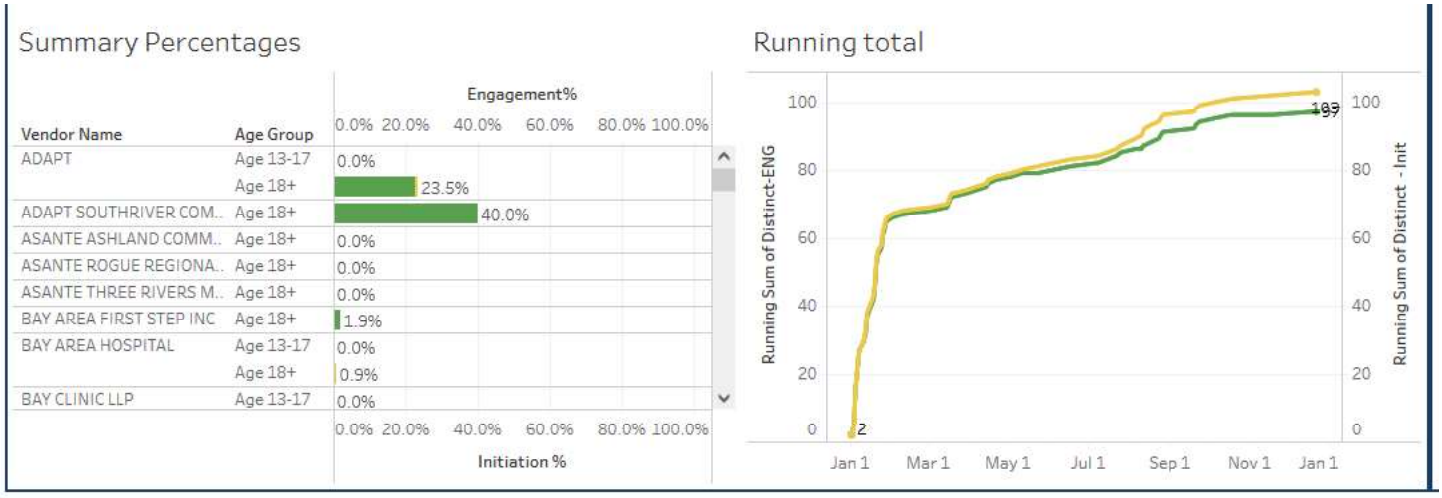
The Interagency Quality Committee recognized that due to the complexity of the metric, Advanced Health was unlikely to achieve improvement targets if work remained isolated within individual provider organizations. The committee deemed the work to be aligned with the Patient Centered Primary Care Home 5-Star designation requirements related to coordination of care and cooperation with community service providers. In addition, this work aligns with the

priorities identified in the Advanced Health Community Health Improvement Plan, approved by the Community Advisory Council, by supporting individual prevention services and improving access to integrated services and delivery of addiction services as priority areas.

The committee requested that Advanced Health conduct data analysis using Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) metric to determine the main source of referrals for treatment and to shift the focus to better understanding barriers for referral and follow up treatment given the current referral pathways.

This evaluation was done in October 2021 using 2020 full year data as it was the most comprehensive data set available at the time. Data analysis revealed that 40 percent of index diagnoses were generated from primary care and only 15 percent from substance use providers. The committee identified the lack of workflow process to assist in the patient transition from diagnosis in the primary care setting to treatment as the root cause of poor performance in initiation and engagement of treatment. Interventions were built to leveraging either peer support specialists or existing Integrated Behavioral Health teams in the clinic setting could aid in the process. The Committee identified key points around building trust relationships to encourage members to start treatment and how the peer support role was appropriate.

The rate of initiation and engagement of Alcohol and other substance use disorder rose drastically in the first quarter with a gradual increase for the remainder of 2022. There is a slight divergence between the rate of initiation and the rate of engagement toward the mid to late portion of the year with the highest rate of both initiation and engagement being our SUD service provider ADAPT.



In addition to the review of claims-based dashboards for the IET incentive measure, the MEPP dashboard was used to further highlight the cost of SUD diagnosis groups. Analysis of the MEPP dashboard CY2018-CY2020 for Substance Use Disorder shows that the costliest diagnosis groups for substance use disorder treatment for our CCO are alcohol, cocaine and amphetamines. Adverse Actionable events make up 42 percent of total spending for alcohol related SUD treatment with the average paid per episode at just under $5,000. For Cocaine and Amphetamine related SUD treatment Adverse Actionable Events account for 46 percent of total spending and have an average paid per episode of just over $4,000. The top AAE dollars by rendering provider clearly identifies a large amount of avoidable spending happens at our local hospitals which further justifies the new intervention for this episode which focuses more on identifying SUD in the primary care setting and using integrated behavioral health teams to assist members in navigating to outpatient treatment.

E. **Brief narrative description**:

The designed intervention aimed to increase timely access to treatment using the care team, warm hand-off model from the primary care provider to behavioral health staff, who can engage the member using techniques to assist them in

understanding the pathway to treatment. Clinic-based Integrated behavioral health teams have been leveraged to cover the continuum of care from positive screening to initiation and engagement in treatment. The access to services for the member in this aspect of the process can be almost instantaneous. Once the member has agreed to treatment, access to SUD treatment providers is well within the timely access standards set in contract. Once the member initiates treatment the behavioral health team will hand that member off to a peer support specialist to assist navigation through the engagement in treatment process all the way to completion.

Better coordination and integration of referral pathways from PCP provider organizations to SUD treatment provider organizations would improve timely access to SUD treatment. Using established integrated behavioral health services to bridge the gap between diagnosis and initiation and engagement in treatment will improve member outcomes and support member engagement in their treatment plan through a more equitable, patient-centered care model. This care team model is inclusive as it is available to all patients of the clinic regardless of primary care provider or insurance coverage. Therefore, reducing unintended health disparities.

In early 2022 one of our network primary care offices, Bay Clinic joined forces with Oregon Health and Science University (OHSU) in the ANTECEDANT project. This project aims to improve identification of unhealthy alcohol use and increase rates of substance use services interventions. Clinic-based Integrated Behavioral Health (IBH) staff has been supporting members through reducing barriers to community substance use treatment by supporting engagement with community-based peer services or IBH-in clinic support. Initial interventions focused on clinic workflow and integration of screening tools with their Electronic Health Record which provides a standardized documentation of substance use screening tools. Their initial review of their internal data revealed a delay of community follow up or patient follow through following community referral being placed. The IBH staff have been following the patient process to identify and address barriers to care as indicated. Through 2022 the IBH team at Bay Clinic was unable to capture baseline data due to a recent EHR conversion. They continue to work through these barriers with hopes of establishing the baseline and applying that to their PDSA cycle.

Advanced Health worked tirelessly throughout 2022 to update and maintain the IET measure dashboard. Internal staffing and other priority items took precedence, and this dashboard is the primary focus in early 2023. Future iterations of this internal dashboard will include stratification by RealD and SOGI data for the analysis of both initiation and engagement rates and to identify disparities. Advanced Health currently incorporates RealD data into the majority of its internal claims-based dashboards and plans to do the same when SOGI data is available for our member population. Review of Advanced Health's internal claims-based IET dashboard stratified by REALD data reveals the largest race/ethnic group utilizing these services is white and English speaking. Understanding the screening process in primary care, it is evident that more evaluation is needed to determine if this finding is a true disparity or a result of our member population.

Interventions slated for the coming year addresses both the Behavioral Health Integration and Utilization Review components. The use of Integrated Behavioral Health in this project highlights the full integration of Behavioral Health staff in the primary care setting and supports the Patient Centered Primary Care Home model. The aim of this project also is to assist the member in navigating the continuum of care and can identify areas in the continuum that lead to reduced rates of either initiation or engagement in treatment. This model of care promotes equity as the services provided by the IBH team are not exclusive to Advanced Health members. Utilization review is addressed with this project as it actively reviews, evaluates and ensures appropriate use of medical resources and services. In addition, it aims to understand barriers to care and trends in utilization of SUD treatment services.

Effectiveness of interventions will be monitored using the CCO's Initiation and Engagement of alcohol and other substance abuse treatment incentive measure. The review and analysis of internal dashboards will be brought to the Interagency Quality and Accountability committee at least twice a year.

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

Activity 1 description: Collect and analyze baseline data from pilot clinic to understand the effectiveness of the established workflows.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Collect and analyze baseline data			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No baseline data collected (2022)	Baseline data collected and analyzed	12/2023	Year end performance data compared to baseline to determine effectiveness of interventions	02/2025

Activity 2 description: Through collaboration with clinic IBH teams and members, develop workflows and strategies to improve rate of initiation and engagement of alcohol and other substance use disorder treatment.

☐ Short term or ☒ Long term

Monitoring measure 2.1	In collaboration with pilot clinic and members, develop workflows to identify unhealthy substance use in primary care and referral to treatment pathway			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Workflows established and documented	Review of workflows through the lens of efficiency	12/2023	Continuous monitoring of workflows	12/2024
Analyze current referral process/pathway for areas where a member may encounter barriers	The development of navigation and warm hand off model of care from diagnosis to treatment	12/2023	Monitor these workflows/pathways to ensure consistent good outcomes	12/2024
Collaborate with established clinic patient/family groups to gather patient experience with referral pathway from primary care to treatment.	Understand where the member encounters barriers to treatment	12/2023	Mitigate these barriers to treatment on a system level or system level model of care.	12/2024

Activity 3 description: Measuring the impact of SUD screening in primary care on overall performance on the IET metric.

☐ Short term or ☒ Long term

OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

Monitoring measure 3.1	Increased alcohol and drug abuse screening in primary care			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
SBIRT performance for 2022	2% increase in the rate of SBIRT screenings in primary care	12/2023	5% increase in the rate of SBIRT screenings	12/2024
Monitoring measure 3.2	Improved performance on IET CCO incentive measure			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
IET measure performance 2022	2% increase in initiation of treatment and 2% increase in engagement of treatment	12/2023	5% increase in the initiation of treatment and 5% increase in the engagement of treatment	12/2024

A. **Project short title**: Improve Language Services Access

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

If continued, insert unique project ID from OHA: 45

B. **Components addressed**

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

Advanced Health is dedicated to the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs through the allocation of resources, education, and organizational culture change.

In 2022 Advanced Health continued its commitment to promoting health equity to all members in Coos and Curry Counties by assuring access to culturally responsive services. We ensured that communications and interactions with our members and providers were respectful of and relevant to the member's beliefs, practices, culture, and linguistic needs. We did this through auditing files, reviewing complaints, monitoring data, and promoting current resources while creating new ones. Advanced Health has adopted OHA's Health Equity definition as a cornerstone for developing and operationalizing the organization-wide Health Equity Plan.

OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

Advance Health uses all laws and regulations to make sure we are strictly adhering to all including The Americans with Disabilities Act, Title V1 of the Civil Rights Act of 1965 and Section 1557 of the Affordable Care Act requiring all federally funded agencies to provide free of charge Language Access Services. The Americans with Disabilities Act requires all places of public accommodation to ensure that communication with individuals with disabilities are as effective as communications with everyone else. Advanced Health holds all subcontractors, vendors, and providers accountable to those same standards while working with both members and providers to break down any barriers. We assure compliance by our contracted providers and vendors through our audit process. We also provide additional notification and education of any changes in policy or law to all contracted providers through our Provider Services Representative. In 2022 our Provider Services Representative was instrumental in notifying CCO Network providers of our enhanced video interpreting service, educating providers on the process for obtaining these new services, and providing Language Line Materials.

Oregon House Bill 2359 has put new requirements on interpreting services for healthcare. All health care providers who receive public funding now must use qualified or certified interpreters, found on the Oregon HCI registry, for on-site appointments. In 2021, Advanced Health began offering scholarships to our contracted providers who would like to have onsite staff trained to be a qualified or certified interpreter to be listed on the Oregon HCI registry. In response to House Bill 2359, we have seen an increase in the number of staff embedded with provider offices who are applying for the scholarships. In anticipation of an increase in needs from our providers based on this new bill, Advanced Health also authorized the expansion of our Video Interpretation system to meet these changing needs and requirements.

As the CCO grows, we continue to improve our responsiveness to the diverse issues of our community which can be evidenced in our continued improvements of our assessments, policies, and trainings for both staff and members. This past year the CCO has updated the Health Risk Assessment Survey to be more inclusive of the member's cultural and linguistic preferences. We have written additional policies such as the Language Line Policy and Procedure to assure that all CCO and provider staff are fully trained on how to provide language access to any member in need. We have promoted existing resources and researched new ones to assure CCO members receive the information they need in a way that is best for them. The CCO also added trainings including Language Access & Using the Relay System to continue to improve our staff's abilities to effectively assess and meet all members' needs.

Advanced Health has focused Health Equity and CLAS efforts both internally and externally throughout 2022. Internally, Advanced health has adopted the definition of cultural competence in OAR 943-090-0010. This means the CCO will continue the ongoing process of examining the values and beliefs of our members while using an inclusive approach to health care so that we recognize the context of provider-patient communication and interactions so that we will preserve the dignity of each and every individual we serve. These definitions paired with the CLAS Standards have guided Advanced Health's actions and commitment to assure we are providing culturally responsive services to all members. Advanced Health collaborates with the Community Advisory Council (CAC) and the Health Equity Steering Committee to address Health Equity and work toward ways to improve upon our existing standards. In 2022 a CLAS Champions work group was added to further develop and discover new ways to engage our members no matter what their cultural or linguistic preferences. In addition to leveraging the collective member voice of our CAC, Advanced Health engages in cross-cultural conversations with members and groups representing underserved populations in our community, with the goal of understanding barriers to care.

Externally, Advanced Health has developed and promoted a Provider Network Training Plan used to promote access and delivery of services in a culturally competent manner. Advanced Health continues to promote trainings and activities in the Coos and Curry communities related to health equity and culturally responsive services. Over the past few years, Advanced Health has contributed to the South Coast Diversity Conference, and the ResCUE Model for Cross-cultural Clinical Care and Recognizing and Overcoming Unconscious Bias. Additionally, Advanced Health shares REALD data with

the provider network via the monthly capitation rosters and via the incentive measure gap lists to assist in identification of interpreter service needs.

Advanced Health uses a variety of data to identify member primary language and interpreter service needs. The OHA 834 enrollment data is used as the primary data for the linguistic and cultural needs of our members with supplemental data from our Health Risk Assessment and ICC enrollment. These other points of contact from our CCO staff allows the member to self-identify primary language as well as interpreter service needs. Advanced Health leverages all data sources to paint a broad picture of our membership and to identify any disparities that may exist. In collaboration with the OHA, Advanced Health has been a vehicle for updating member enrollment data via the OHA Data Submission Portal. This process allows members to call the CCO and update their REALD data with those updates reflected in the OHA data. This not only allows members to self-identify leading to the identification of additional members who need interpreter services, but also removes erroneous identification of members needing interpreter services.

Advanced Health monitors the utilization of interpreter services by our provider network via Internal data dashboards that allow for the identification of members who require interpreter services and have had a service for the audit of interpreter services by our provider network. The resulting audit report is reviewed by the Interagency Quality and Accountability Committee (IQAC) at least annually. Analysis is used to support clinic workflows that support Patient Centered Primary Care Home standards and data collection for improved performance.

Advanced Health leverages REALD data to stratify all internal dashboards for a broader view of Advanced Health's membership. Internal data reveals the following enrollee characteristics:

2022 demographic data identifies the following enrollee characteristics:

Race and Ethnicity	
American Indian or Alaska Native	1%
Asian	0.5%
Black or African American	0.3%
Hispanic/Latino/Latina/Latinx	3.3%
Native Hawaiian or Pacific Islander	0.1%
White	60.5%
Other	8.2%
Declined to Answer	12.7%
Did Not Answer/Unknown	13.4%

Language	
Unknown	1.0%
Chinese	0.1%
English	97.6%
Spanish	1.2%

*Note languages reported by fewer than 20 members are suppressed from this report

In 2022 Spanish remained the prominent non-English language spoken by Advanced Health's membership with 335 members identifying Spanish as their primary language. This is a 33-member increase from 2021. Members with disability are also identified and monitored using this internal dashboard which shows 1.4% of our population as deaf

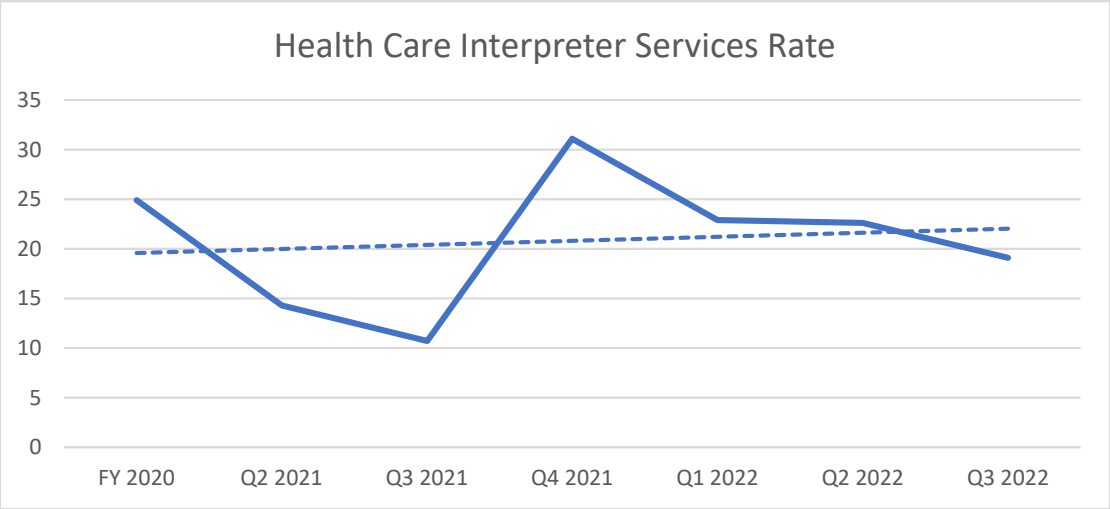
and overall, 12% of the overall membership living with a disability. Internal dashboards are monitored frequently when considering member materials development and to identify potential health equity concerns.

All enrollees with limited English proficiency are offered the option of being assigned to a provider who speaks their preferred language, if that language is represented among the panel of providers. Within Advanced Health's PCP network, there are multiple bilingual providers: Spanish (8); Hindi (7); Mandarin (1); Malayalam (2); Portuguese (2); Gujarati (1); Tamil (1); Teluga (2); and Nepali (1). Within the mental health and addiction treatment system, there are providers who speak the following non-English languages: Spanish (24), Russian (2), Lakota (2), and Hindi (1). There are also (24) mental health providers who are fluent in American Sign Language, supporting those members who are deaf or hard of hearing. Within the oral health provider network, there are four providers who speak Spanish and one provider fluent in American Sign Language. One of the oral health providers who speaks Spanish and the provider fluent in ASL are both available to attend appointments in multiple Advantage Dental clinic locations within the Advanced Health service area.

During 2022 Advance Health's Qualified Health Care Interpreters completed 21 interpreter assignments. Of those 21, 6 were for medical services, 0 for dental, 11 for behavioral health services, and 4 were considered other which include providing interpretation at community events.

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

Review of Language Access quarterly chart review data reveals a large variance in rate of interpreter services over 2021 and 2022. This is in part due to the sample size and change in quarterly report format; from quarterly to rolling year. Overall performance for interpreter services in 2022 was consistent around 21% through quarter three of 2022. Data presented to the Interagency Quality and Accountability Committee reiterated the need for continued focus on interpreter services in the healthcare setting.



Advanced Health continues to support both internal and external efforts to ensure that the CCO and its provider network provide cultural and linguistically appropriate services to members regardless of the care setting. These efforts include provider education, member voice, and internal interventions around CLAS standards.

Remote trainings continued in 2022 due to COVID in-person restrictions. Plans for hybrid in-person and virtual trainings for 2023 are in the preliminary stages currently. As requested by the Coos County CAC, Trauma Informed Language courses will be added to the existing training plan. This course will assist the provider network to better understand and serve members who may have suffered trauma. These efforts aim to increase member satisfaction with the CCO and

provider network by ensuring communication, assessments and interactions with our diverse member population are member-centered and trauma-informed.

Advanced Health provides Language Line interpreter services to our membership and provider offices through the use of Language Line Solutions. All materials including posters, flyers, administrative desk stands, and new for 2022 badge cards with the Language Line information on it to allow providers access to the Language Line information at any time. Advanced Health has many offerings to promote the use of certified healthcare interpreters to ensure that our membership and provider network can access telephonic and in-person interpretation services, as well as understand the value interpreter services bring to quality healthcare. Advanced Health established and promoted the Health Care Interpreter Scholarship, which provided financial support for current allied staff in our provider network to become certified healthcare interpreters. In 2022, six clinic employees were awarded the scholarship with completion expected in early 2023.

Additionally, Advanced Health employs one Spanish language OHA qualified Health Care Interpreter. This interpreter is a Customer Service Representative (CSR) within the Customer Service Department and is available to assist any Spanish-speaking members who call or come to the CCO office. There is also another Spanish speaking CSR that has gone through healthcare interpreter training and is able to assist with incoming/outgoing calls with the Spanish-speaking population. Both CSRs are able to offer high-quality, in-person interpreter services for members leveraging Language Line Solutions On Demand Video Interpretation Program through the use of mobile tablets. Advanced Health's contract with Language Line Solutions allow our Customer Service Representatives to facilitate Certified interpretation to 3 separate individuals at once in any language, while also having the ability for our Qualified Spanish Healthcare interpreter to provide services to a 4th Spanish speaking member. These staff are also able to lend their skills and knowledge to the process of developing and verifying translated member materials and member health education information to ensure it is culturally and linguistically appropriate. More details are available in the Advanced Health *Language Access and Health Care Interpreter Services* policies and procedures.

Advanced Health values the diversity of its membership and incorporates the member voice when considering interventions to improve interpreter services and access to care. In 2022 a listening session was held with a member of one of the local Native American Indian Tribes. During this discussion, needs including access to culturally appropriate recipe books were discussed. Advanced Health was able to help provide access by removing the financial barrier of this member through the use of Flexible Funding. This has also started conversation within our internal committees as to how we could locate additional culturally appropriate resources and make them available to our members.

In the recent past, Advanced Health and the Ko-Kwel Wellness Center have collaborated to increase access to care for members of the Coquille Tribe. This collaboration allows tribal members to enroll in Advanced Health and utilize the full provider network. This collaboration has been instrumental in developing a model to make sure the CCO helps each individual meet their healthcare needs by offering the Tribal Clinic some special considerations such as enrollees are only assigned to the clinic as their PCP if they request it or are established patients; the clinic has allowed their patients to choose whether or not to enroll in the CCO.

This past year Advanced Health revised the Health Risk Assessment Survey. The CCO created additional questions focusing on culture and language preferences which allow members to self-identify language and interpreter needs. This process collects additional data on the member's linguistic and cultural needs. The additional questions focus on member preference for primary language as well as deaf, blind, hard of hearing status and the use of assistive devices. Allowing member self-identification provides supplemental data and improves the completeness and accuracy of READ data.

To address member education around CCO benefits, in 2022, Advanced Health created "Easy Guides". These guides are focused on member benefits in the areas of Transportation, Pharmacy, Medical, and Dental with the aim to help

members better understand their benefits. The initial four focus areas for the "Easy Guides" were selected after collecting survey data from members who called the health plan with benefit questions. Advanced Health plans to continue developing "Easy Guides" in 2023, with focus areas of Behavioral Health and Intensive Care Coordination. We plan to continue to provide additional Easy Guides including one on Behavioral Health benefits for the year 2023.

Advanced Health has reviewed internal processes through the lens of CLAS and Health Equity by establishing the CLAS Champions workgroup. This workgroup includes representatives from Grievance and Appeals, Compliance, Intensive Care Coordination, and member services with the aim to ensure health equity and CLAS is considered organization-wide in the development of processes and outputs. The CLAS Champions workgroup has planned a series of lunch and learn educational sessions for staff and providers to reinforce how to be culturally and linguistically sensitive while meeting the member's needs. These will also address The Americans with Disabilities Act, Title V1 of the Civil Rights Act of 1965 and Section 1557 of the Affordable Care Act requiring all federally funded agencies to provide free of charge Language Access Services.

One of the ways Advanced Health works to operationalize health equity and cultural competence is in the continual improvement of language services offered to and used by Advanced Health members with limited English proficiency and member focused information on our website. Improving the quality and utilization of language services will empower members to fully access the health care services available to them to improve and maintain their health.

In 2022 improvements to Advanced Health Website were implemented including increasing the number of documents translated to Spanish that are provided on the website. A Policy and Procedure for the Language Line has also been created and will be distributed in 2023 to assure all staff are aware of how to utilize the language line when needed. Completion is expected in early 2023. In November the CLAS Teams channel was created to help educate Advanced Health staff on culturally and linguistically appropriate services, educational materials, updates, trainings, and culturally significant stories will be added on an ongoing basis to be viewed company wide.

To increase timely and accurate member information via the Advanced Health Website, an internal website committee was created in 2022. The member section of the website informs members of language services available to them at no cost, how to access those services, and best practices for high quality language services, including use of qualified or certified interpreters. This past year Advanced Health translated additional member-facing materials into Spanish including the Health Risk Assessment Survey and our Flex Fund Request Form to assure member's understanding of the service. Advance Health also offers Large Print whenever possible and as requested by any member. The AH Easy Guides are in process of being added in both English and Spanish to the website. The provider web page includes information about regulatory and contractual compliance related to language services, as well as Advanced Health's policies and procedures for language access and interpreter services, and best practices to ensure high quality services are delivered to patients with limited English proficiency.

Externally, Advanced Health incorporates CLAS standards into routine provider network auditing via provider attestation. The provider attestation survey includes compliance with CLAS standards 5-8 and results are reported to internal compliance teams and the Health Equity Steering Committee.

In 2022 Advanced Health added translation services through Language Line Solutions in addition to interpretation. This has proven to be more accurate and faster than our previous translation vendor. This allows us to get the information into the members hands faster. The additional step of final review after the translation by the Advanced Health Qualified Interpreter is completed to assure appropriate content. We will continue to utilize this service through 2023 as it has proven beneficial. This is evidenced in the reduction of translation time for the Spanish language Annual Member Handbook from 4 weeks to 2 weeks.

While improving ways to reach our members, Advanced Health has identified some barriers to getting the information to the members. Efforts in 2022 included individualized language letters to members with information about the enhanced video interpretation program, encouragement to contact the CCO to assure language identification preference and provided the updated Relay number for the deaf and hard of hearing. The CCO included a Language ID Card which the member could write their preferred language in and also included an identification card for those who are deaf or hard of hearing. Updated provider materials were distributed throughout the provider network regarding the enhanced healthcare interpreter program highlighting that the service is free to providers and members and outlined ADA statements to reinforce the importance of interpreter services. Other barriers identified included privacy concerns while using third-party vendors like Language Line. To combat this, Advanced Health leverages in house Spanish speaking CSRs to outreach Spanish speaking members to explain the service and its benefits in the members preferred language.

Toward the end of 2022 there was a decrease in utilization of the in-house interpreter services. This may be in part due to providers having their internal staff trained as qualified/certified interpreters. A key goal from Advanced Health's Health Equity plan was to increase access to health care interpreters by increasing the number of OHA qualified and certified interpreters available locally for in-person, telephonic, and virtual language assistance. Training opportunities were identified, Advanced Health awarded scholarships to local individuals interested in becoming an OHA qualified or certified health care interpreter and offering services to Advanced Health members and the community.

In late 2022 we contracted with Krames, a technology driven solution and tool for educational Healthcare materials. Educational materials are offered in five languages including English, Spanish, and close-captioned video format for individuals who are deaf or hard of hearing. Materials can be sent in the mail or electronically or leveraged in the primary care setting. Finalization and provider education on the platform are planned for yearly 2023.

The Interagency Quality and Accountability Committee reviews and monitors the quarterly language interpreter services report and the annual Language Access self-assessment. The Interagency Quality Committee includes representatives from organizations representing physical health, behavioral health, substance use treatment, oral health, and non-emergency medical transportation services. The Committee meets monthly to review and discuss the data and identify new trends, needs, and services. The quality staff at Advanced Health continues to use the Tableau dashboard developed to improve identification of members requiring interpreter services and give feedback to provider organizations as to where members with limited English proficiency are accessing health care.

E. **Brief narrative description**:

Advanced Health's quality staff continues to work with the Interagency Quality Committee and the analytics team to improve data collection and reporting processes for the quarterly language interpreter services reports. The results of the quarterly reports will be monitored by the Quality Committee and will be presented to the Community Advisory Councils.

To increase access to OHA certified healthcare interpreters, Advanced Health expanded the existing Health Care Interpreter Program with Language Line Solutions in early 2022. The new program expands our member's access to not only additional languages but also creates the ability to have a face-to-face video interaction in their preferred language increasing accuracy and allowing for facial cues to be read by both the provider and member. This video enhancement has also allowed us to assist in community events for members with different cultural and language needs. Activities involve the training of staff, development, distribution of informational materials, and monitoring utilization.

Advanced Health's Qualified Health Care Interpreter has been an integral part of the community and community events including providing support for events such as the Annual South Coast Diversity Conference, South Coast Food Town Hall meeting, Catch the Wave Wellness fair, and System of Care Restoring Hope Health Festival by providing access to those who may not typically have it. In 2023 we will continue to hold Listening Sessions with various cultural organizations in

our community to better understand their challenges and needs in accessing care and approaches to serving members in a manner more compatible with their cultural health beliefs, practices, preferred language, and communication needs. The CCO will continue to improve and adapt our services to meet these needs of all members.

To increase the number of certified Health Care Interpreters within the provider network, Advanced Health Interagency Quality Committee and our internal Health Equity Steering Committee have worked to create and continue to offer scholarship programs to support local healthcare interpreters to become certified. This program offers a full scholarship for current bilingual allied health staff to become certified using any one of the OHA approved courses. This scholarship opportunity has been communicated regularly via the Interagency Quality Committee by dissemination of an electronic application process and resources on the OHA approved certification courses. Understanding the continued bandwidth issues faced by our community provider partners this scholarship will remain open until the allocated funding is exhausted. Anticipated to continue until all award funds have been exhausted or the need no longer exists within the community.

Interventions specific to member education, access to quality interpreter services and a culturally diverse provider network allow Advanced Health to break down language access barriers to ensure that members receive effective, understandable, and respectful care from all CCO staff and the provider network in a manner compatible with members' cultural health beliefs, practices, preferred language, and communication needs.

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

Activity 1 description: Award scholarships to local allied staff to become Certified Healthcare Interpreters listed on the Oregon HCI Registry.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Award of scholarships for providers to be trained			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
6 Scholarships awarded in 2022.	3 additional participants awarded scholarships for certification	12/2023	5 additional participants awarded scholarships for certification	12/2024

Activity 2 description: Hold listening sessions with culturally specific organizations to better understand barriers to care and approaches to serving members in a manner more compatible with their cultural health beliefs, practices, preferred language, and communication needs.

☒ Short term or ☐ Long term

Monitoring measure 2.1	**Number of listening sessions and barriers tracked at each listening session.**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
1 listening session completed in 2022.	2 Listening sessions completed	12/2023	3 Listening sessions completed	12/2024

Activity 3 description: Increase utilization of Health Care Interpreter Services, monitored via the Language Access Quarterly Reporting

OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health

☐ Short term or ☒ Long term

Monitoring measure 3.1				
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
19.1% of members receiving interpreter services in the healthcare setting (OHA rolling chart review Oct 1 2021-September 30 2022)	2% increase in number of members needing interpreter services received interpreter services	12/31/2023	2% increase in number of members needing interpreter services receiving interpreter services	12/2024

A. **Project short title**: Roadmap to Improved Behavioral Health Access and Integration

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

If continued, insert unique project ID from OHA: 46

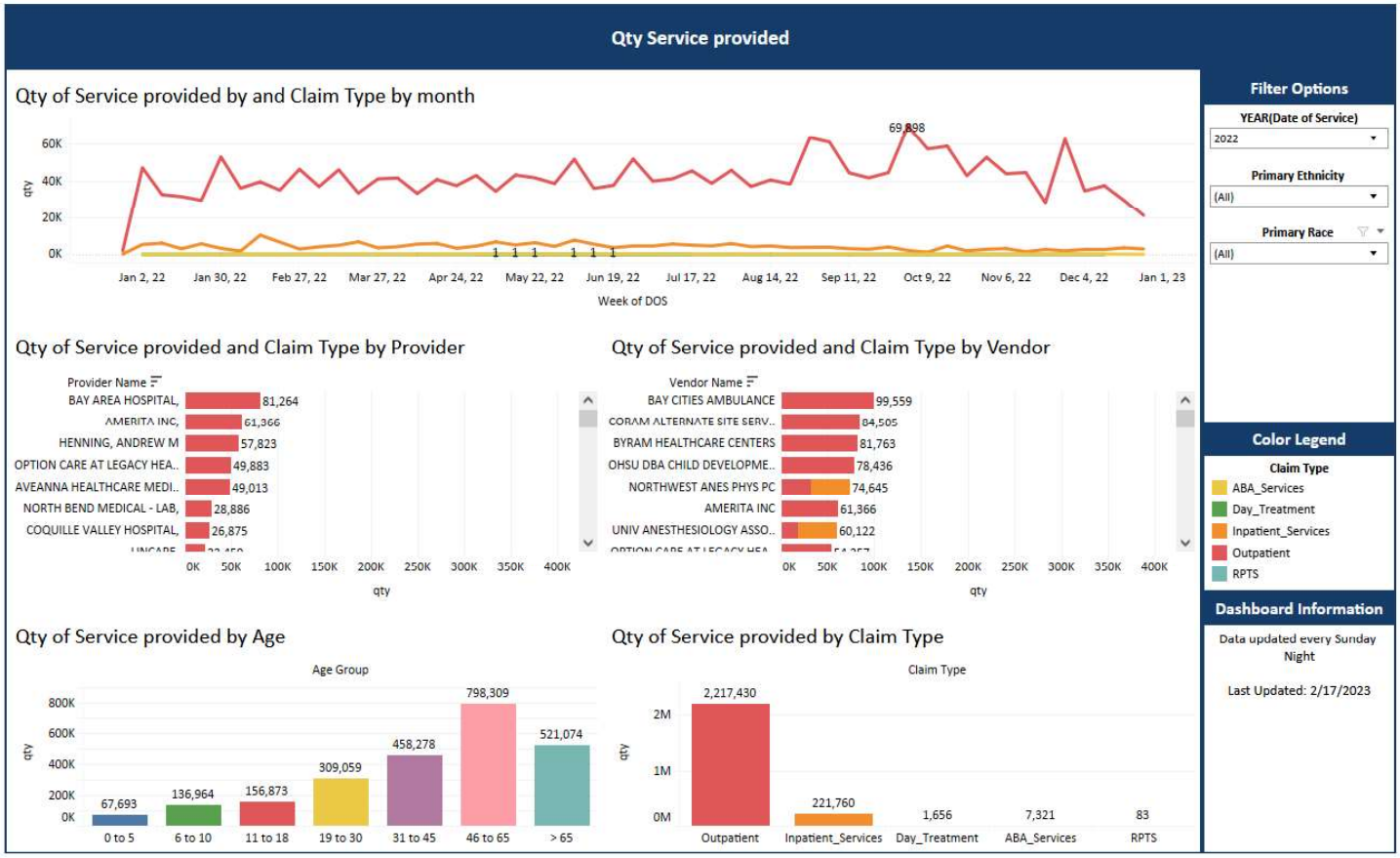
B. **Components addressed**

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

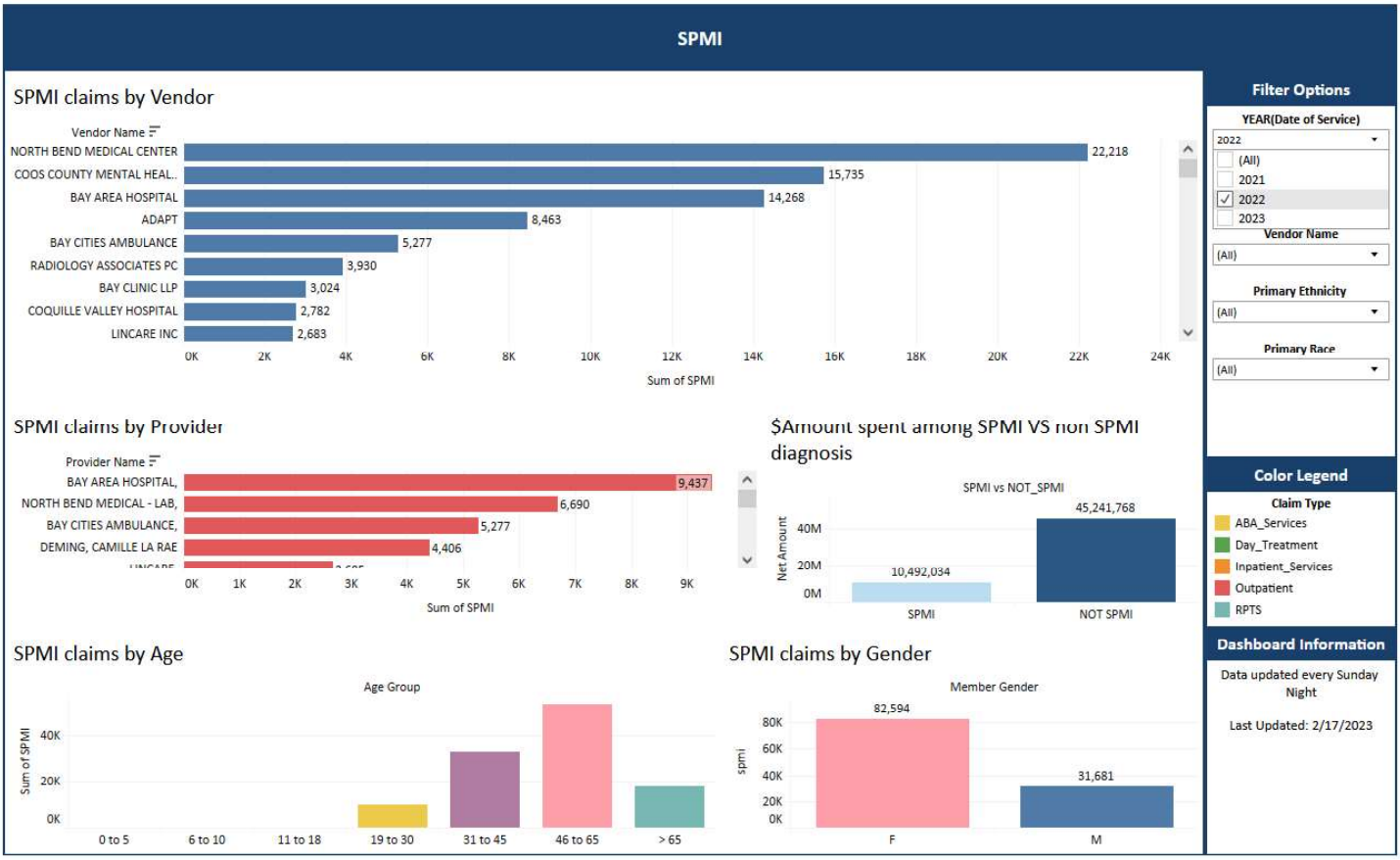
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

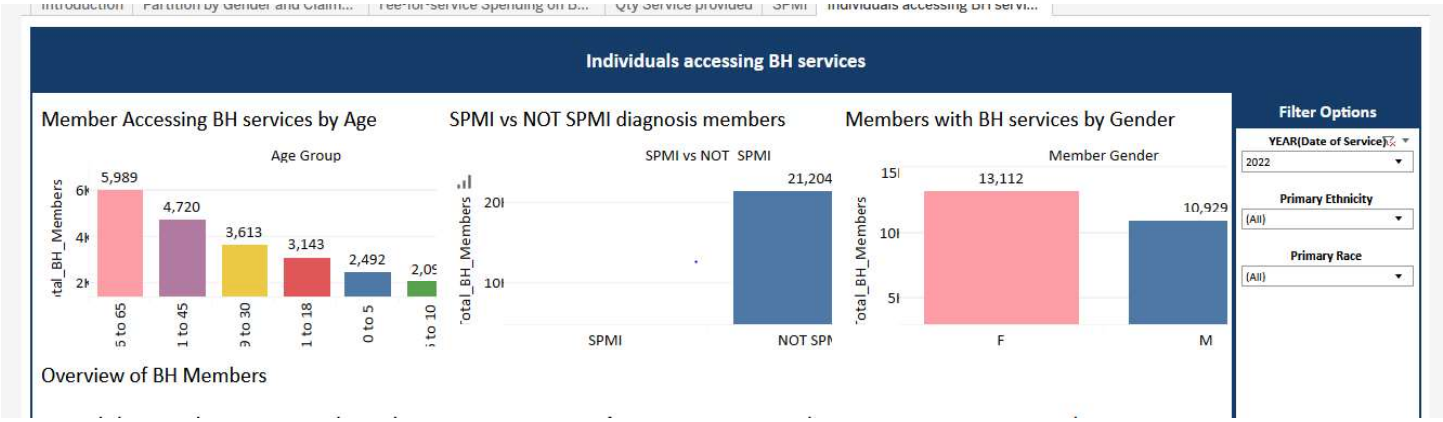
Advanced Health is currently serving approximately 27,497 Medicaid Members, up by 1,500 lives in 2022. Six months after the federal state of emergency pandemic response ends, we expect to see a significant decrease in membership once the redetermination process is implemented by the Oregon Health Authority (OHA). The decline in membership is expected be gradual over the course of about 12 months, after which membership levels are expected to remain two to three percent higher than pre-pandemic levels. We assume we will be serving more clients with mental health needs as the stresses and social isolation of the pandemic response continues to deteriorate the health and wellbeing of our population. The toll this pandemic has taken on the mental health of our communities will be felt for years to come, and we must be prepared to assist with the healing. The graph below shows us a good overview of mental health utilization and encounter data in 2022.

OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health



Advanced Health uses claims data to identify utilization of services by members with Serious and Persistent Mental Illness (SPMI) diagnoses. Through visualization of this data, a global picture is created depicting access to behavioral health services for members with SPMI as seen in the graph below. Claims can be filtered by types of services accessed including care coordination, therapy, and medication management to ensure equitable access for Advanced Health Members with an SPMI diagnosis. The stratification of members with an identified SPMI diagnosis in 2022 is listed below. Advanced Health will continue to track these data points to determine network adequacy and to ensure that members are receiving the appropriate care. The dashboard also allows Advanced Health to identify issues of health equity, ensuring all members have equal access to care.

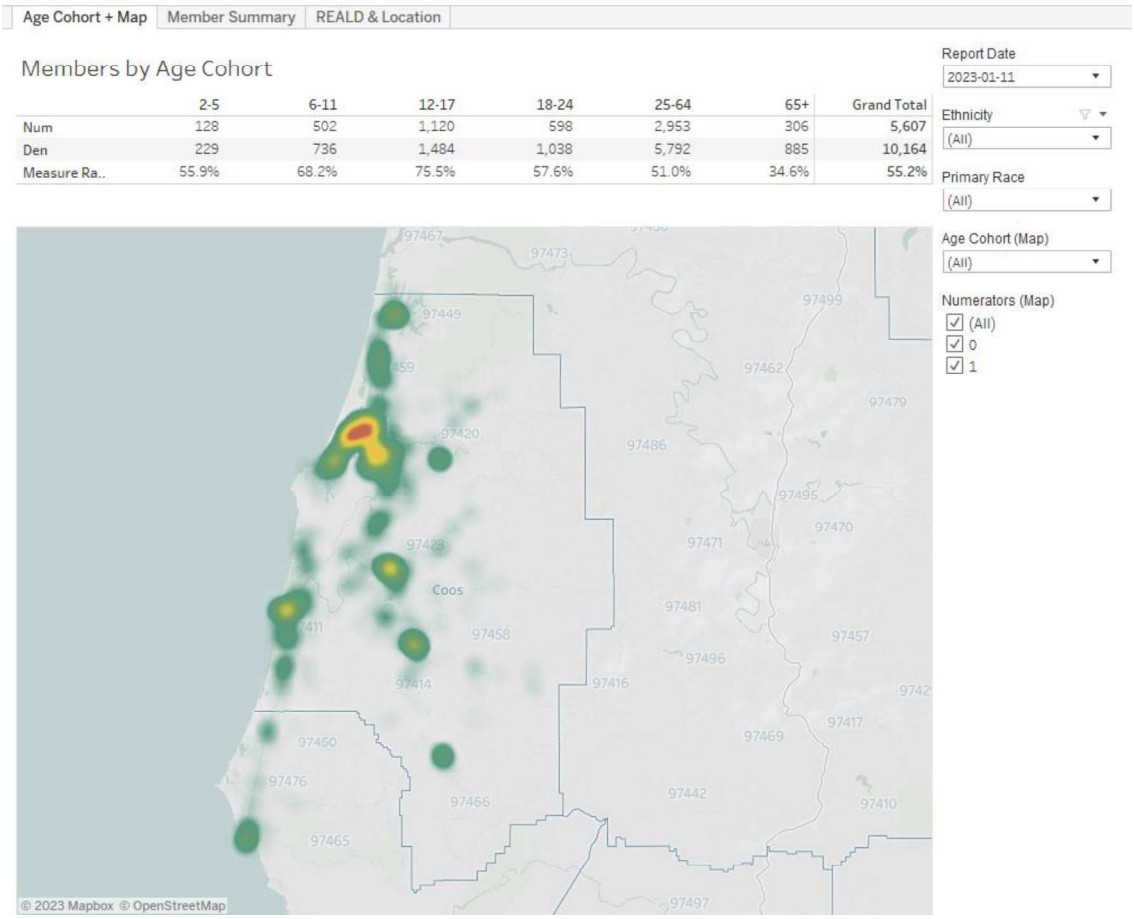




The graph above reveals that female members of Advanced Health utilize Behavioral Health services more often than male members. The internal use of REALD data has allowed Advanced Health to understand its member population and ensure that all written education and documentation is also available in Spanish.

Another way that Advanced Health analyzes claims-based data is via geographical location. The graph below shows a heat map of individuals with a behavioral health diagnosis based on zip code which allows us to better understand how we can improve access to care and care delivery options to better serve our members.

OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health



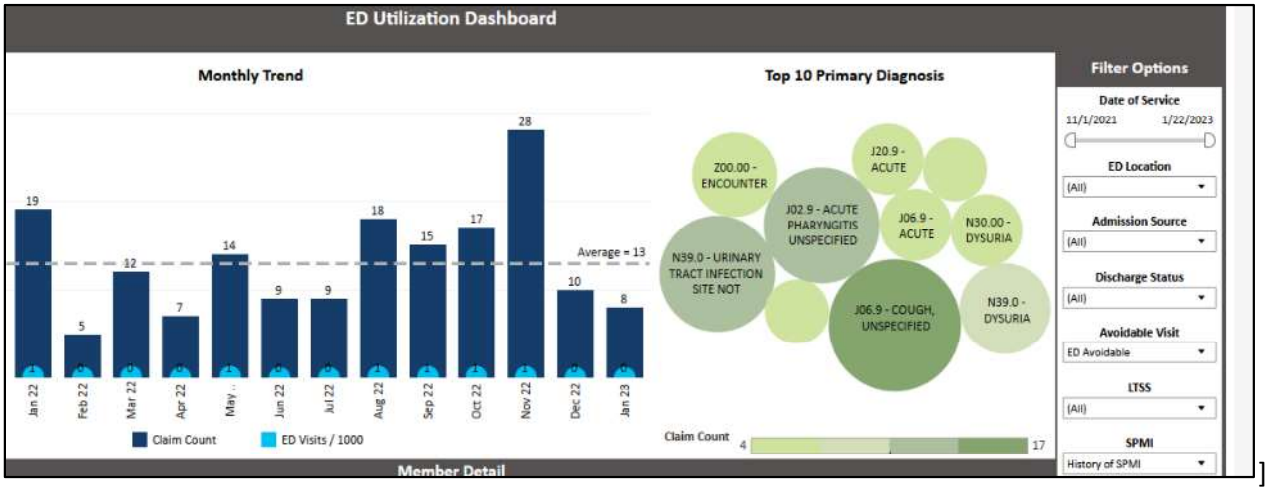
When addressing SPMI, Advanced Health utilizes a mixture of utilization data (claims) and member self-determination using the Health Risk Assessment (HRA) Screening tool. The HRA screenings are delivered to the member upon initial enrollment with the plan and annually thereafter. Members who do not respond to the mailed surveys are contacted by phone by customer service to ensure that all members needing additional services are identified. Members are also referred for additional services, including Intensive Care Coordination (ICC), through primary care providers, case managers, community, or social service organizations, or by self-referral or referral by a guardian or caregiver. Our new director of Customer Services is currently looking at ways to expand the information that is collected with the HRA while developing clear lines of communication to share the needs of specific members with ICC, and local care providers when indicated.

Advanced Health also has a dashboard to identify specific members with an SPMI diagnosis, REALD characteristics, and determine what services they are accessing to evaluate the need for additional services including Assertive Community Treatment (ACT), Early Assessment and Support Alliance (EASA), or Intensive In-home Behavioral Health Treatment (IIBHT). Individual cases are staffed by the ICC director with the ICC teams to evaluate high-needs members for care coordination and possible linkages to other special services with the goal of preventing crisis and relapse by providing a robust, member-centered treatment plan and working with the member to meet their health care goals.

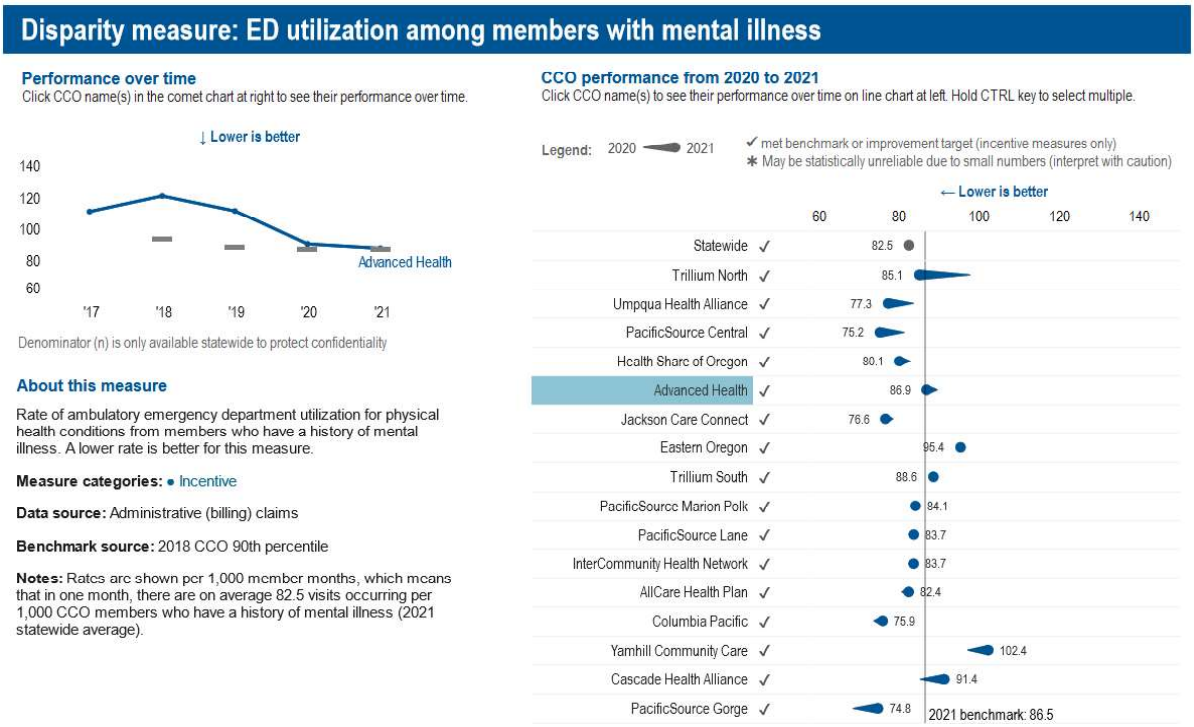
Additional ways Advanced Health monitors utilization of behavioral health services is through the statewide Performance Improvement Project (PIP) stratified by REALD data. The dashboard is claims-based and built to statewide PIP specifications and allows Advanced Health to monitor access to Behavioral Health services on demand and quarterly for PIP progress report submission. Data analyzed and reviewed from this dashboard fuels interventions for improvement, outlined in our quarterly PIP report submissions.

OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health

Advanced Health monitors utilization of Emergency Department services for members with SPMI through an internal claims-based dashboard. Findings are reviewed at least annually with Advanced Health's Interagency Quality and Accountability Committee and are used to fuel interventions for the Emergency Department Utilization PIP report submitted quarterly. This dashboard also incorporates filters for REALD data elements. The rate of ED utilization among members with SMPI remains low and steady with an average of 13 claims per month.



OHA data from 2021 shows Advanced Health performing slightly above the benchmark on this measure at 86.9/1,000 MM. Advanced Health has shown a steady decline of ED utilization for members with SPMI since 2018 which can in part be attributed to the public health messaging with the onset of the Covid-19 pandemic. Additional credit is given to Advanced Health's effort in messaging the Behavioral Health benefits to members and increasing access to care.



OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health

The stratification of this data by REALD is standard practice for both internal claims-based dashboard as well as the OHA interactive dashboard. Review of Advanced Health specific data reveals an increase of Hispanic/Latinx and American Indian accessing Emergency Department services, each group over 90/1,000 MM.

Advanced Health utilizes a number of data visualizations to understand the broad scope of behavioral health services that are utilized in our community. The graph below, developed by the Systems of Care Committees throughout Oregon, leverages statewide claims data, stratified by REALD and captures utilization of Behavioral Health services by CCO and service region. This data is reviewed and analyzed through our local Systems of Care (SOC) groups with the aim to monitor access to Behavioral Health Care and identify disparities and gaps in services.

Advanced Health's geographical area of Coos and Curry counties made significant gains in terms of access to and availability of providers over the course of the previous year. Overall, Advanced Health has contracted with a total of 126 Behavioral Health and SUD providers. Advanced Health continues to accept applications to enter the network from providers meeting credentialing criteria.

In addition to direct contracting with independent providers and Behavioral Health organizations, Advanced Health utilized Integrated Behavioral Health clinicians at our four largest primary care clinics. These Integrated behavioral health teams are located in clinics that serve approximately 80% of Advanced Health members, allowing members and PCPs quick access to mental health consults. Integrated behavioral specialists are trained in referrals to specialty programs once a member has been identified as needing additional behavioral health or substance abuse services. While meeting with our integrated behavioral health teams in the surrounding clinics we heard just how important this role has been in strengthening the alliance of the physical wellbeing with mental health. Our local primary care providers lean heavily on their integrated behavioral health teams to meet the needs of our members swiftly, seamlessly, and effectively. The partnership is highly valued by the professional team as well as our members who have a warm hand-off and care within the same visit.

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

To address Behavioral Health access issues in our provider network, Advanced Health transformed the delivery system from delegation to direct contracting with providers in our community. Advanced Health continues to contract with the local CMHPs while expanding network providers to include individual behavioral health providers, independent practice and integrated behavioral health providers co-located in primary care and specialty clinics. This shift provided expanded and increased access to Behavioral Health services for all members, and particularly for those with serious and persistent mental illness (SPMI).

The service expansion created foundational changes to services to include:

- New contracts with local mental health providers allowing a broader network for Members to choose from.
- Greater accountability for mental health programs including more fee-for-service encounters, incentivizing agencies to increase services to Members.
- Integrated services for mental health services within medical clinics.
- Care coordination for high-risk members with Serious and Persistent Mental Illness.

The roadmap to improving behavioral health access and integration focuses on creating a data-driven approach to identify the high risk and vulnerable population of members with SPMI and then to extend that data to the behavioral health provider network. Analysis of multiple data sources available have led to the interventions outlined below which are monitored and reported in various OHA reports.

Advanced Health has built guidelines to ensure members with SPMI are not only connected with an appropriate Integrated Behavioral Health care team but also enrolled in Intensive Care Coordination Services (ICC), or Assertive Community Treatment (ACT), when needed, and offered Skills Coaching and Supported Employment. These care standards when utilized together provide a comprehensive treatment model to support members with SPMI in a member-centered, empowering recovery-based model.

The guidelines for the expansion of services are focusing on addressing the following needs:

- SPMI: Early intervention involves connecting members with SPMI with the appropriate levels of supportive services and decreases the need for higher levels of care. Ongoing monitoring and identification for this vulnerable group will be key to improved health outcomes.
- Cultural Considerations: Interventions must be targeted and culturally appropriate to be useful to members literacy and language needs.
- Access: Quality and adequacy of services
- Health equity: Implementation of identification and tracking mechanisms to better serve the SPMI population through identification, referral, and ongoing tracking.

Advanced Health continues to define the context of this project as it is written above. We are thoroughly committed to monitoring the needs of the member population with SPMI while focusing heavily on cultural considerations, access, and health equity strategies.

E. **Brief narrative description**:

Advanced Health collaborates with multiple community partners and providers to meet the needs of our members, increase access to services and improve member satisfaction with the Behavioral Health care system. These efforts are mainly focused on provider network, integrated settings, workforce, member education, funding community projects, care coordination, referrals and data sharing, networking, and collaboration.

Advanced Health serves members in Coos and Curry counties with a robust provider network including county and community based Behavioral Health programs. In Coos County, local County Mental Health Provider (CMHP), Coos Health and Wellness, (CHW) continues to have great success and positive outcomes. The program served an increased number of Advanced Health's youth members in 2022 through the Intensive In-Home Behavioral Treatment (IIBHT) program. CHW actively participates in all behavior health collaborations with our local hospital and provides immediate support to in-patient youth. The IIBHT team also bridges treatment needs of youth whenever an acute in-patient hospitalization is needed for those in the program. Additionally, the IIBHT team and/or the Intensive Care Coordination (ICC) team has provided supportive transitional services for both youth and family upon return home. Great outcomes and word of mouth has made it a well-known and sought after option for our highest risk youth.

The ACT team at Coos Health and Wellness has provided services to a substantial number of individuals, 32 members, who benefitted from the quality preventive care included with this program. Curry County's ADAPT ACT team served 4 Advanced Health members. While one might be able to deduce that this service assists with lowering our emergency room utilization for care, Advanced Health will be attempting to show this with statistical data in 2023. Advanced Health hopes to increase the number of members served and utilize Advanced Health's and CHW's ICC program to ensure those who need the additional care are referred to the ACT teams. This is a well paved pathway that also continues to grow as there were 418 referrals to ICC in 2022 up from 350 in 2021. The ICC team relies heavily on the use of Activate Care; a system that allows our teams to track ED visits, develop and share care plans with others, and wrap high utilizers of emergency services into higher levels of care within the community. The team continues to grow with the addition of nurses who have physical and mental health backgrounds, as well as Traditional Health Workers.

In Curry County, ADAPT was successful in building and supporting a robust Community Mental Health Program that includes a Mobile Crisis Team, outpatient Behavioral Health providers for adults/youth/families, Psychiatric Nurse Practitioners (NP), Psychiatric Security Review Board (PSRB) services, case management, .370 Aid and Assist, fidelity programs, ACT/EASA/Wraparound/Supported Employment, Substance Use Treatment for youth and adults, and prevention services for problem gambling and suicide. Real time data analysis revealed a drop in referrals to ICC and ACT teams in Curry County in the last 6 months of 2022. Advanced Health continues to work closely with ADAPT via monthly meetings to aid in building processes, reporting, identification of members in need, data sharing, and the expansion of services.

Starfish is a program sponsored by Waterfall Community Health Clinic with the help of Advanced Health, that serves both children with mental health diagnoses as well as those with autism. The program launched in April 2021, and in its first year Starfish has served just shy of 200 individual patients; 45 of whom have autism. The program was expected to double in 2022, but nearly tripled, serving 740 individual patients and 124 of whom have autism. Starfish had 1405 ABA appointments rendered as well as 93 speech therapy appointments. The program looks to expand even further based on need demonstrated by the large waitlist. The center now employees two Behavior Analysts and hopes to expand ABA

services into the schools. AH was able to fund safe outdoor playground equipment this past year through our SOC grant process, a greatly needed and appreciated bonus for the children served by the center.

Historically and currently, workforce within our community is a barrier to access to care. In 2022, work began in collaboration with our local Southwestern Oregon Community College (SOCC) to develop an education pathway for Social Workers and Therapists that would support them through licensure while remaining in the area. This program is modeled after our local nursing program which has proven invaluable in combating nursing shortages over the past decade. After a year of collaboration between Advanced Health, SOCC and our local network of therapists and social workers a curriculum was successfully developed. This curriculum is currently undergoing the educational determination process with hopes of Fall 2023 implementation.

Member education on benefits and conditions is a key component to this roadmap. In late 2022, Advanced Health licensed KRAMES, a patient education platform. This comprehensive and multifaceted educational program leverages printable education, brochures, workbooks, and videos to educate patients on a variety of physical, mental health, and substance use disorders and illnesses in plain language that is health literacy centered. KRAMES offers clinically reviewed, evidence-based health content in easy-to-understand language that helps patients become a part of their health care experience and thus improving outcomes. This service will be available to the entire Advanced Health membership free of charge through the member-facing website. Provider office staff and case managers will be educated on how to assist members in navigating the website to find the information relevant to their health.

Coos County has built a highly functional Systems of Care (SOC) Governance structure and in 2022 Advanced Health was instrumental in the development of a Curry County Systems of Care Executive/Advisory Governance system. A separate Curry SOC structure will assist in receiving Grant funds specific to Curry Counties barriers and gaps in service for children, youth and families who experience healthcare inequities.

Coos and Curry SOC Grant funds are used to address a wide array of barriers submitted by youth, families, peer support specialists, family support specialists, and other paraprofessionals and supervisors in the child and family profession. Grant funds supported Be Strong Parenting Cafes that addressed Parenting needs, Youth Council development, LGBTQIA+ scholarship funds, Respite Care, Insurance funds for Coos Hispanic Allies, and Youth leadership training. SOC funds were also used to purchase Sensory Playground equipment to support Autistic children and youth in the Coos community. To address county wide cultural diversity the SOC Grant helped fund a pilot program for Social Emotional Development through South Coast Educational School District. Also, to increase cultural competency, the SOC funded Safe Zone Training for SOC and community members. Collaborative Problem-Solving Training (CPS) addressed significant behavioral health techniques for SOC members, school personnel, and health care professionals.

Wraparound Fidelity services continue to be operated by Kairos in Coos County and now ADAPT in Curry County. Kairos current served an average of 32 youth and families monthly during 2022 and ADAPT served five youth and families on average. Wraparound Review meetings are conducted twice a month in Kairos and once a month at Adapt. Both counties are actively involved with the schools and conduct regular presentations to each school district. ADAPT's Wraparound team this year has already exceeded the amount of youth and families served in the previous year.

In response to the growing need for clear referral pathways between our provider network and social service organizations, Advanced Health contracted with Unite Us, a Health Information Exchange. Unite Us will be the vehicle used to capture Social Determinants of Health screenings and referrals within our community and ensure easy access for all members to receive assistance with identified physical, mental health, and Social Determinants of Health needs. Advanced Health plans to recruit a robust network of users to the platform across both Coos and Curry Counties and use data gathered to fuel analysis and interventions aimed to address gaps in services in our community.

OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

Member care coordination has continued to be a large focus in 2022 as well. In addition to the community wide adoption of Epic in 2021, community and provider partners are also able to coordinate care plans through Activate Care. Activate Care is the software platform Advanced Health purchased to facilitate care coordination information and care plans and ensure timely outreach by care coordinators. Activate Care also allows those care plans and coordination information to be shared with the member directly as well, as other members of the care team outside of Advanced Health.

To further support care coordination for Transitions of Care (TOC) members, Advanced Health has approved and is hiring a patient navigator who will be placed in our largest hospital on the Southern Oregon Coast. They will assist patients who are transitioning out of the Emergency Department and inpatient hospital settings to continue to receive appropriate mental health care easily in the outpatient settings. This new role will monitor for social determinants of health gaps and needs of our members and work within the Unite Us platform to make referrals as needed and follow up with the patients to assure they received the support and help they needed. Making a warm hand off to programs such as ICC will also be a value and service we have struggled to hardwire.

Collaboration is one of the main avenues through which Advanced Health serves members with a robust network of healthcare and social services providers. The Behavioral Health team at Advanced Health participates in several community collaborative meetings monthly in Coos and Curry Counties. These meetings include cross-sector representation from the Behavioral Health provider network, law enforcement, social service agencies serving the houseless population, hospital psychiatric and emergency medicine liaisons, the South Coast Equity Coalition, youth-focused organizations, and consumer members through the Consumer Advisory Counsel. Meetings were well attended in 2022 and aimed to promote information sharing between organizations with the purpose of resource education, problem solving and networking. Highlighted below are some of the prominent projects that are the result of this collaboration.

Advanced Health appreciates the wide age range of its members and collaborates with our community to offer services that fill gaps in care discovered by data and network analysis. Specifically, in 2022, Advanced Health collaborated with our local branch of Youth Era to re-open their 'Coos Drop' center which paused in-person services during the public health emergency. By summer of 2022, Coos Drop recruited new members, developed a summer work program, and employed two youths to work in community gardens and at the Farmers Market. The Coos Drop program focuses on youth and young adults aged out from foster care, and low-income families. The last quarter of 2022 the Coos Drop was able to serve 28 new youth, with 11 youth provided housing assistance. Youth involved in these programs learned about mental health and behavior modification techniques to increase the likelihood of maintaining future employment.

In addition to offering services for youth in our community, Youth Era provides Applied Suicide Intervention Skills Training (ASIST) training to staff to ensure they are equipped to intervene with a youth who may be actively planning suicide. The Peer Support Specialist (PSS) model is used to assist at-risk youth in redirecting feelings to reduce being overwhelmed. Staff at Youth Era also encountered crises involving domestic violence and provided resources about healthy relationships and access to Safe, Advocacy, Freedom, Empowerment (SAFE). A Peer Recovery Specialist at Coos Drop has been instrumental in bridging the gap between schools and SUD programs/resources. Services offered by Youth ERA at the Coos Drop reached a total of 98 youth in our community just in quarters three and four of 2022.

With the efforts to reinstate services, Youth Era has pivoted their efforts to reach the youth of our community, using social media to recruit new members and market new programs like Photography club, Creative Writing Club, Tutoring, sewing class, support groups focused on the LGBTQIA+ population as well as a high school ambassador program.

Historically our community has operated in a siloed fashion which created difficulties in sharing information across all sectors of our healthcare and social services network. Over the course of 2022, this issue was addressed with the planning and development of a psychiatric full-service clinic and 1-800 psychiatric case management service called "The

HUB". This project is the result of the collaboration of many cross-sector organizations and led by Waterfall Community Health Center, a local Federally Qualified Health Center. The purpose of this project is to provide a sense of community, collaboration, support, and mentorship for behavioral health clinicians. The HUB will serve as a no-cost consultant service for both primary care and other psychiatric providers in our service area. The HUB will process referrals to clinicians based on patient need and timely access as well as offer education and Morbidity and Mortality reviews. The HUB is expected to be operational by quarter two of 2023.

Collaboration is at the heart of many of Advanced Health's interventions with the aim to increase the utilization of services available to our members in our community. Coos and Curry Counties are both rural with a large barrier to care being transportation. In addition to a robust transportation benefit, Advanced Health plans to partner with community organizations and providers to develop ways to bring healthcare to our less mobile members. Advanced Health's partners HIV Alliance and SUD providers Bay Area First Step and ADAPT are developing plans to develop pop up clinics in our more remote areas. Services offered at these clinic sites will vary based on the need but will include OHP application assistors for health plan enrollment.

Community behavioral health meetings, gatherings, and educational events will continue into this next year as they have proven to be successful in bringing this group of practitioners closer together. Support, referrals and understanding of resources available has been very beneficial. The HUB and Behavioral Health Coordinator will only serve to strengthen the network and make finding the right services at the right time for our members easier than ever before. This in turn will continue to be a highlight for provider recruitment into our rural area.

Advanced Health plans to continue collaboration with providers, members, partners, and the Oregon Health Authority to identify data needs in 2023. We have started work within the Systems of Care to identify data that we can provide that will better drive the work being done in the committee. Advanced Health, as previously mentioned, has not been able to build the all the necessary data sets due to lack of staffing within the analytics department. This team has recently become fully staffed and data requests are being identified and prioritized based on urgency of request. Once the appropriate dashboards are built, Advanced Health will offer access and education that will allow for ongoing initiatives aimed at identifying gaps in services with an emphasis on our most vulnerable populations. Data, along with our current venues to identify gaps and member needs such as SOC committee, Community Advisory Councils (CAC), grievances and appeals, claims, and prior authorizations, will provide the overall view of our Behavioral Health Delivery System Network. Advanced Health is eager to continue working with the community of providers in this effort. Advanced Health is also working on identifying additional areas of potential health inequities within our network with the goal of breaking down services accessed by race/ethnicity and language. We continue to reach out in SOC and CAC meetings where we have great community member engagement to identify gaps and look for solutions that readily meet our members' needs.

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

Activity 1 description: Identify additional Licensed Behavioral Health Providers and expand contracted network to increase access to Behavioral Health services.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Identify Behavioral Health providers not contracted with Advanced Health and practicing in Coos and/or Curry County and work to contract with them to bring them into the Advanced Health provider network.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
270 contracted providers in Q4 2022 DSN Provider Capacity Report	280 contracted providers by the end of 2023	12/2023	290 contracted providers by the end of 2024	12/2024

Activity 2 description: Rollout Tableau dashboards to community providers.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement:

Monitoring measure 2.1	Train and implement Tableau Dashboard for community providers. Monitor percentage of providers actively using software and number of Members actively enrolled in behavioral health services. Due to Covid restrictions and pandemic-related strains on the local health care system, these targets and benchmarks are still in the development phase. Advanced Health will continue to engage with providers to educate on access and provide community-based solutions.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No documented procedure	Develop written procedure to monitor dashboards and reach out to providers	05/2023	Roll out dashboards and procedure to community providers	08/2023
No improvement targets set	15% of providers actively engaging with data	06/2023	25% of providers actively engaging with data dashboard	12/2023

Activity 3 description: Increase ACT team capacity and monitor utilization of services.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement:

Monitoring measure 3.1	Increase in ACT services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
37 clients served (CY 2022)	50 clients served	12/2023	Maintain capacity to serve 50 clients per year	12/2024

A. **Project short title**: Patient-Centered Primary Care Home Advancement and Enrollment

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

If continued, insert unique project ID from OHA: 361

B. Components addressed

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

The advancement in PCPCH enrollment has not been linear for Advanced Health and its provider network. Multiple barriers to attestation and obtainment of higher tiers have existed since 2020 due to the pandemic response. A combination of reduction in tier obtainment and fluctuation of providers at higher tier practices impacted the weighted PCPCH rate, which was 75.6% and below the statewide average for 2021.

Clinic and provider technical assistance continued to be the methods for improvement efforts in 2022, leveraging in-house subject matter experts and peer clinics. Due to the timing of the attestation cycles, we had few clinics working toward attestation in 2022. Of those who were, the CCO provided valuable one-on-one technical assistance when requested. Advanced Health anticipates the overall performance on the weighted PCPCH enrollment measure to improve over 2021 and be at or above the statewide average mainly due to retention of 5-star status for the two largest clinics in the provider network. In 2022, one clinic returned to PCPCH tier 3 recognition after failing to re-attest it in 2021. As anticipated, this increased the percentage of members empaneled at a tier 3 clinic to 15%.

It has always been the policy of Advanced Health to promote patient choice and continuity of care in the Primary Care Provider assignment process. Previously eligible members who come onto the plan are assigned to the last provider they were assigned to prior to loss of eligibility for continuity. Brand new members are assigned based on which providers have access. Advanced Health Members can call at any time during their eligibility to request specific providers to accommodate patient choice. Advanced Health has 82 individual primary care providers at current PCPCH clinics all accepting member assignments, which makes the possibility of PCPCH assignment high. By supporting clinics in achieving either first time PCPCH recognition, or increasing tier status, Advanced Health is increasing the possibility of member empanelment at a PCPCH recognized clinic.

The Advanced Health member population is categorized through REALD data as predominately White with 61% of the population identifying as White. The second largest group is Hispanic and Latino/a/x at 3.4%. Just over 30% of the race and ethnicity data is listed as “unknown” or “declined to answer.” English is the predominant primary language for our membership with the primary language being English for nearly 98%, and our second largest group speaking Spanish at almost 1.2%.

SOGI data is not yet available from OHA, but Advanced Health intends to incorporate this data into our internal metrics and demographic dashboards when it becomes available. Advanced Health is in the exploration stage of discovering other avenues to collect REALD and SOGI data including Electronic Health Record and Community Information Exchange data. However, this data has its limitations based on the Electronic Health Record in use and will be used as supplemental only due to the concerns around completeness.

OHA’s final calculation of CCO performance rates are not yet available for 2022. Advanced Health’s overall performance is still expected to improve over the 2021 rate as the majority of Advanced Health members are still enrolled with a 5

Star PCPCH clinic. The details on Advanced Health's year-end 2022 PCPCH member assignment at all tier levels is given below. At the end of 2022 there were 10% of members (or 2,645 members) receiving PCP care with a provider not recognized as a PCPCH. This is a decrease from 12% (or 2,985 members) at the end of 2021, which is an improvement in the overall proportion of members empaneled at PCPCH recognized clinics, even as total membership continued to rise in 2022.

PCPCH Recognition Level	Number of Members Assigned	% of Total Advanced Health Members
5 Star	14601	53%
Tier 4	6101	22%
Tier 3	4010	15%
Tier 2	0	0
Tier 1	0	0
Not recognized	2645	10%

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

At the end of 2022, the largest provider in Advanced Health's network; North Bend Medical Center retained their PCPCH 5-star status at its main Coos Bay location. With Bay Clinic also retaining their PCPCH 5-star status in 2022, 53% (14,601) of our members were empaneled at a 5-star recognized clinic. Advanced Health currently has 10% of its members empaneled at non-PCPCH recognized clinics, which is a byproduct of the multiple single provider or small multi-provider clinics we have in our rural area.

Coquille Valley Hospital obtained Tier 3 PCPCH status in early 2022 and plans to maintain this through the next accreditation cycle as they manage other clinic priorities. Their PCPCH status had lapsed in 2021. Waterfall Community Health Center has two locations that are PCPCH recognized, the Coos Bay location is their main PCPCH clinic which obtained Tier 4 in 2021 and plans to maintain Tier 4 during the accreditation process in quarter two of 2023. The North Bend Location is a School Based Health Center which obtained tier three after a site visit in 2021 and plans to obtain tier 4 during the accreditation process in quarter two of 2023. Waterfall Community Health Center has clinic specific goals and interventions for the upcoming year focused on workflows and specific Process Improvement Projects.

Brookings Harbor Medical Center, Curry Medical Center, Oak Street Health Center, and Dr. Mike and Friends Pediatrics retained their Tier 4 status throughout 2022. The satellite locations of North Bend Medical Center in Coquille, Bandon, Myrtle Point, and Gold Beach who have historically obtained tier 3, each attested to Tier 4 in December of 2022 with review and site visits pending.

Southern Coos Hospital and Health Center, who has historically not been PCPCH recognized plans to attest in 2023 with the hopes of obtaining tier 3 recognition. At the end of 2022 there were 583 members assigned to Southern Coos Hospital and Health Center which would provide an anticipated increase in the percentage of members empaneled at a tier 3 PCPCH clinic to 17%.

E. **Brief narrative description**:

As of December 31, 2022, 90% of Advanced Health members had a source of primary care with a PCPCH recognized clinic. This is due in part by the number of clinics who maintained tier status and our largest clinics who hold a large majority of our member population retaining their 5-Star recognition status. Advanced Health is committed to offering technical assistance in the form of learning collaboratives, general PCPCH education and one-on-one sessions with clinic

who aim to increase their tier status or attest for the first time. Throughout 2022 Advanced Health held discussions with clinics to better understand their PCPCH goals and barriers to tier advancement and found that the residual effects of the pandemic kept the clinics focused on maintaining rather than achieving higher tier levels. The PCPCH recognition process and resources are reviewed at least annually via the Interagency Quality and Accountability Committee (IQAC), and on demand between clinic partners and the Advanced Health Quality team. These approaches allow for clinics to leverage the combined experience and knowledge of their peers as well as other resources available through the CCO.

In 2023, Advanced Health plans to continue to offer education and resources for PCPCH tier advancement and recognition with a focus on assisting new PCPCH clinics as they navigate the attestation and site review process. Due to the specific nature of the technical assistance requested by each individual clinic, it has been a challenge for Advanced Health to implement technical assistance that is value added on a large scale.

In 2023 Advanced Health plans to engage a sub-committee of the IQAC to focus on PCPCH focused technical assistance. This group will hold quarterly "office hour" meetings with peer clinic subject matter experts who will be available to answer questions about recognition criteria, share how they meet the aim of standards, and offer example workflows they have established to ensure compliance and performance. The goal of these meetings is not to have every clinic present, but to have clinics feel that the office hours are a valuable addition to their knowledge base and a resource when they encounter questions along the way. This is reflected in the monitoring activity below.

Monitoring of member empanelment via the quarterly Delivery System Network (DSN) report provides real time analysis of the impact of membership churn and assignment methodologies on the overall performance of the Patient-Centered Primary Care Home enrollment metric. Due to the current empanelment of over half of our members at a 5-Star PCPCH clinic, new PCPCH clinics added and assignment of new members to established clinics is not anticipated to make a large impact. This is reflected in the goals set in the monitoring activities below.

The community-wide Epic implementation in Mid 2021 halted the steady stream of reliable Electronic Health Record Data forcing the progress on the MedInsight provider portal to stop completely. The primary and only focus of the collaboration with this third-party vendor became consumption of EHR data for the incentive measure reporting. By the end of 2022 this process was improved but not perfected and the focus remained the same. With the data consumption and reporting process expected to stabilize in early 2023, it is the hope of Advanced Health to return to efforts to provide a robust provider portal for real-time performance on quality measures. In the meantime, however, this monitoring activity has been removed to make room for other interventions.

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

Activity 1 description: Establish IQAC sub-committee lead by CCO quality staff and peer clinic subject matter experts, focused on providing education and resources for PCPCH recognition and tier advancement for clinics in our network.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Establish IQAC sub-committee and monitor attendance by clinic representatives			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No Sub-committee established	Sub-committee established lead by CCO quality staff and peer clinic subject matter experts	6/2023	4 Quarterly Meetings held	06/2024

No utilization of "office hours" meetings	3 clinics represented at each meeting	12/2023	6 clinics presented at each meeting	12/2024

Activity 2 description: Monitor both the PCPCH tier levels of primary care providers in the Advanced Health network and the proportion of Advanced Health's membership assigned to PCPCH recognized clinics. Targets are set based on anticipated changes as the clinics achieve their goals for 2023 PCPCH tier attainment.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Monitor progress quarterly as part of the DSN capacity reporting process.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
90% of Advanced Health members receive primary care from a PCPCH (Q4 2022 reporting)	92% of Advanced Health members receive primary care from a PCPCH	12/2023	94% of Advanced Health members receive primary care from a PCPCH	12/2024

Activity 2 description: Improve CCO performance on Patient Centered Primary Care Home (PCPCH) weighted enrollment metric. Return to performance over the statewide average.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Monitor progress annually for PCPCH weighted enrollment metric			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
75.6% weighted enrollment (MY 2021)	77% weighted enrollment	12/2023	78% weighted enrollment	12/2024

A. **Project short title**: Improved coordination of care and increased depression screening and follow up for FBDE LTSS members with SHCN in a Medically Underserved and Health Professional Shortage Area

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

If continued, insert unique project ID from OHA: 409

B. **Components addressed**

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

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) for the component(s) selected with CCO- or region-specific data.

Advanced Health's previous Community Health Assessment (CHA) in 2018 was a look into the health status of our citizens and provided a better understanding of key health issues facing our communities and direction for planning of improving services to the more challenging areas. Our CCO's approach to gathering data included expanding their efforts into hospitals, federally qualified health centers, public health, tribal services, and other human service organizations. The CHA committee recognized our community's social determinant of health (SDOH) factors strongly influence health inequities which can affect access to health care services. Many community health models suggest that up to 40% of the health in the community is related to socioeconomic factors. Access to providers and lack of specific health services was determined to be a one of the top barriers for our members as further indicated by an Oregon Health Sciences University study in 2016 and as indicated by the Oregon Office of Rural Health which has designated Coos and Curry Counties as a Medically Underserved Area (MUA) and Health Professional Shortage Area.

Our CCO service area has a high percentage of the population on publicly funded insurance which includes Medicare, Medicare, and Veterans. 2017 estimates from Oregon DMAP and RUPRI, shows that 62.5% (Coos) and 65.8% (Curry) of the population is on Medicaid, Medicare, or both. The age distribution of residents receiving Medicaid is older in Coos and Curry Counties than in the state as a whole.

According to our recently submitted Care Coordination Activities Report to OHA, Advanced Health has approximately 7,700 members eligible for ICC services of which include over 600 FBDE LTSS members and less than 40 Pacific Source Medicare Advantage Members.

Mental health and depression were listed as top concerns by the 2018 CHA focus groups and survey participants. Self-reported mental health issues and depression also show higher rates in Coos and Curry counties than statewide, for both adults and youth. Nearly one in three adults in Coos County indicate they are struggling with depression.

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

Within our CCO's membership are Full Benefit Dual Eligible (FBDE) individuals with chronic conditions and SDOH needs that are receiving Long Term Services and Supports (LTSS). Meeting the intention of OAR 410-141-3860, FBDE Long-Term Services and Supports (LTSS) members are considered one of the Special Health Care Needs (SCHN) population groups given priority for referral to our Intensive Care Coordination program because these members experience a higher degree of complex medical issues, comorbidities such as depression, hospitalizations, higher healthcare costs and are known to have trouble in successfully attending their primary care appointments. Individuals needing LTSS include older adults and younger people with intellectual and development disabilities, physical disabilities, behavioral health diagnoses, spinal cord, or traumatic brain injuries, and/or disabling chronic conditions and can experience many SDOH barriers such as poverty, inadequate transportation, and lack of access to medical providers. Through the development of this TQS project, our team has discovered that a very low percentage of these LTSS members are being screened for depression and subsequently did not receive follow up peer support or mental health care.

Due to the high SDOH needs of FBDE LTSS members and other priority population groups, OHA concurrently required the CCO to stand up an Intensive Care Coordination program and significantly improve our administrative partnership and population tracking abilities between Advanced Health and the Oregon LTSS system. Advanced Health's Intensive Care Coordination (ICC) program offers care coordination services to Advanced Health Members that have been identified as in need of specialized health care and our updated memorandum of Understanding (MOU) with LTSS required the CCO to strengthen our partnership, quality of care, and enhance our coordination efforts. Advanced Health

tracks monthly interdisciplinary team meetings, referrals, sharing of care plans, and improved use of the Collective Medical health information exchange and hospital event notification system.

Advanced Health's ICC program provides care planning and gathers information on our priority population groups through the administration of our initial ICC referral screen and social needs assessment, the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) for every member that agrees to participate and enroll. The ICC referral screen indicates mental health symptoms as a significant concern and 43% are worried of losing their home, 40% are unemployed, 48% were unable to get the medical care needed, and 13% stated transportation has kept them from medical appointments or getting their medications. Of the members in ICC care who were assessed in 2022, 99% speak English, with the primary race being White (86.9%) followed by American Indian/Alaskan Native (3.27%), and Hispanic/Latino (1.3%).

E. **Brief narrative description**:

Advanced Health's ICC team will increase their coordination of care for the FBDE LTSS subpopulation group by continuing to strengthen partnerships, monitor referrals, increase use of Collective Medical, and creation of new referral pathways. Advanced Health plans to maintain the collaboration with local APD/LTSS partner and associated Pacific Source Medicare Advantage Plan as well as continue CCO/APD interdisciplinary team monthly meetings. Additional focus areas for 2023 include promoting the use of the Collective Medical notification system and creating a new referral pathway to Intensive Care Coordination services by identifying FBDE LTSS members who have not been screened for depression in the primary care setting. Data collected through the Electronic Health Record based quality incentive measure for depression screening and follow up will allow Advanced Health to understand the FBDE LTSS population meeting denominator requirements who are not receiving depression screenings in the primary care setting. Analysis of the 2022 performance filtered to members with LTSS revealed only 2% of FBDE LTSS members were screened for depression and if positive had a follow up plan which is a significant disparity compared to the CCO average rate of 19.7%.

Advanced Health's ICC team plans to use this data source to identify FBDE LTSS members who have not yet received screening for depression in the measurement year for outreach and coordination with their primary care provider. Through this outreach and coordination, Advanced Health anticipates an increase in the rate of FBDE LTSS members screened for depression as outlined in the metric below.

Mental Health First Aid is a nationally recognized course that teaches individuals how to identify, understand, and respond to signs of mental illness and substance use disorders. The training improves staff skill in reaching out, providing initial help and support to someone who may be developing a mental health, substance use problem, or experiencing a crisis. Advanced Health staff trained in the program increase their knowledge of mental health, can identify professional and self-help resources, show reduced stigma and increased empathy, increase their confidence in helping an individual in distress, and utilize the skills and information to manage their own mental health. This training is scheduled for ICC and Member Services staff in the Spring and Fall of 2023.

In 2022, Advanced Health made over 7,000 outreaches to members enrolled in ICC. According to our recently submitted Care Coordination Activities Report to OHA, Advanced Health has approximately 7,700 members eligible for ICC services of which include over 600 FBDE LTSS members and less than 40 Pacific Source Medicare Advantage Members. Our ICC program will continue to increase the penetration rate into the FBDE LTSS membership by focusing on the mental health needs of these members ensuring they are being screened and referred to the proper mental health services either in their provider's office or by ICC staff themselves.

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

Activity 1 description: Train CCO staff in Mental Health First Aid (MHFA) to increase their ability in recognizing the signs and symptoms of depression and make the proper follow up referral for mental health care.

☒ Short term or ☐ Long term

Monitoring measure 1	**Participate in training**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No staff are currently trained in MHFA	Document 50% of ICC and Customer Service staff are MHFA trained.	12/2023	Document 100 % of ICC and Customer Service staff are MHFA trained.	12/2024

Activity 2 description: Increase rate of depression screening and referral for FBDE LTSS members.

☐ Short term or ☒ Long term

Monitoring measure 2.1	**Track number of APD referrals to the ICC Program**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Average of 2 referrals per month for 2022	Document 50 % percent increase in the number of LTSS members referred to the CCO for ICC and CM services/ supports Track REALD and SOGI data to ensure equitable referral process	12/2023	Document 100 % increase of LTSS member referred to the CCO for ICC and CM services/ supports Track REALD and SOGI data to ensure equitable referral process	12/2024

Monitoring measure 2.2	**Monitor rate of depression screening and referral for FBDE LTSS members**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2% of FBDE LTSS members receiving screening and referral for depression in primary care (CY 2022)	4 percentage point increase in rate of FBDE LTSS members receiving screening and referral in primary care	12/2023	4 percentage point increase in rate of LTSS members receiving screening and referral in primary care	12/2024

Activity 3 description: **Establish a process evaluation and outcome evaluation for our shared FBDE Medicare Advantage Pacific Source Members for tracking and improvement of depression screening.**

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: **Collaborate with Medicare Advantage Pacific Source to screen FBDE members for depression.**

Monitoring measure 3.1	**Standardize process for depression screening for Medicare Advantage Pacific Source FBDE population**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No process exists for tracking of administered PHQ-9	Collaborate with Medicare Advantage Pacific Source to develop a process to track depression screening	6/2023	Incorporate Pacific Source depression screening and follow up data into overall project	12/2023
Monitoring measure 3.2	**Track percentage of Medicare Advantage Pacific Source FBDE members that receive a PHQ-9 depression screening**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of Medicare Advantage Pacific Source FBDE members screened for depression	25% of Medicare Advantage Pacific Source FBDE members screened for depression Track READLD and SOGI data to ensure equitable screening process	12/2023	50% of Medicare Advantage Pacific Source FBDE members screened for depression Track READLD and SOGI data to ensure equitable screening process	6/2024

Activity 4 description: **Maintain CCO/APD Interdisciplinary Team (IDT) monthly meeting to coordinate FBDE LTSS members.**

☒ Short term or ☐ Long term

Monitoring activity 4 for improvement: **Maintain partnership between the CCO and APD LTSS system.**

Monitoring measure 4.1	**Track number of monthly IDT meetings for FBDE LTSS members**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
CCO/APD IDT care coordination meetings scheduled twice per month in 2022.	Increase CCO/APD IDT meetings by 100% per month.	12/2023	Increase CCO/APD IDT meetings by 100% per month	12/2024
Monitoring measure 4.2	**Track number of individual FBDE LTSS members whose data is shared between CCO care coordinators and APD case managers**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

18 LTSS members per month in 2022	Document 20 % percent increase of LTSS members prioritization data shared between the CCO and APD	12/2023	Document 20 % percent increase of LTSS members prioritization data shared between the CCO and APD	12/2024

Activity 5 description: **Build Activate Care workflow to include the administration of PHQ-9 screenings of FBDE LTSS ICC members.**

☒ Short term or ☐ Long term

Monitoring measure 5.1	**Standardized process for depression screening for FBDE LTSS ICC population**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No workflow exists for administration and tracking of PHQ-9 in Activate Care	Develop a workflow to administer and track PHQ-9 screening in Activate Care	6/2023	Incorporate Activate Care workflow into ICC process.	12/2023
Monitoring measure 5.2	**Track increase of FBDE LTSS ICC members that receive a PHQ-9 depression screening**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of LTSS members screened for depression using PHQ-9	25% of LTSS ICC members screened for depression using PHQ-9 Track READLD and SOGI data to ensure equitable screening process	12/2023	50% of LTSS ICC members screened for depression using PHQ-9 Track READLD and SOGI data to ensure equitable screening process	12/2024

A. **Project short title**: Integrated Clinical Pharmacist

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

If continued, insert unique project ID from OHA:

B. **Components addressed**

i. Component 1: 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 READL data. This is broader than the specific TQS project.

Utilization review is the process of reviewing, evaluating, and ensuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

Utilization of care is directly linked to quality of care in the way that is indicates proper management of chronic conditions, preventive services, access to care and promotes improved health outcomes. Advanced Health promotes utilization of services in many ways; reduction of barriers to accessing care, a robust provider network, and continuous monitoring of claims data for utilization trends. Advanced Health also pairs with Milliman analytics to better understand our member population, the services they utilize, and the chronic conditions they manage through analysis and predictive analytics.

Advanced Health's Interagency Quality and Accountability Committee serves as evidence of the collaboration and coordination between Advanced Health's leadership, contracted organizations, and community partners in monitoring the quality, accountability, and utilization review activities of the entire CCO. In addition to continuous monitoring of incentive measure dashboards which provide analysis of utilization of preventive services, Advanced Health captures data on our referral process, including approved, denied or cancelled authorizations to further reduce barriers to access to specialists and second opinions for our member population. It was thorough review of these dashboards that unintended barriers were identified and mitigated through changes to the prior authorization process. The same is true for pharmacy benefits and our formulary.

Advanced Health maintains and monitors internal claims driven dashboards, which are used in the analysis of utilization including both under-utilization and over-utilization of services. These dashboards are reviewed internally quarterly and with the IQAC at least annually. Advanced Health has continued to incorporate READL data for claims driven dashboards which allows for analysis of utilization trends and the detection of disparities. SOGI data will be incorporated when available.

In 2022, overall utilization for preventive services for the 0-18 population is slowly recovering since the onset of the Covid-19 pandemic. Performance on the Adolescent Well Care Visits for ages 3-6 dropped dramatically in 2020, with a slight increase in 2021. Final performance on this measure for 2022 is not yet determined, however our internal claims-based dashboards reflect the efforts to improve utilization of preventive services for this age group with a rate that is more aligned with pre-pandemic performance.

Our internal dashboards are also stratified by READL data, which allows for the identification of disparities. For Children 3-6 years old who meet denominator criteria for the Adolescent Well Care visits incentive measure, 69% identify as Hispanic. In addition, this race/ethnic group generate 63% of the numerator compliant visits. This supports the open access to preventive services for this age group regardless of race/ethnicity, language, or disability.

In addition to the utilization of preventive services, Advanced Health also monitors the use of Emergency Department Utilization. This allows our internal teams to monitor and build interventions to address over utilization. In 2022, Emergency Department Utilization remained low at 46.7/1,000mm as per the most recent OHA rolling dashboard. This is in line with performance since 2020.

Emergency Department utilization for Advanced Health members identified as having Spanish as their primary language was minimal during 2022. On average, 10 claims a month with increased utilization in November and December for reasons like chest pain, fever, and cough.

Monitoring outpatient utilization can be an indicator for the level of access within our provider network, Advanced Health does this by reviewing the OHA rolling dashboard, which calculates the rate of Outpatient utilization of services. The most recent OHA rolling dashboard has outpatient utilization at 248.7/1,000 which continues the downward trend since 2019 (317.1/1000). This steady decline in utilization of services is mainly attributed to the public health messaging to avoid preventive care that coincided with the pandemic.

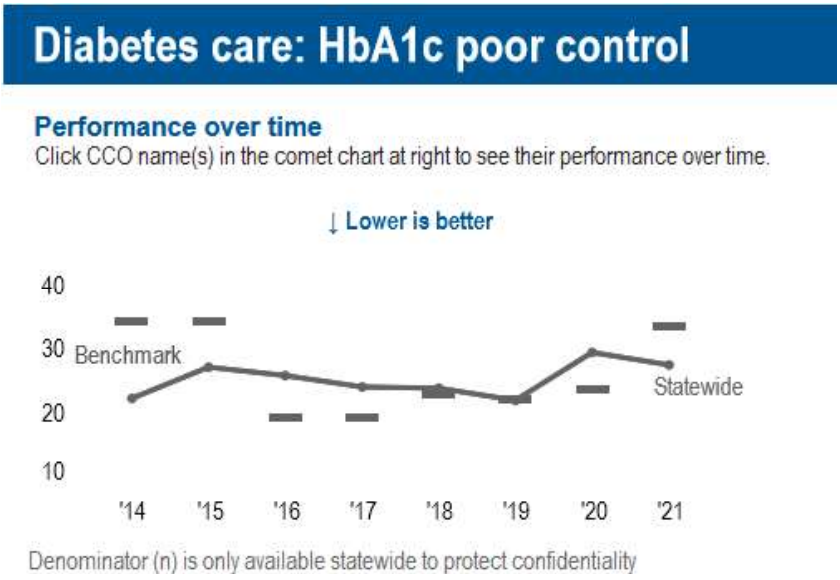
Advanced Health continues to consider ways to monitor utilization of Behavioral Health and Oral Health services with advancements in our internal dashboards. In addition, our internal teams are focused on identifying utilization trends for sub-populations within our membership, like those needing Long Term Supports and Services (LTSS), those with Severe and Persistent Mental Illness (SPMI) and incorporating SOGI data when available.

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 addition to the MEPP dashboard, Advanced Health monitors diabetic members through the review of incentive measures for Oral Health evaluations and A1c poor control, and utilization of services through claims. These internal dashboards assist in the visualization of diabetes prevalence, under and over utilization of services, helps to identify disparities by race, ethnicity, age, language, and disability as well as gaps in services.

Analysis of the MEPP CY2018-CY2020 dashboard filtered by Inpatient and outpatient services at both A&B hospitals and DRG hospitals shows that the Adverse Actionable Events (AAE) costs are twice as much as the typical costs for diabetes treatment. The goal of outlined interventions is to reduce hospital Adverse Actionable Events for the diabetes episode of care. These interventions assist with diabetes control through education, care management for newly diagnosed diabetics, and Integrated Clinical Pharmacist to reduce avoidable inpatient and emergency department utilization.

Advanced Health's performance on the Diabetes Poor control has historically varied with rates closest to the benchmark in 2018 and 2020. In 2021 performance was well above the benchmark at 40.8%. Preliminary performance for 2022 shows Advanced Health at 31% which is below the CCO specific improvement target. Improved performance is attributed to the efforts from our primary care provider network to manage chronic diabetes and the addition of Clinical Pharmacist to the primary care team.



As part of Advanced Health's monitoring activities around Diabetes and utilization of services, an internal dashboard was created to capture Oral Evaluations for members with Diabetes. This dashboard captures required information for the

incentive measure and produces rate of evaluations by provider and clinic as well as generates gap lists that aim to focus clinic outreach activities. In 2022, the overall rate of Oral Evaluations for members with Diabetes per our internal dashboard was 21.6%, which is in line with the most recent OHA rolling dashboard. Advanced Health's internal dashboard stratifies members in the denominator by gender, race, ethnicity, and primary language using REALD data. Of the Advanced Health members in the denominator for the Oral Evaluations for members with Diabetes measure, 3.3% are Hispanic and 1.2% have Spanish as their primary language.

In addition to the internal dashboard built to reflect performance on the incentive measure, Advanced Health monitors our Diabetic members. This dashboard leverages claims with a diabetes diagnosis and allows Advanced Health to understand the diabetic population size in general and by quarter, to assess growth of the population and prevalence of the disease state amongst our members as well as where members are seeking care.

Focus on members with diabetes and utilization of services is in response to the overall monitoring of the CCO incentive measure. Advanced Health has historically performed at or above the improvement target since the introduction of this metric in 2019, however the rate suffered in 2020 and 2021 due to the pandemic. Advanced Health's rate of members with diabetes receiving an oral health evaluation has largely improved in 2022, preliminarily meeting the improvement target but continues to remain below 25%. This has prompted multiple interventions and collaboration with clinic and oral health providers in our network and are outlined in the Diabetes Care Process Improvement Project (PIP).

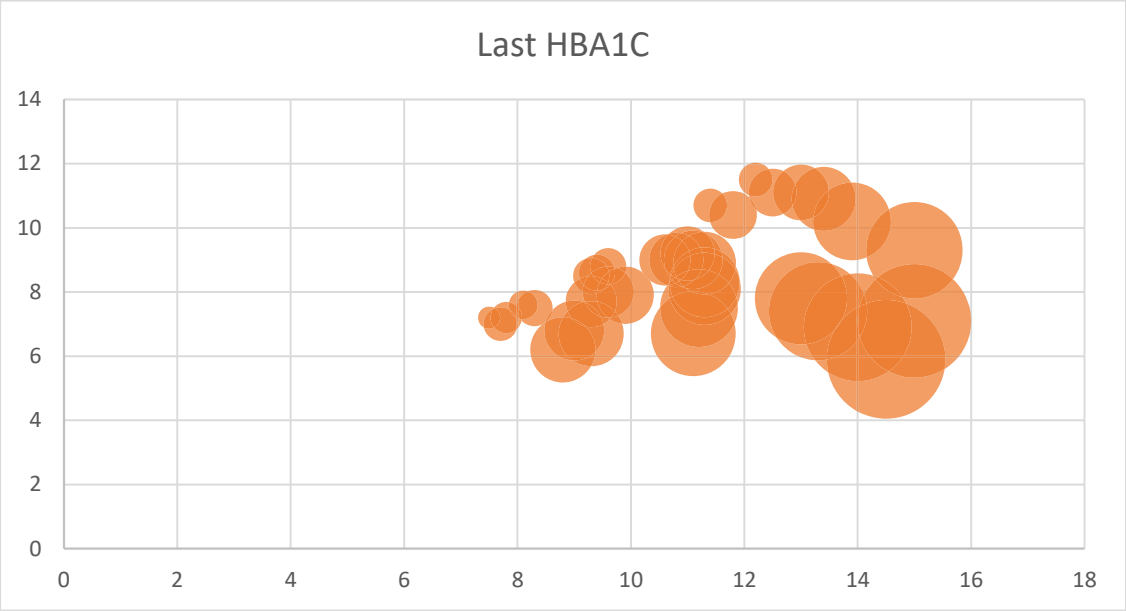
E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

Overall monitoring of costs associated with members with Diabetes as well as our performance on key incentive measures lea to the development of the Integrated Clinical Pharmacist program. This intervention aims to decrease the overall costs of diabetes care and improve performance on the A1c poor control measure through medication adherence, optimization, and member education.

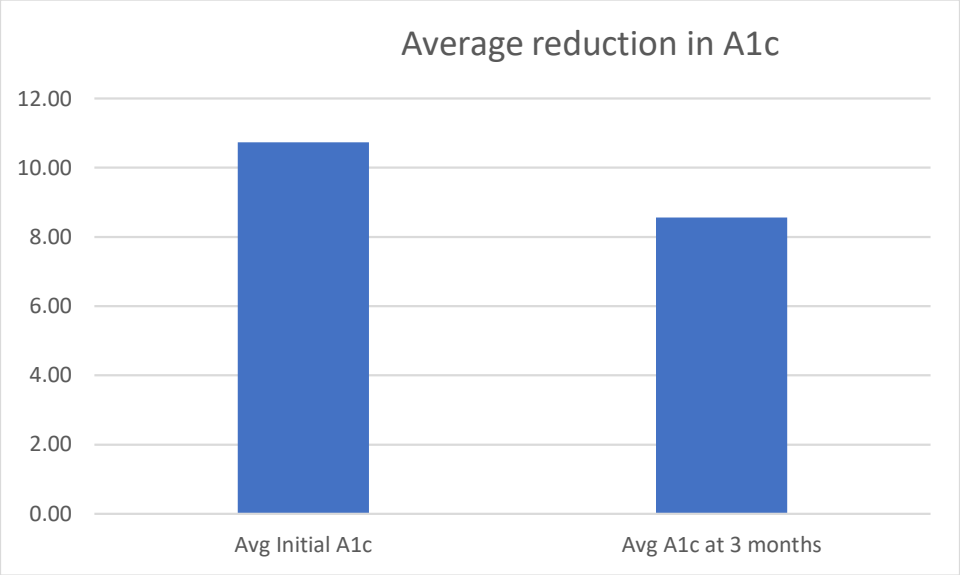
This program is a different type of intervention that allows primary care to add a clinical pharmacist to the care team with the aim to improve medication management for members with poorly controlled diabetes. An Integrated Clinical Pharmacist can meet the needs of the member pertaining to medication changes, optimization, and member education. This targeted intervention aims to reduce A1c values and improve health outcomes for medically complex members. Other interventions focus on care management and member education for Diabetic patients in our community. This expansion puts those same objectives in the hands of a clinician who is integrated as part of the primary care team.

2022 was the first year for this program. North Bend Medical Center with the aid of Advanced Health hired a full-time clinical pharmacist working within an integrated model based on Patient Centered Primary Care Home (PCPCH) standards. Initial metrics developed were aimed at reducing A1c values for Medicaid members as well as tracking utilization of the clinical integrated pharmacist services to determine the reach and impact of the program. Advanced Health was included in the design process of this program and during 2022 the metrics developed were reported to Advanced Health quarterly. Additional information around governance, workflow, and lessons learned were shared with the Advanced Health implementation team throughout 2022. The expected impact of this program was a reduction in the cost of care for diabetes due to improved medication adherence and optimization with both CCO incentive measure performance and data from the AAE for Diabetes diagnosis group in the MEPP dashboard used to determine effectiveness of the intervention.

Through 2022 the pharmacist was able to participate in the care of 44 unique members at North Bend Medical Center. Data received from the program is not exclusive to Advanced Health members as the program is designed to be inclusive for all patients who are referred. However, the overall impact of the program has been significant. The average A1c value of patients referred to the program was 10.74 mg/dl.



Through intense medication review, management and optimization paired with regular focused visits with both the clinical pharmacist and the primary care provider, we observed an average reduction of 2.1 points in their A1c values. Patients with higher pre-program A1c values saw a larger reduction in A1c overall, with the largest reduction being 8.6 mg/dl.



In 2022, there were 20 individual Primary Care Providers (PCPs) referring members to the Integrated Clinical Pharmacist Program. On average, this group of providers referred 3.6 members to the program throughout the year, with the top referring provider generating 13 referrals alone.

The future growth of this program will be based on a qualitative review of the 2022 year and the establishment of an upper limit of referrals that the single clinical pharmacist can manage. Once the established max level of referrals is determined, the goal will be to hire additional clinical pharmacists to allow for increased utilization. Strategies for recruiting new referring providers include additional provider focused messaging to educate primary care providers on the program and its efficacy as well as sharing of first year data.

Future iterations of the data collection process for this program will include RealD data as well as other valuable health outcome related data points to further understand the unintended impacts of chronic diabetes management. Advanced Health anticipates quarterly reporting from NBMC on this project. Data will be reviewed, analyzed, and reported to the Interagency Quality and Accountability committee at least annually.

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

Activity 1 description: Improved performance on the CCO Diabetes Poor Control incentive measure

☐ Short term or ☒ Long term

Monitoring measure 1.1	Improved performance on the Diabetes Poor Control quality incentive measure			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
31.0 (lower is better) Preliminary MY 2022 performance	Two percentage point reduction in the number of members with an A1c over 9 mg/dl	12/31/2023	Two percentage point reduction in the number of members with an A1c over 9mg/dl	12/31/2024

Activity 2 description: Utilization of the Integrated Clinical Pharmacist Program

☒ Short term or ☐ Long term

Monitoring measure 2.1	Increase in referrals from primary care to the integrated clinical pharmacist			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
44 patients referred in 2022	10% increase in the number of referrals	12/2023	5% increase in the number of referrals	12/2024
Monitoring measure 2.2	Increase number of PCP providers referring to the Integrated Clinical Pharmacist (ICP) program			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
20 PCP providers referring in 2022	5% increase in the number of PCP providers referring to the ICP program	12/2023	5% increase in the number of PCP providers referring to ICP program	12/2024

Activity 3 description: Incorporation of REALD data during program data collection process to identify disparities that may exist.

Monitoring measure 3	Create process for collection and reconciliation of REALD data for analysis and identification of disparities			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No process for collection of clinic provided REALD data for ICP program	Process established	9/2023	REALD data provided with quarterly reports	12/2023

No process for reconciling clinic provided REALD data with OHA provided REALD data	Process established	06/2024	Clinic provided and OHA provided REALD data reconciled with every quarterly report	12/2024
Program data analyzed to identify potential disparities	Analysis completed and findings reviewed	12/2024	Analysis completed and findings reviewed at least annually	12/2024

A. **Project short title**: Asthma Medication Adherence and Optimization

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

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

B. **Components addressed**

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

Utilization review is the process of reviewing, evaluating, and ensuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

Utilization of care is directly linked to quality of care in the way that is indicates proper management of chronic conditions, preventive services, access to care and promotes improved health outcomes. Advanced Health promotes utilization of services in many ways; reduction of barriers to accessing care, a robust provider network, and continuous monitoring of claims data for utilization trends. Advanced Health also pairs with Milliman analytics to better understand our member population, the services they utilize, and the chronic conditions they manage through analysis and predictive analytics.

Advanced Health's Interagency Quality and Accountability Committee serves as evidence of the collaboration and coordination between Advanced Health's leadership, contracted organizations, and community partners in monitoring the quality, accountability, and utilization review activities of the entire CCO. In addition to continuous monitoring of incentive measure dashboards which provide analysis of utilization of preventive services, Advanced Health captures data on our referral process, including approved, denied, or cancelled authorizations to further reduce barriers to access to specialists and second opinions for our member population. It was thorough review of these dashboards that

unintended barriers were identified and mitigated through changes to the prior authorization process. The same is true for pharmacy benefits and our formulary.

Advanced Health maintains and monitors internal claims driven dashboards, which are used in the analysis of utilization including both under-utilization and over-utilization of services. These dashboards are reviewed internally quarterly and with the IQAC at least annually. Advanced Health has continued to incorporate REALD data for claims driven dashboards which allows for analysis of utilization trends and the detection of disparities. SOGI data will be incorporated when available.

In 2022, overall utilization for preventive services for the 0-18 population is slowly recovering since the onset of the Covid-19 pandemic. Performance on the Adolescent Well Care Visits for ages 3-6 dropped dramatically in 2020, with a slight increase in 2021. Final performance on this measure for 2022 is not yet determined, however our internal claims-based dashboards reflect the efforts to improve utilization of preventive services for this age group with a rate that is more aligned with pre-pandemic performance.

Our internal dashboards are also stratified by REALD data, which allows for the identification of disparities. For Children 3-6 years old who meet denominator criteria for the Adolescent Well Care visits incentive measure, 69% identify as Hispanic. In addition, this race/ethnic group generate 63% of the numerator compliant visits. This supports the open access to preventive services for this age group regardless of race/ethnicity, language, or disability.

In addition to the utilization of preventive services, Advanced Health also monitors the use of Emergency Department Utilization. This allows our internal teams to monitor and build interventions to address over utilization. In 2022, Emergency Department Utilization remained low at 46.7/1,000mm as per the most recent OHA rolling dashboard. This is in line with performance since 2020.

Emergency Department utilization for Advanced Health members identified as having Spanish as their primary language was minimal during 2022. On average, 10 claims a month with increased utilization in November and December for reasons like chest pain, fever, and cough.

Monitoring outpatient utilization can be an indicator for the level of access within our provider network, Advanced Health does this by reviewing the OHA rolling dashboard, which calculates the rate of Outpatient utilization of services. The most recent OHA rolling dashboard has outpatient utilization at 248.7/1,000 which continues the downward trend since 2019 (317.1/1000). This steady decline in utilization of services is mainly attributed to the public health messaging to avoid preventive care that coincided with the pandemic.

Advanced Health continues to consider ways to monitor utilization of Behavioral Health and Oral Health services with advancements in our internal dashboards. In addition, our internal teams are focused on identifying utilization trends for sub-populations within our membership, like those needing Long Term Supports and Services (LTSS), those with Severe and Persistent Mental Illness (SPMI) and incorporating SOGI data when available.

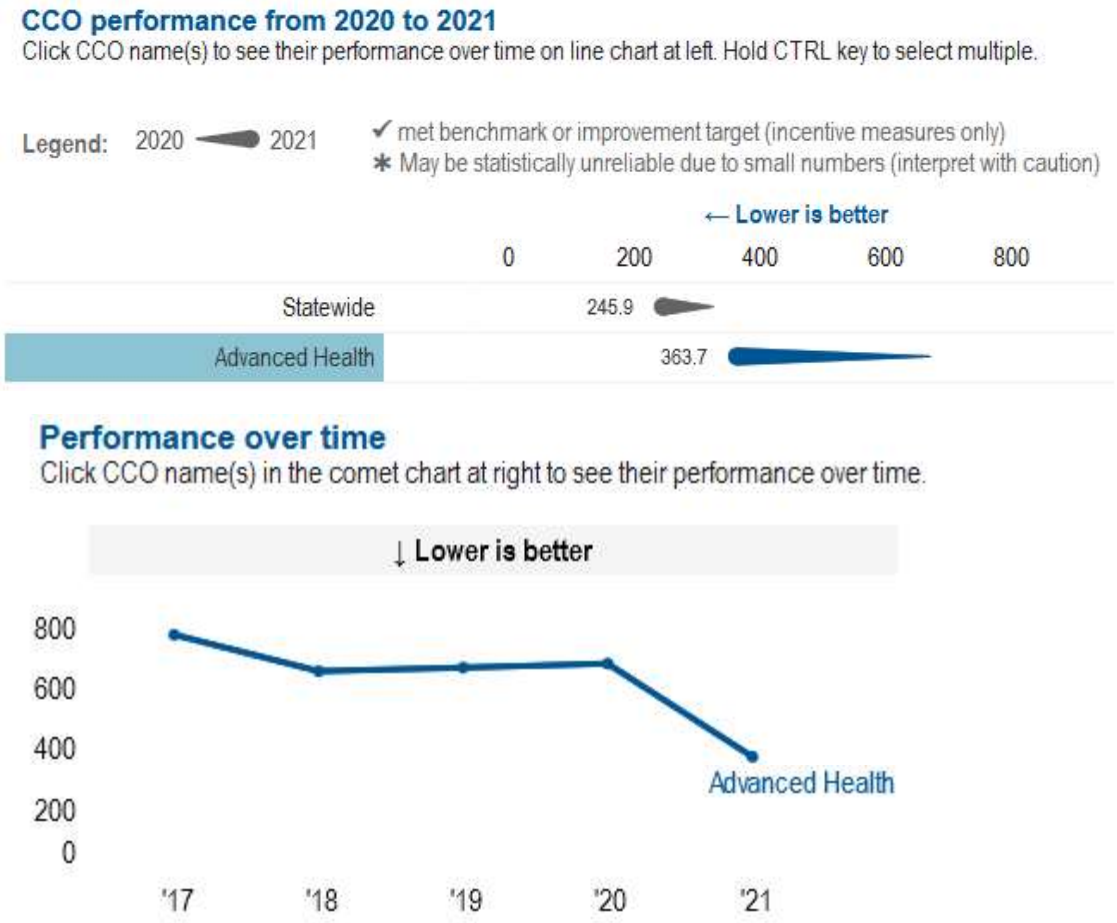
D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and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

Analysis of the MEPP CY2018-CY2020 dashboard filtered by Inpatient and outpatient services at both A&B hospitals and DRG hospitals shows that the Adverse Actionable Events (AAE) costs are five times as much as the typical costs for asthma treatment. Advanced Health's cost for the asthma episode were $1,566,004 according to the MEPP dashboard with data from 2018-2020. Goals of outlined interventions is to reduce hospital Adverse Actionable Events for the asthma episode of care. These interventions assist with chronic disease management through care management and member education opportunities to reduce avoidable inpatient and emergency department utilization.

Despite the outlined interventions, the cost of Asthma in our population continues to rise. Review of the updated MEPP dashboard with data from 2019-2021 shows and increase in AAE for asthma at $1,915,371.

As reported by OHA in the annual metrics report and now through the interactive dashboard, the PQI05 metric captures the rate of inpatient services for adults over 40 years old due to asthma or COPD in 100,000 member years (lower is better). In 2021, Advanced Health performed at 363.7, which was above the statewide average of 245.9. However, Advanced Health's rate has steadily decreased since 2017.

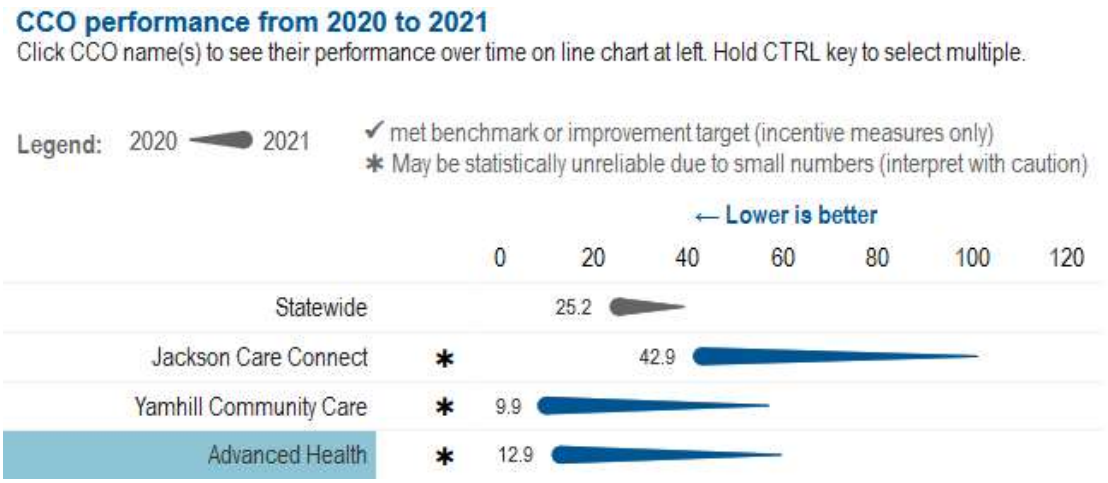
PQI105: COPD or asthma in older adults admission rate

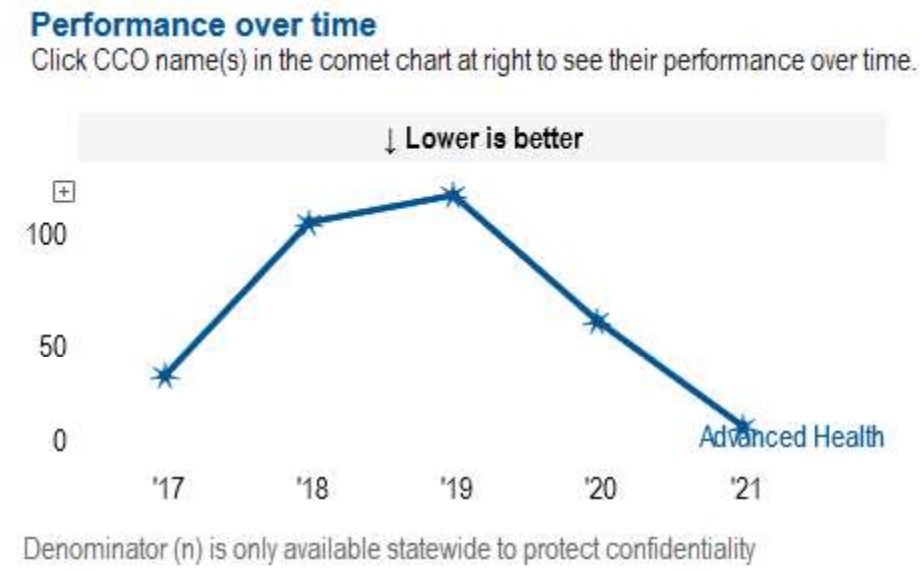


Also reported by OHA in the annual report, PQI15 reflects the number of younger adults (age 18-39) who had a hospital admission due to asthma. In 2021, Advanced Health performed below the statewide average for the PQI15 measure at 12.9. Advanced Health's performance on this measure has reduced dramatically since 2019.

PQI15: Asthma in younger adults admission rate

OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health





Advanced Health has experienced improved performance on this metric over 2020 and 2021 as per the OHA CCO performance metrics dashboard although rates may be statistically unreliable due to the small numbers reported.

A deeper dive into the REALD data for these metrics outlined in the OHA 2021 CCO performance metrics dashboard reveal a largely "white", English speaking demographic for both metrics with small group sizes reported.

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

After a greater than one year pause, the Advanced Health Member Engagement and Education Committee (MEEC) resumed operations in September of 2022. This group merged with the Advanced Health website committee with a focus of leveraging the website, member direct mailing, and social media for member education on benefits, preventive medicine, and chronic disease management.

In 2022 this committee was successful in drafting and distributing member education around benefits in the form of a "quick guide". These guides were specific to the different types of benefits available to our members including but not limited to Oral Health, Behavioral Health, and transportation. The goal of the MEEC is to develop "quick guides" that are geared toward chronic disease management like Diabetes and Asthma. These guides will promote evidence-based standards of care, promote the trust-based relationship with the primary care provider as well as outline pharmacy benefits that aim to remove barriers to medication adherence for prevention of acute exacerbation. These "quick

guides" will be developed using educational resources from Krames. Krames is an on- demand member education system that Advanced Health contracted with at the end of 2022. This cloud-based platform provides specific health related educational resources in multiple languages, mediums and is written at a 6th grade reading comprehension level. This resource is aimed at providing member education on a wide array of healthcare topics/conditions, in any language or medium desired on demand.

Members eligible and entering Intensive Care Coordination (ICC) are screened using the PRAPARE, which promotes member self-reporting of chronic conditions, race/ethnicity, language, disability status and other social determinants of health. Advanced Health's internal ICC team collects screening results in Activate Care, an interactive platform for care planning and tracking of outreach efforts by the ICC team. Asthma is prevalent in roughly 10% of the ICC population but it is not often the primary diagnosis self-reported by the member in care.

Hospital or emergency room discharge is a triggering event for Advanced Health's internal ICC team. Advanced Health's ICC team leverages the Activate Care platform to gather triggering events from the hospitals in our service region. Part of this data collection process includes a cohort of members who were recently discharged from the hospital with a new diagnosis of asthma. In 2022 there were on average 28 members per month in this cohort. Originally the focus of reduction in asthma related hospital admissions was focused on younger adults (age 18-39) however the most recent OHA metrics dashboard finds Advanced Health performing below the statewide average. This is not the case for older adults (age 40+) so the measure of efficiency will be a reduction in hospital admissions for the older group instead.

The previously outlined Transitions of Care coordinator role at Advanced Health was not an active role in the ICC team during 2022. Instead, the ICC program focused on meeting the ever-growing referral demands of our community. In late 2022 a patent navigator role specific to Bay Area Hospital was created for the purpose of assisting members during their transition out of the hospital. This position will work closing with both Bay Area Hospital discharge planners as well as the Advanced Health ICC team to ensure that members experiencing social determinants of health or are at risk for homelessness or food insecurity get connected with resources during their transition.

Historically one approach to minimizing exacerbation of chronic asthma and reducing acute hospital events, was to reduce barriers to medication adherence. In 2021, Advanced Health added several generic asthma medications to formulary, removing the prior authorization requirement. These medications were Fluticasone/Salmeterol products known by the brand names AirDuo, Advair Diskus and Advair HFA. In 2022 there were a total of 1,202 claims for these medications compared to 399 in 2021. Budesonide/Formoterol or generic Symbicort was added to the formulary in 2022 as well to further the efforts to improve medication adherence. Another data point Advanced Health has used historically is the overall per member per month (PMPM) cost for asthma related medications. This has also seen a drastic decrease since the addition of these medications. The PMPM for the top 50 asthma medications in 2022 was $5.16 down from $6.47 in 2021. Overall AAE for the Asthma episode of care as per the 2019-20201 MEPP dashboard has increased with unclear etiology, however the interventions outlined above should start to positively impact the overall cost of asthma for our population over time.

Activities and monitoring for performance improvement:

Activity 1 description: PQI 05: inpatient services for adults over 40 years old due to asthma or COPD rate as collected and reported by OHA in the annual report.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Monitor rate of admissions for older adults (age 40+) due to asthma or COPD (lower is better)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

363.7/100,000 member years (MY) in 2021	58.9/100,000 MY decrease which is half the distance to statewide average	12/2023	58.9/100,00 MY decrease which is the remainder of the difference to the statewide average	12/2024

Activity 2 description: Member education for the management of chronic asthma

☒ Short term or ☐ Long term

Monitoring measure 2.1	Develop member education using KRAMES specifically for management of chronic asthma			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No member education materials from KRAMES	Member education developed using KRAMES	12/2023	Well established evidence-based member education for the management of Asthma	12/2024
No distribution plan for member education.	Distribution plan for member education developed including timelines and distribution methods.	12/2023	Member education workplan that highlights when this specific messaging will be distributed to members	12/2024

Activity 3 description: Evaluation of interventions on overall avoidable costs for Asthma

☐ Short term or ☒ Long term

Monitoring measure 3.1	Reduction in AAE for asthma using the MEPP dashboard			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
$1,915,371 AAE 2019-2021	5% reduction in AAE with the next dashboard publication (2020-2022)	12/2023	5% reduction in AAE with the next dashboard publication (2021-2023)	12/2024

Section 2: Discontinued Project(s) Closeout

A. Project short title: Provider Network Training

B. Project unique ID (as provided by OHA): 411

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): Upon review of OHA feedback from 2022, Advanced Health acknowledged that this project was not entirely meeting the aim of the CLAS standards component. This project is being closed as a TQS project to highlight other innovative work the CCO is doing in this space. Work on the Provider Network training plan will continue and will be reported through the Health Equity Plan annual assessment and update.

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's quality improvement committee documentation as outlined in TQS guidance.
   1. Q-Advanced Health QAPI_Policy and Procedure_03142023_FINAL – signed
   2. Advanced Health_QAPI Assessment and Work Plan_2023
   3. Interagency Quality Committee Charter 2023 final

B. OPTIONAL: Supporting information
   - Attach other documents relevant to the TQS components or your TQS projects, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.
   - Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS: Click or tap here to enter text.

Advanced Health

2022 QAPI Assessment and 2023 Workplan

2022 Quality Program Evaluation

The *Quality Program Evaluation* is the second component of Advanced Health's overall Quality Assurance and Performance Improvement Program. This assessment of the previous year's performance is reviewed annually, and the results are used to plan improvement projects for the coming year. More details on the evaluation process can be found in the attached Quality Assessment and Program Improvement policy and procedure.

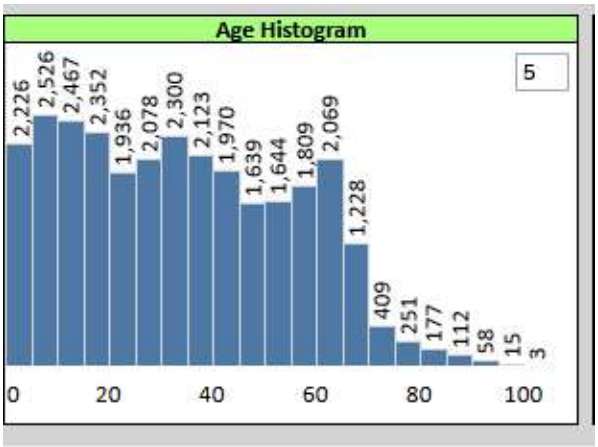
Interagency Quality and Accountability Committee Minutes

Three months of minutes from the Advanced Health IQAC committee are included as Attachment A, beginning on page 38, as a demonstration of the work of the committee in monitoring Advanced Health's quality activities. These meeting minutes provide evidence of the collaboration and coordination between AH's leadership, delegate organizations, and community partners in monitoring the quality, accountability, and utilization review activities of the entire CCO.

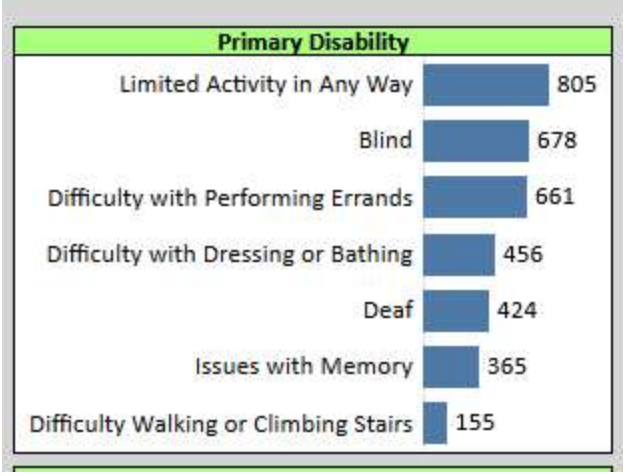
Quality and Appropriateness of Care for All Members

Membership Demographic Information

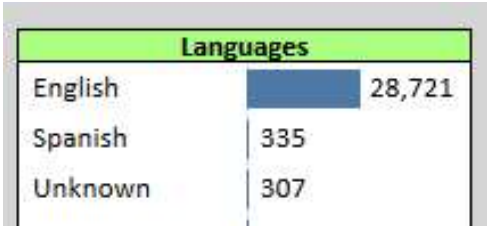
Advanced Health's service area covers Coos and Curry counties. Approximately 87% of AH's members reside in Coos County and 13% in Curry County. Using enrollment files Advance Health has built internal dashboards that allow for population analysis. These internal dashboards leverage enrollment files produced by OHA and includes general demographic and REALD data. Advanced Health membership is majority white with the largest age group enrolled is 19-50 at 43% followed by the 0-18 year old age group at 31%.



Advanced Health also reports 12% of its membership with a disability.



Language information gathered from enrollment files shows the top five spoken languages by the Advanced Health membership to be English, Spanish, Hindi, Vietnamese and Russian.



Utilization Review

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2023 Workplan: see project description and monitoring activities included in the 2023 TQS report for the following projects:

- Community Collaborative – Initiation and Engagement in SUD Treatment
- Integrated Clinical Pharmacist
- Asthma Medication Adherence and Optimization

Availability of Services, Second Opinions, & Timely Access

Advanced Health is proud that nearly every provider of health services in our service area participates in our CCO.

Advanced Health has approximately 95 primary care providers (PCPs) who care for an identified panel of members. Approximately 45% of members are assigned PCPs with North Bend Medical Center (NBMC), which has sites in Coos Bay, Coquille, Myrtle Point, Bandon, and Gold Beach. Approximately 18% of patients have PCPs at Bay Clinic, and approximately 10% receive primary care at Waterfall Community Health Center, a Federally Qualified Community Health Center. Around 13% of our members reside in Curry County; where 12% (or 1.6% of our total population) have PCPs through Curry Health Network, 12% are with Oak Street Clinic, and the remainder are distributed among multiple other offices.

Bay Area Hospital is a district hospital in Coos Bay and a partner in our CCO. It provides 80% of hospital services to our members. Our service area also includes three critical access hospitals: Coquille Valley, Southern Coos, and Curry General. The remaining 20% of hospital services are provided by a combination of these hospitals and tertiary care centers outside our services area, such as Sacred Heart Riverbend in Springfield, Asante Rogue Regional Medical Center in Medford, and Oregon Health and Science University in Portland.

Behavioral health services are administered by the CCO through multiple contracted Behavioral Health Providers in Coos and Curry counties and in conjunction with growing integrated primary care behavioral health at NBMC, Waterfall Community Health Center, Bay Clinic, and Coast Community Health Center.

Oral Health services are provided by Advantage Dental, through a combination of Advantage-owned dental offices and local dentists in private practice. Advantage partners with local school districts to improve access to dental sealants and other preventive services through the Everybody Brush program.

Treatment for chemical dependency is provided through Adapt in both Coos and Curry County.

Health Equity Cultural and Linguistic Considerations

Advanced Health is dedicated to the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs through the allocation of resources, education, and organizational culture change.

In 2022 Advanced Health continued its commitment to promoting health equity to all members in Coos and Curry Counties by assuring access to culturally responsive services. We ensured that communications and interactions with our members and providers were respectful of and relevant to the member's beliefs, practices, culture, and linguistic needs. We did this through auditing files, reviewing complaints, monitoring data, and promoting current resources while creating new ones. Advanced Health uses health equity as a cornerstone for developing and operationalizing the organization-wide Health Equity Plan.

Advance Health uses all laws and regulations to make sure we are strictly adhering to all including The Americans with Disabilities Act, Title V1 of the Civil Rights Act of 1965 and Section 1557 of the Affordable Care Act requiring all federally funded agencies to provide free of charge Language Access Services. The Americans with Disabilities Act requires all places of public accommodation to ensure that communication with individuals with disabilities are as effective as communications with everyone else. Advanced Health holds all subcontractors, vendors, and providers accountable to those same standards while working with both members and providers to break down any barriers. We assure compliance by our contracted providers and vendors through our audit process. We also provide additional notification and education of any changes in policy or law to all contracted providers through our Provider Services Representative. In 2022 our Provider Services Representative was instrumental in notifying CCO Network providers of our enhanced video interpreting service, educating providers on the process for obtaining these new services, and providing Language Line Materials.

Oregon House Bill 2359 has put new requirements on interpreting services for healthcare. All health care providers who receive public funding now must use qualified or certified interpreters, found on the Oregon HCI registry, for on-site appointments. In response to this announcement, Advanced Health began offering scholarships to our contracted providers who would like to have onsite staff trained to be a qualified or certified interpreter to be listed on the Oregon HCI registry. In anticipation of an increase in needs from our providers based on this new bill, Advanced Health also authorized the expansion of our Video Interpretation system to meet these changing needs and requirements.

As the CCO grows, we continue to improve our responsiveness to the diverse issues of our community which can be evidenced in our continued improvements of our assessments, policies, and trainings for both staff and members. This past year the CCO has updated the Health Risk Assessment Survey to be more inclusive of the member's cultural and linguistic preferences. We have written additional policies such as the Language Line Policy and Procedure to assure that all CCO and provider staff are aware of how to provide language access to any member in need. We have promoted existing resources and researched new ones to assure CCO members receive the information they need in a way that is best for them. The CCO also added trainings including Language Access & Using the Relay System to continue to improve our staff's efforts in effectively assessing and meeting all our member's needs.

Advanced Health has focused Health Equity and CLAS efforts both internally and externally throughout 2022. Internally, Advanced health has adopted the definition of cultural competence in OAR 943-090-0010. This means the CCO will continue the ongoing process of examining the values and beliefs of our members while using an inclusive approach to health care so that we recognize the context of provider-patient communication and interactions so that we will preserve the dignity of each and every individual we serve. These definitions paired with the CLAS Standards have guided Advanced Health's actions and commitment to assure we are providing culturally responsive services to all members. Advanced Health collaborates with the Community Advisory Council (CAC) and the Health Equity Steering Committee to address Health Equity and work toward ways to improve upon our existing standards. In 2022 a CLAS Champions work group was added to further develop and discover new ways to engage our members no matter what their cultural or linguistic preferences. In addition to leveraging the collective member voice of our CAC, Advanced

Health engages in cross-cultural conversations with members and groups representing underserved populations in our community, with the goal of understanding barriers to care.

Externally, Advanced Health has developed and promoted a Provider Network Training Plan used to promote access and delivery of services in a culturally competent manner. Advanced Health continues to promote trainings and activities in the Coos and Curry communities related to health equity and culturally responsive services. Over the past few years, Advanced Health has contributed to the South Coast Diversity Conference, and the ResCUE Model for Cross-cultural Clinical Care and Recognizing and Overcoming Unconscious Bias. Additionally, Advanced Health shares REALD data with the provider network via the monthly capitation rosters and via the incentive measure gap lists to assist in identification of interpreter service needs.

Advanced Health uses a variety of data to identify member primary language and interpreter service needs. The OHA 834 enrollment data is used as the primary data for the linguistic and cultural needs of our members with supplemental data from our Health Risk Assessment and ICC enrollment. These other points of contact from our CCO staff allows the member to self-identify primary language as well as interpreter service needs. Advanced Health leverages all data sources to paint a broad picture of our membership and to identify any disparities that may exist. In collaboration with the OHA, Advanced Health has been a vehicle for updating member enrollment data via the OHA Data Submission Portal. This process allows members to call the CCO and update their REALD data with those updates reflected in the OHA data. This not only allows members to self-identify leading to the identification of additional members who need interpreter services, but also removes erroneous identification of members needing interpreter services.

Advanced Health monitors the utilization of interpreter services by our provider network via Internal data dashboards that allow for the identification of members who require interpreter services and have had a service for the audit of interpreter services by our provider network. The resulting audit report is reviewed by the Interagency Quality and Accountability Committee (IQAC) at least annually. Analysis is used to support clinic workflows that support Patient Centered Primary Care Home standards and data collection for improved performance.

Advanced Health leverages REALD data to stratify all internal dashboards for a broader view of Advanced Health's membership. Internal data reveals the following enrollee characteristics:

2022 demographic data identifies the following enrollee characteristics:

Race and Ethnicity	
American Indian or Alaska Native	1%
Asian	0.5%
Black or African American	0.3%
Hispanic/Latino/Latina/Latinx	3.3%
Native Hawaiian or Pacific Islander	0.1%
White	60.5%
Other	8.2%
Declined to Answer	12.7%
Did Not Answer/Unknown	13.4%

Language	
Unknown	1.0%
Chinese	0.1%
English	97.6%
Spanish	1.2%

*Note languages reported by fewer than 20 members are suppressed from this report

In 2022 Spanish remained the prominent non-English language spoken by Advanced Health's membership with 335 members identifying Spanish as their primary language. This is a 33-member increase from 2021. Members with disability are also identified and monitored using this internal dashboard which shows 1.4% of our population as deaf and overall, 12% of the overall membership living with a disability. Internal dashboards are monitored frequently when considering member materials development and to identify potential health equity concerns.

All enrollees with limited English proficiency are offered the option of being assigned to a provider who speaks their preferred language, if that language is represented among the panel of providers. Within Advanced Health's PCP network, there are multiple bilingual providers: Spanish (8); Hindi (7); Mandarin (1); Malayalam (2); Portuguese (2); Gujarati (1); Tamil (1); Teluga (2); and Nepali (1). Within the mental health and addiction treatment system, there are providers who speak the following non-English languages: Spanish (24), Russian (2), Lakota (2), and Hindi (1). There are also (24) mental health providers who are fluent in American Sign Language, supporting those members who are deaf or hard of hearing. Within the oral health provider network, there are four providers who speak Spanish and one provider fluent in American Sign Language. One of the oral health providers who speaks Spanish and the provider fluent in ASL are both available to attend appointments in multiple Advantage Dental clinic locations within the Advanced Health service area.

During 2022 Advance Health's Qualified Health Care Interpreters completed 21 interpreter assignments. Of those 21, 6 were for medical services, 0 for dental, 11 for behavioral health services, and 4 were considered other which include providing needed interpretation at community events.

Policy

Advanced Health strives to improve health care access and utilization and to enhance the quality of services within culturally diverse and underserved communities and promote cultural and linguistic competence as essential approaches in the elimination of health disparities. It is the policy of Advanced Health to participate in OHA's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Advanced Health provides oral interpretive services to members and potential members for all non-English languages and provides written information in prevalent non-English languages in our service area. Advanced Health notifies members, as well as providers and their staff, of the interpretive services available to them.

Health Equity Plan

Advanced Health operates under a robust Health Equity Plan that highlights its organizational commitment to health equity as well as efforts within the provider network and community at large. The Health Equity Plan outlines focus areas including Member Grievance System, demographic data, and Culturally and Linguistically Appropriate Services (CLAS). Detailed accounts of efforts and interventions are captured in the Health Equity plan that is submitted to OHA at least annually.

2023 Workplan: See the project narrative and monitoring activities and measures included in the 2023 TQS for the project entitled Improve Language Services Access.

Behavioral Health Integration

Historically, Advanced Health has worked alongside our provider network to identify and mitigate delivery service network deficiencies and barriers to care. This included service expansion, the expansion of our internal Behavioral Health staff, and taking time to understand the perspective of our network of Behavioral Health providers to hear and mitigate barriers. The service expansion in previous years created foundational changes to services including:

- New contracts with local mental health providers allowing a broader network for Members to choose from.

- Greater accountability for mental health programs including more fee-for-service encounters, incentivizing agencies to increase services to Members.
- Integrated services for mental health services within medical clinics.
- Care coordination for high-risk members with Serious and Persistent Mental Illness.

Integrated healthcare is a collaborative approach to patient care that combines the physical, mental, and behavioral aspects of healthcare. This has been the main goal of the Patient Centered Primary Care Home model since its conception in 2009. Patient-Centered Primary Care Homes are health care practices that have been recognized by the Oregon Health Authority for their commitment to providing high quality, patient-centered care. This model of care fosters strong relationships with patients and their families to better care for the whole person. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention and wellness, and managing chronic conditions. The core attributes of the PCPCH model includes "coordinated" which specifies that care is integrated, and practices help patients navigate the health care system to get the care they need in a safe and timely way. Advanced Health contracts with community clinics who are PCPCH recognized with our largest providers being 5-Star clinics. In 2022, 53% of our population was empaneled at a 5-star clinic with 90% empaneled at a PCPCH of any tier or star rating.

Integrated Behavioral Health continues to be established in the largest clinics in our provider network serving approximately 80% of Advanced Health members and providers members and PCPs quick access to mental health consults. Integrated behavioral specialists are trained in referrals to specialty programs. These well-established programs aim to strengthening the alliance of the physical wellbeing with mental health. Our local primary care providers lean heavily on our behavioral health teams to meet the needs of our members swiftly, seamlessly, and effectively.

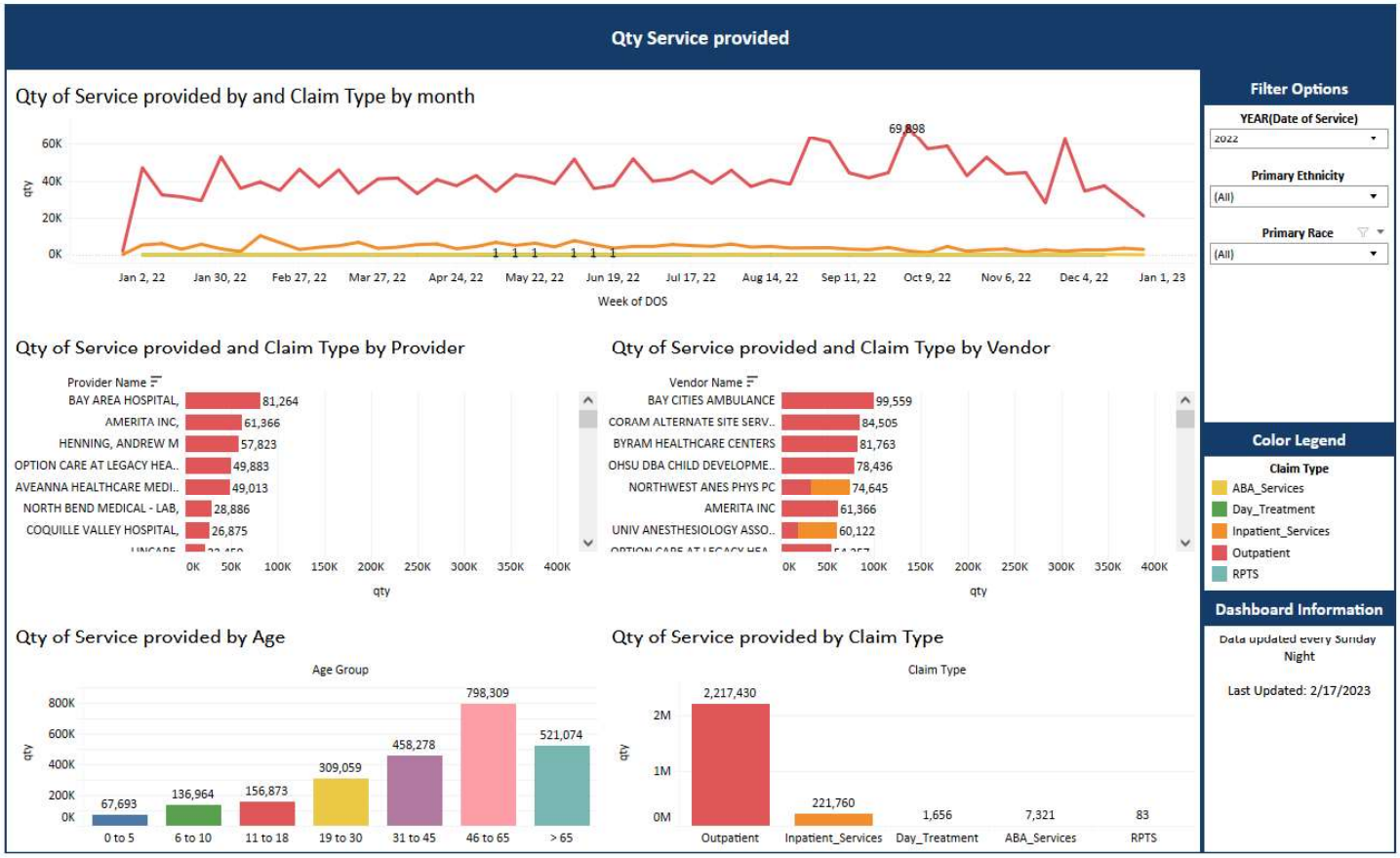
The integrated model of care for behavioral health reduces stigma associated with seeking mental health services and leverages the trust-based patient provider relationship of primary care. This model often allows primary care providers, patients, and mental health providers to seize the opportunity to shepherd a patient from diagnosis to treatment in a timely manner by reducing barriers related to access and transportation. Through the equity lens, integration of mental and physical health is often built to allow for all patients to access care, and services are not rendered based on race/ethnicity, gender, disability, insurance, or ability to pay.

The use of the community wide Electronic Health Record (EHR) Epic during 2022 revealed some unanticipated challenges to data collection in the areas of data reliability during the screening process, as well as accuracy in capturing the work that clinicians are completing. Clinic data mangers continue to work with the electronic health record reporting capabilities to understand the structured data and determine how best to modify reporting to capture value added data points. Creating standardized workflows was the focus of 2022 which aims to improve timeliness of referral processing and loop closure.

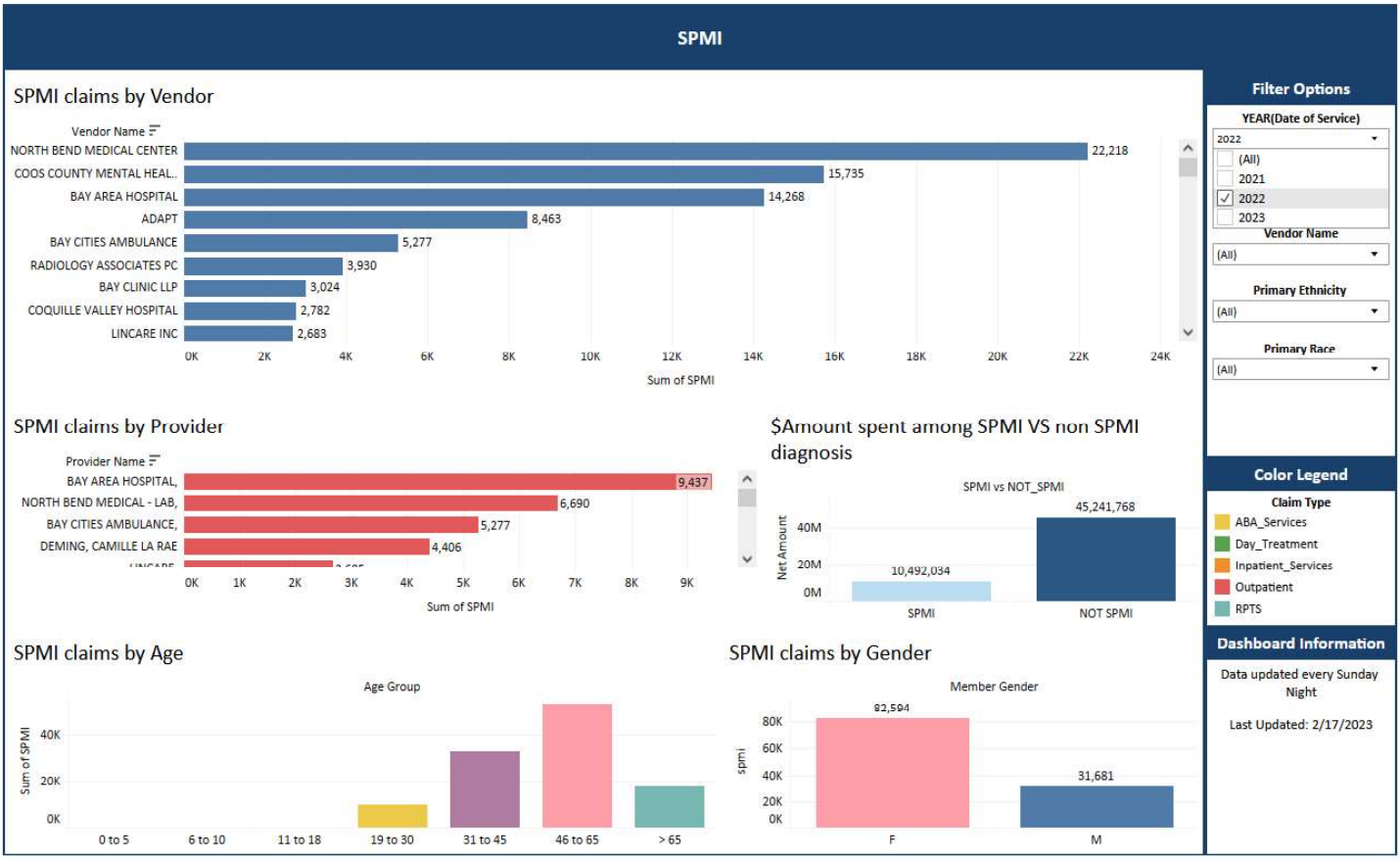
2023 Workplan: see the project description and monitoring activities included in the 2023 TQS project entitled Community Collaborative – Initiation and Engagement in SUD Treatment.

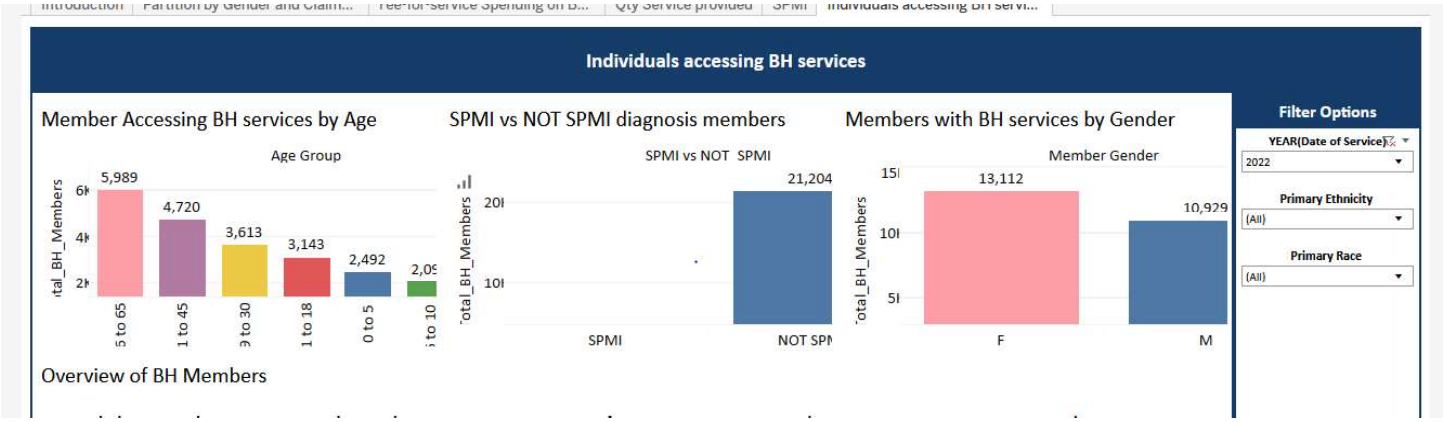
Serious and Persistent Mental Illness (SPMI)

Advanced Health is currently serving approximately 27,497 Medicaid Members, up by 1,500 lives in 2022. Six months after the federal state of emergency pandemic response ends, we expect to see a significant decrease in membership once the redetermination process is implemented by the Oregon Health Authority (OHA). The decline in membership is expected be gradual over the course of about 12 months, after which membership levels are expected to remain two to three percent higher than pre-pandemic levels. We assume we will be serving more clients with mental health needs as the stresses and social isolation of the pandemic response continues to deteriorate the health and wellbeing of our population. The toll this pandemic has taken on the mental health of our communities will be felt for years to come, and we must be prepared to assist with the healing. The graph below shows us a good overview of mental health utilization and encounter data in 2022.



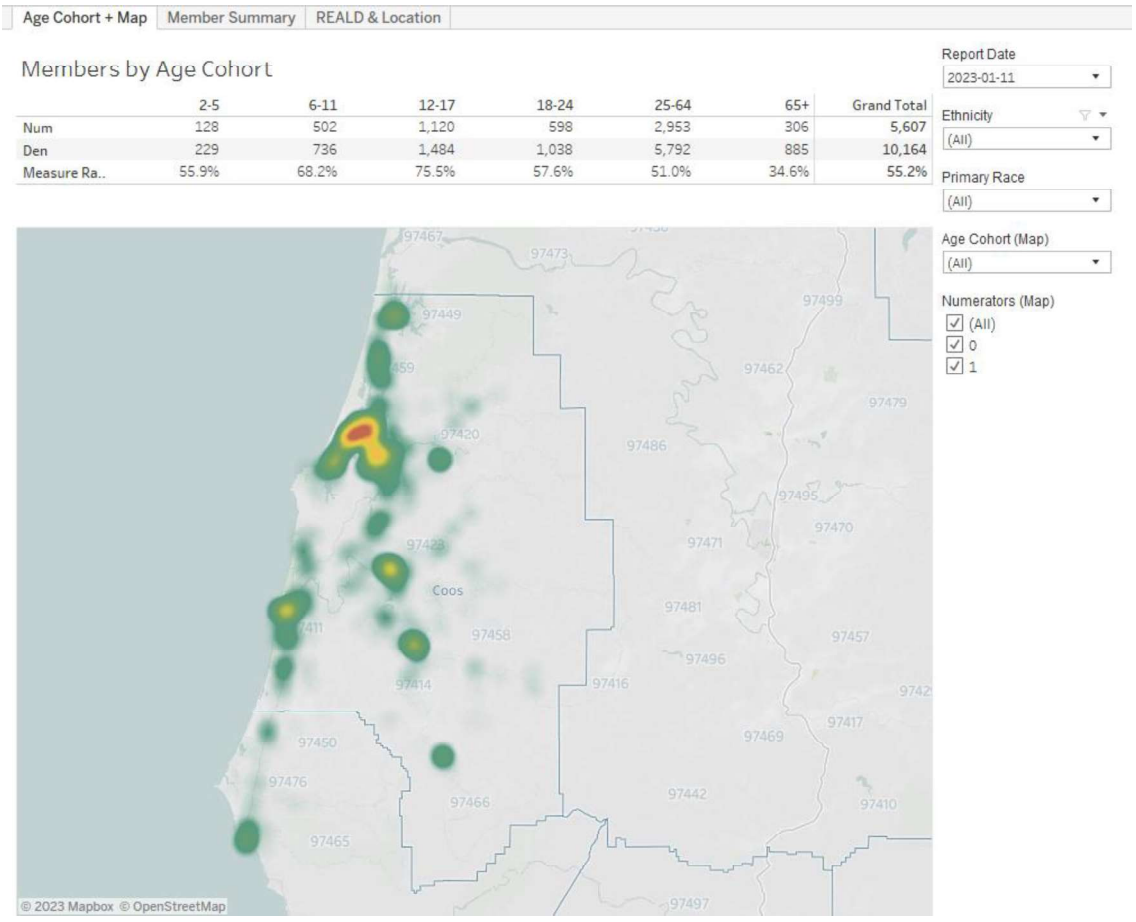
Advanced Health uses claims data to identify utilization of services by members with Serious and Persistent Mental Illness (SPMI) diagnoses. . Through visualization of this data, a global picture is created depicting access to behavioral health services for members with SPMI as seen in the graph below. Claims can be filtered by types of services accessed including care coordination, therapy, and medication management to ensure equitable access for Advanced Health Members with an SPMI diagnosis. The stratification of members with an identified SPMI diagnosis in 2022 is listed below. Advanced Health will continue to track these data points to determine network adequacy and to ensure that members are receiving the appropriate care. The dashboard also allows Advanced Health to identify issues of health equity, ensuring all members have equal access to care.





The graph above reveals that female members of Advanced Health utilize Behavioral Health services more often than male members. Advanced Health's member population is made up of 66% "not hispanic", which is our largest group of non-white members. The internal use of REALD data has allowed Advanced Health to understand its member population and ensure that all written education and documentation is also available in Spanish.

Another way that Advanced Health analyzes claims-based data is via geographical location. The graph below shows a heat map of individuals with a behavioral health diagnosis based on zip code which allows us to better understand how we can improve access to care and care delivery options to better serve our members.

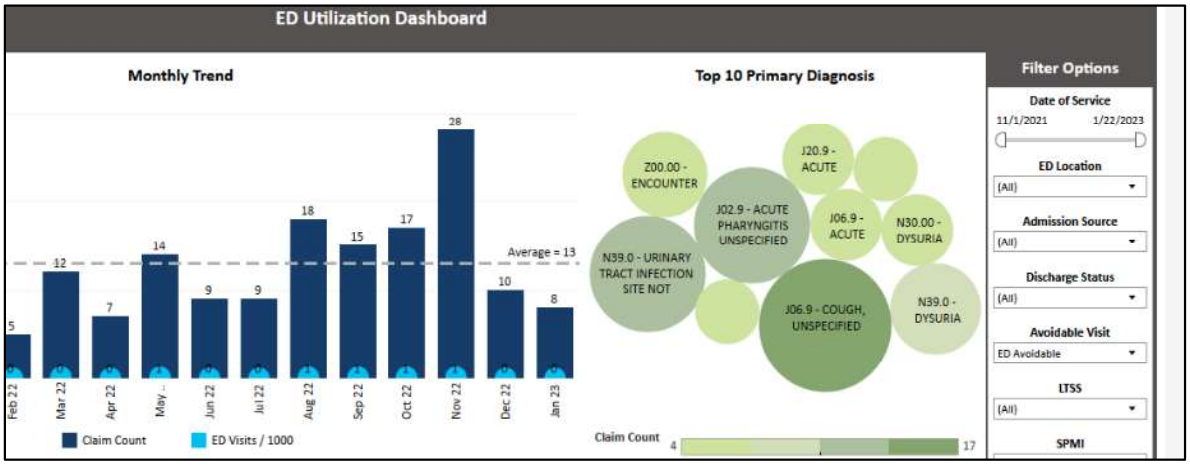


When addressing SPMI, Advanced Health utilizes a mixture of utilization data (claims) and member self-determination using the Health Risk Assessment (HRA) Screening tool. The HRA screenings are delivered to the member upon initial enrollment with the plan and annually thereafter. Members who do not respond to the mailed surveys are contacted by phone by customer service to ensure that all members needing additional services are identified. Members are also referred for additional services, including Intensive Care Coordination (ICC), through primary care providers, case managers, community, or social service organizations, or by self-referral or referral by a guardian or caregiver. Our new director of Customer Services is currently looking at ways to expand the information that is collected with the HRA while developing clear lines of communication to share the needs of specific members with ICC, and local care providers when indicated.

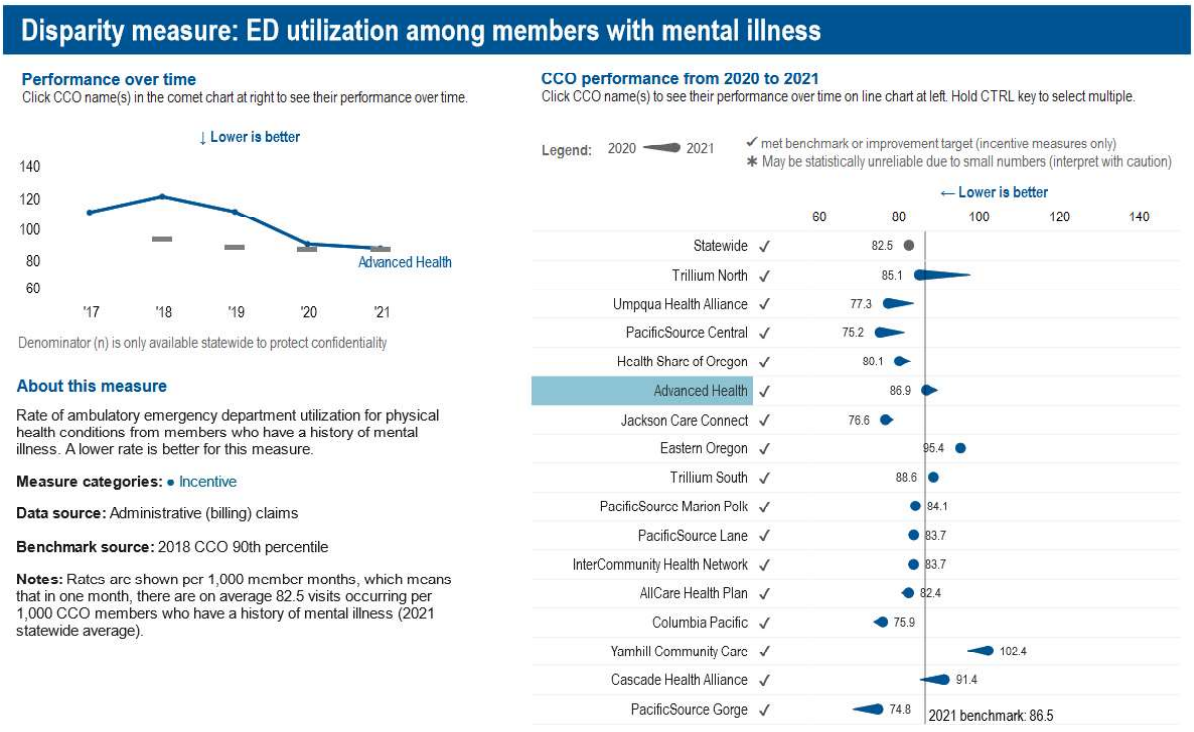
An internal claims-based dashboard allows Advanced Health to identify specific members with an SPMI diagnosis and determine what services they are accessing to evaluate the need for additional services including Assertive Community Treatment (ACT), Early Assessment and Support Alliance (EASA), or Intensive In-home Behavioral Health Treatment (IIBHT). Individual cases are staffed by the ICC director with the ICC teams to evaluate high-needs members for care coordination and possible linkages to other special services with the goal of preventing crisis and relapse by providing a robust, member-centered treatment plan and working with the member to meet their health care goals.

Additional ways Advanced Health monitors utilization of behavioral health services is through the statewide Process Improvement Project (PIP) stratified by REALD data. The below dashboard is claims-based and built to statewide PIP specifications and allows Advanced Health to monitor access to Behavioral Health services on demand and quarterly for PIP submission. Data analyzed and reviewed from this dashboard fuels interventions for improvement, outlined in our quarterly PIP report submissions.

Advanced Health monitors utilization of Emergency Department services for members with SPMI through an internal claims-based dashboard. Findings are reviewed at least annually with Advanced Health's Interagency Quality and Accountability Committee and are used to fuel interventions for the Emergency Department Utilization PIP report submitted quarterly. The rate of ED utilization among members with SMPI remains low and steady with 13 claims per month.



OHA data from 2021 shows Advanced Health performing slightly above the benchmark on this measure at 86.9/1,000 MM. Advanced Health has shown a steady decline of ED utilization for members with SPMI since 2018 which can in part be attributed to the public health messaging with the onset of the Covid-19 pandemic. Additional credit is given to Advanced Health's effort in messaging the Behavioral Health benefits to members and increasing access to care.



The stratification of this data by RealD is standard practice for both internal claims-based dashboard as well as the OHA interactive dashboard. Review of Advanced Health specific data reveals an increase of Hispanic/Latino and American Indian accessing Emergency Department services, each group over 90/1,000 MM.

Advanced Health utilizes a number of data visualizations to understand the broad scope of behavioral health services that are utilized in our community. The graph below, developed by the Systems of Care Committees throughout Oregon, leverages statewide claims data, stratified by REALD and captures utilization of Behavioral Health services by CCO and service region. This data is reviewed and analyzed through our local Systems of Care (SOC) groups with the aim to monitor access to Behavioral Health Care and identify disparities and gaps in services.

Advanced Health's geographical area of Coos and Curry counties made significant gains in terms of access to and availability of providers over the course of the previous year. Overall, Advanced Health has contracted with a total of 126 Behavioral Health and SUD providers. Advanced Health continues to accept applications to enter the network from providers meeting credentialing criteria.

In addition to direct contracting with independent providers and Behavioral Health organizations, Advanced Health utilized Integrated Behavioral Health clinicians at our four largest primary care clinics. These Integrated behavioral health teams serve approximately 80% of Advanced Health members, allowing members and PCPs quick access to mental health consults. Integrated behavioral specialists are trained in referrals to specialty programs once a member has been identified as needing additional behavioral health or substance abuse services. While meeting with our integrated behavioral health teams in the surrounding clinics we heard just how important this role has been in both

strengthening the alliance of the physical wellbeing with mental health. Our local primary care providers lean heavily on their integrated behavioral health teams to meet the needs of our members swiftly, seamlessly, and effectively. The partnership is highly valued by the professional team as well as our members who have a warm hand-off and care within the same visit.

2023 Workplan: See the project description and monitoring activities included in the 2023 TQS project entitled Roadmap to Improved Behavioral Health Access.

Quality and Appropriateness of Care for Members with Special Health Care Needs

Advanced Health's Community Health Assessment (CHA) offered a view of the health status of our citizens and provided a better understanding of key health issues facing our communities and direction for planning of improving services to the more challenging areas. Our Coordinated Care Organization's (CCO) approach to gathering data included expanding their efforts into hospitals, federally qualified health centers, public health, tribal services, and other human service organizations. The CHA committee recognized our community's social determinant of health (SDOH) factors strongly influence health inequities which can affect access to health care services. Many community health models suggest that up to 40% of the health in the community is related to socioeconomic factors. Access to providers and lack of specific health services was determined to be a one of the top barriers for our members as further indicated by an Oregon Health Sciences University study in 2016 and as indicated by the Oregon Office of Rural Health which has designated Coos and Curry Counties as medically Underserved Area (MUA) and Health Professional Shortage Area.

Our CCO service area has a high percentage of the population on publicly funded insurance which includes Medicare, Medicare, and Veterans. 2017 estimates from Oregon DMAP and RUPRI, shows that 62.5% (Coos) and 65.8% (Curry) of the population is on Medicaid, Medicare, or both. The age distribution on Medicaid is older in Coos and Curry Counties than in the state.

Mental health and depression were listed as top concerns by the CHA focus groups and survey participants. Self-reported mental health issues and depression also show higher rates in Coos and Curry counties than statewide, for both adults and youth. Nearly one in three adults in Coos county indicate they are struggling with depression.

Advanced Health's Intensive Care Coordination (ICC) team collected referrals for approximately 420 members with Special Health Care Needs (SHCN) in 2022. The Intensive Coordination Team served 246 of the referred members. Of the 174 Members referred but not enrolled with ICC, 26 were not on Advanced Health, 64 did not respond to outreach, 22 were not interested in ICC and 14 did not need ICC services. An additional 27 were already in care management services with behavioral health or medical clinic care management.

Early in 2022, Advanced Health's ICC program worked toward streamlining the referral process into one central email where all referrals were managed. Most referral screens were received via fax and email, although referral calls continued to be accepted from emergent referral sources (hospitals). During Q1 2022 Advanced health responded to ninety-three percent of referrals within the required ICC time frames (response to referral source within one day). The other quarters of 2022 reflected similar response times, including Q2 2022, Ninety-eight percent, Q3 2022, eighty-seven percent and in Q4 2022, ninety-seven percent of referrals were responded to within the required ICC time frame.

To improve access for our SHCN members, Advanced Health has either created and/or strengthened a myriad of referral pathways and community partnerships to better meet their complex health needs. Members are identified through a variety of established CCO mechanisms and entryway points into Intensive Care Coordination services. Through Advanced Health's Customer Service department, all newly enrolled Advanced Health members are screened with a health risk assessment (HRA) and given the opportunity to self-identify special health care needs for referral to intensive care coordination services. Other pathways into ICC, in 2022, included referrals from other internal Advanced Health departments (pharmacy, medical management, claims), referrals from all local area medical clinics and Bay Area Hospital (BAH), the largest provider of hospital services in Advanced Health's network. Other hospitals, some out of area, also referred to ICC during 2022, including Southern Coos Hospital, Sacred Heart Riverbend Hospital, Oregon

Health & Sciences University, Legacy Emanuel Hospital and Lower Umpqua Hospital. Other medical sources referred to ICC, including Home Health and Wound Care at BAH.

In addition, ICC received referrals for nursing support for members with Severe and Persistent Mental Illness (SPMI) via Curry County Adapt and Coos Health and Wellness, as well as from local private therapists. Substance abuse treatment providers referred to ICC multiple times, including referrals from Crossroads Residential Treatment Center, Adapt in North Bend and Bay Area First Step. Other community partners made referrals for SCHN members to ICC, including ID/DD services (Community Living Case Management) and homeless services (Devereux Center, Curry Homeless Coalition, St. Timothy's Church, and the Gospel Mission). In 2022, ICC's partnership with DHS-APD strengthened, resulting in 40 referrals to ICC from APD during 2022. Often referrals from BAH also included a joint referral to APD, resulting in numerous partnerships with APD, via other pathways. Other referral pathways included DHS-CWS, OHA FFS Nurses, other CCOs (transition of care), Medicare Advantage plans (Dual eligible Members), OHA Ombuds Program, Advantage Dental (delegated dental network provider), Coos County Parole and Probation, and the Homeless Veterans Program. Members self-referred into ICC as well, and there were several referrals from family members who called in to Advanced Health Customer Service.

Advanced Health aims to identify SCHN Members for Intensive Care Coordination at the time of enrollment through screening protocols, through annual re-assessment or Member request. Monitoring systematically for some triggering events such as recent homelessness is challenging. Nonetheless, triggering events also serve as occasions for entry to Intensive Care Coordination. One avenue in which triggering events result in referrals to ICC is via Collective Medical's hospital event notifications (HEN). The ICC Team has built cohorts in Collective Medical which filter Special Populations including high Emergency Department (ED) Utilizers, Pregnancy identification, SPMI ED visits, inpatient or emergency department SUD diagnosis, and HEN all inpatient and ED admissions. Advanced Health's ICC Program Manager and ICC nurse staff routinely check the Collective Medical Cohorts and reach out to Members, if deemed appropriate, to screen for SCHN and a need for ICC services. Furthermore, ICC care coordinators can add themselves to the care team in Collective Medical and tag the ICC program so that the ICC team receives email notifications when enrolled (tagged) members present in the ED or are admitted to hospital, or to long term care or skilled nursing facilities.

Once referred, each ICC member is assigned a Care Coordinator (such as a Traditional Health Worker and/or Registered Nurse) as a single and consistent point of contact. Member's assigned coordinator assists the member in identifying and resolving healthcare barriers from assessment information (PRAPARE assessment), collaboration from the member, and additional information from their care team participants in case conferences such as at Bay Area Hospital, individualized complex coordination meetings and/or collaborative problem-solving monthly meetings with Aging and People with Disabilities.

Members' care plans are built by the assigned Advanced Health care coordinator, in collaboration with the Member, with an emphasis on using a comprehensive and wholistic approach. In 2022, the ICC team has continued to utilize Activate Care as the primary platform for care planning. Care plans are categorized into Medical Needs, Behavioral Health Needs, Dental Needs and Social Determinants of Health (SDOH) Needs. Care plans incorporate interdisciplinary goals, evidence of member participation, distinct roles for care team members and clear tracking of ICC time frames to help remind Advanced Health coordinators of the necessary tasks to complete enrollment, intake, and healthcare specific goals. Current length of care in the ICC program varies from short term to long term, usually spanning a time frame of 3 to 18 months. If a healthcare and/or SDOH barrier is identified by the coordinator that requires a flex fund intervention, Advanced Health has developed an internal ICC flex fund process to reduce the barriers frequently encountered by our SHCN members.

The ICC program administers the PRAPARE social needs screening tool to every member who engages in services. From this screening we can aggregate REALD data. Of the members in ICC care who received a screening during 2022, 99% speak English, with the primary race being White (86.9%) followed by American Indian/Alaskan Native (3.27%), and Hispanic/Latino (1.3%).

For members with Special Health Care Needs, who had a need for access to a specialist, the SHCN designation was composed by an ICC nurse, the ICC Director, or the ICC Program Manager. The SHCN designation includes a description of the complex medical needs, priority population status, behavioral and SUD need, ID/DD concerns, dental concerns and confounding SDOH needs, written in a format which ties the complexity of needs together. This designation is included in the Summary Section of Activate Care, in outreach notes in Activate Care, and is included in Quantum Choice notes (for prior authorization review and determination). For Members designated to have SHCN, Advanced Health allows direct access to a specialist. The specialist should be appropriate for the member's condition and identified needs. The PCP can simply refer the member to the specialist without a prior authorization. The referring provider should notify Advanced Health of the referral. This allows the creation of a standing referral/authorization number for billing purposes. This standing authorization includes pre-approved visits (i.e.,6 visits in 6 months), allowing the member to establish care directly with the appropriate specialist.

Advanced Health's ICC team has developed strong and valuable relationships internally and externally with medical, behavioral, and social service professionals to greatly improve coordination of care and discharge planning for SHCN members. ICC staff are consistently present at weekly hospital complex case meetings, Coos and Curry behavioral health ICC sub-contractor meetings and built a new monthly partnership with DHS APD case management through an updated memorandum of understanding. Additional contracts were awarded to our unhoused population service agencies such as Brookings CORE and Nancy Devereux center to expand the reach of ICC services and provide additional support to one of the most vulnerable SHCN population groups. Through these improved collaborations, Advanced Health invested a combination of SHARE Initiative funds and Health-Related Services funds into the Coalbank Village (pallet sheltered community) operated by the Nancy Devereux center for the purposes of medical sheltering. Currently, the Advanced Health ICC team meets weekly with the Nancy Devereux Center staff to monitor the medial sheltering program which is described in detail in the subsequent sections of this report below.

The Devereux Center offers support systems and advocacy for the homeless, those suffering from mental illness, and veterans. The Devereux Center serves an average of 80 to 100 people a day. The Devereux Center is a 501(C)3 tax-exempt non-profit organization founded in 1979. The Center is a day facility that is open from 9 am to 2 pm every week on Monday, Tuesday, Wednesday, and Friday. Breakfast and lunch are served on Thursdays, but access to case management, showers and laundry is not available.

Coalbank Village is located on the South side of Coos Bay. Coalbank has 25 Pallet Shelters available, which are designed to provide temporary sheltering to homeless individuals who are seeking resolution of their homeless status. Through providing a safe environment and improved access to needed resources, sheltered individuals have improved opportunities to obtain housing. Coalbank residents share access to a full kitchen area, a restroom shelter with electricity and shower facilities, as well as a covered recreation area. Furthermore, residents have access to the Devereux Center services via provided transportation which takes Coalbank residents to the Devereux Center in the morning and returns them to Coalbank Village after lunch.

2023 Workplan: See the project description and monitoring activities included in the following 2023 TQS projects

- Medical Shelter Program
- Improved coordination of care and increased depression screening and follow up for LTSS members with SCHN

Quality and appropriateness of care for LTSS members

Advanced Health's previous Community Health Assessment (CHA) in 2018 was a look into the health status of our citizens and provided a better understanding of key health issues facing our communities and direction for planning of improving services to the more challenging areas. Our CCO's approach to gathering data included expanding their efforts into hospitals, federally qualified health centers, public health, tribal services, and other human service organizations. The CHA committee recognized our community's social determinant of health (SDOH) factors strongly influence health inequities which can affect access to health care services. Many community health models suggest that up to 40% of the

health in the community is related to socioeconomic factors. Access to providers and lack of specific health services was determined to be a one of the top barriers for our members as further indicated by an Oregon Health Sciences University study in 2016 and as indicated by the Oregon Office of Rural Health which has designated Coos and Curry Counties as medically Underserved Area (MUA) and Health Professional Shortage Area.

Our CCO service area has a high percentage of the population on publicly funded insurance which includes Medicare, Medicare, and Veterans. 2017 estimates from Oregon DMAP and RUPRI, shows that 62.5% (Coos) and 65.8% (Curry) of the population is on Medicaid, Medicare, or both. The age distribution on Medicaid is older in Coos and Curry Counties than in the state.

Mental health and depression were listed as top concerns by the 2018 CHA focus groups and survey participants. Self-reported mental health issues and depression also show higher rates in Coos and Curry counties than statewide, for both adults and youth. Nearly one in three adults in Coos county indicate they are struggling with depression.

Within our CCO's membership are Full Benefit Dual Eligible (FBDE) individuals with chronic conditions and SDOH needs that are receiving Long Term Services and Supports (LTSS). Meeting the intention of OAR 410-141-3860, FBDE Long-Term Services and Supports (LTSS) members are considered one of the Special Health Care Needs (SCHN) population groups given priority for referral to our Intensive Care Coordination program because these members experience a higher degree of complex medical issues, comorbidities such as depression, hospitalizations, higher healthcare costs and are known to have trouble in successfully attending their primary care appointments. Individuals needing LTSS include older adults and younger people with intellectual and development disabilities, physical disabilities, behavioral health diagnoses, spinal cord, or traumatic brain injuries, and/or disabling chronic conditions and can experience many SDOH barriers such as poverty, transportation, and lack of access to medical providers. Through the development of this TQS project, our team has discovered that a very low percentage of these LTSS members are not being screened for depression and subsequently did not receive follow up peer support or mental health care.

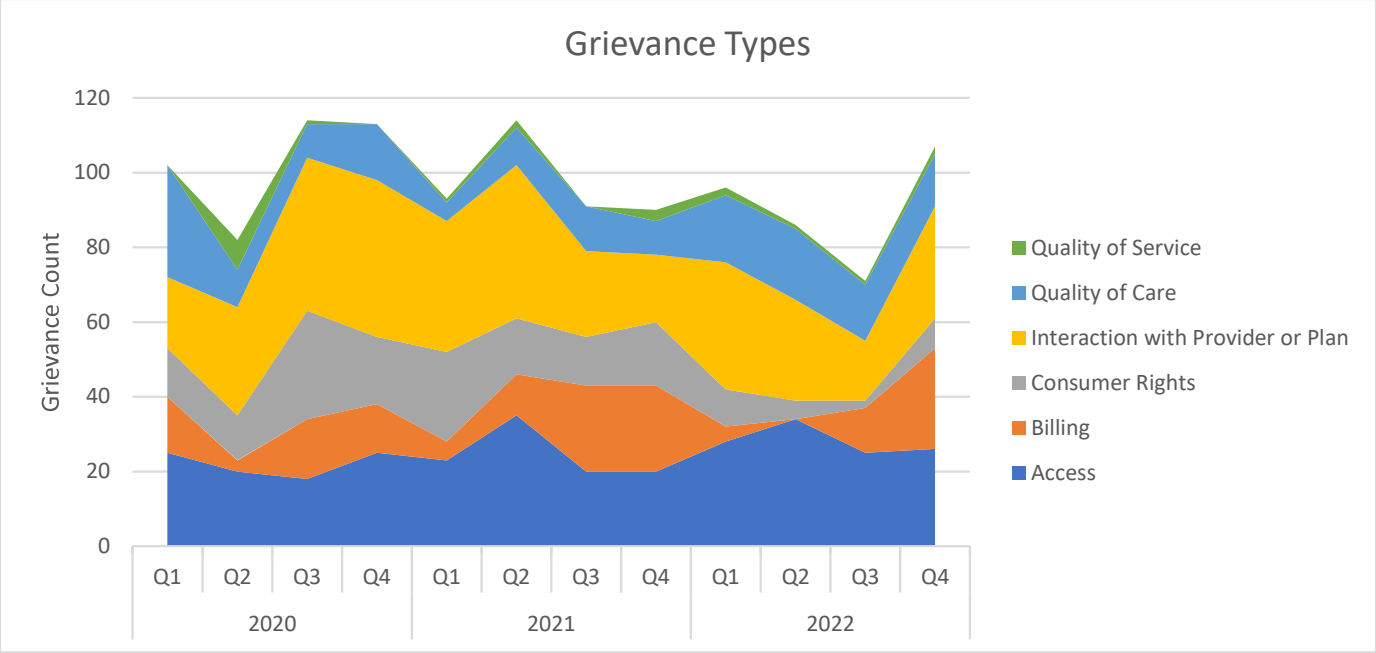
Due to the high SDOH needs of FBDE LTSS members and other priority population groups, OHA concurrently required the CCO to stand up an Intensive Care Coordination program and significantly improve our administrative partnership and population tracking abilities between Advanced Health and the Oregon LTSS system. Advanced Health's Intensive Care Coordination (ICC) program offers care coordination services to AH Members that have been identified as in need of specialized health care and our updated memorandum of Understanding (MOU) required the CCO to strengthen our partnership, quality of care, and enhance our coordination efforts. Advanced Health tracks monthly interdisciplinary team meetings, referrals, sharing of care plans, and improved use of the Collective Medical Notification system.

Advanced Health's ICC program provides care planning and gathers information on our priority population groups through the administration of our initial ICC referral screen and social needs assessment, the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) for every member that agrees to participate and enrolled. The ICC referral screen indicates mental illness as a significant concern and 43% are worried of losing their home, 40% are unemployed, 48% were unable to get the medical care needed, and 13% stated transportation has kept them from medical appointments or getting their medications. Of the members in ICC care who were assessed in 2022, 99% speak English, with the primary race being White (86.9%) followed by American Indian/Alaskan Native (3.27%), and Hispanic/Latino (1.3%).

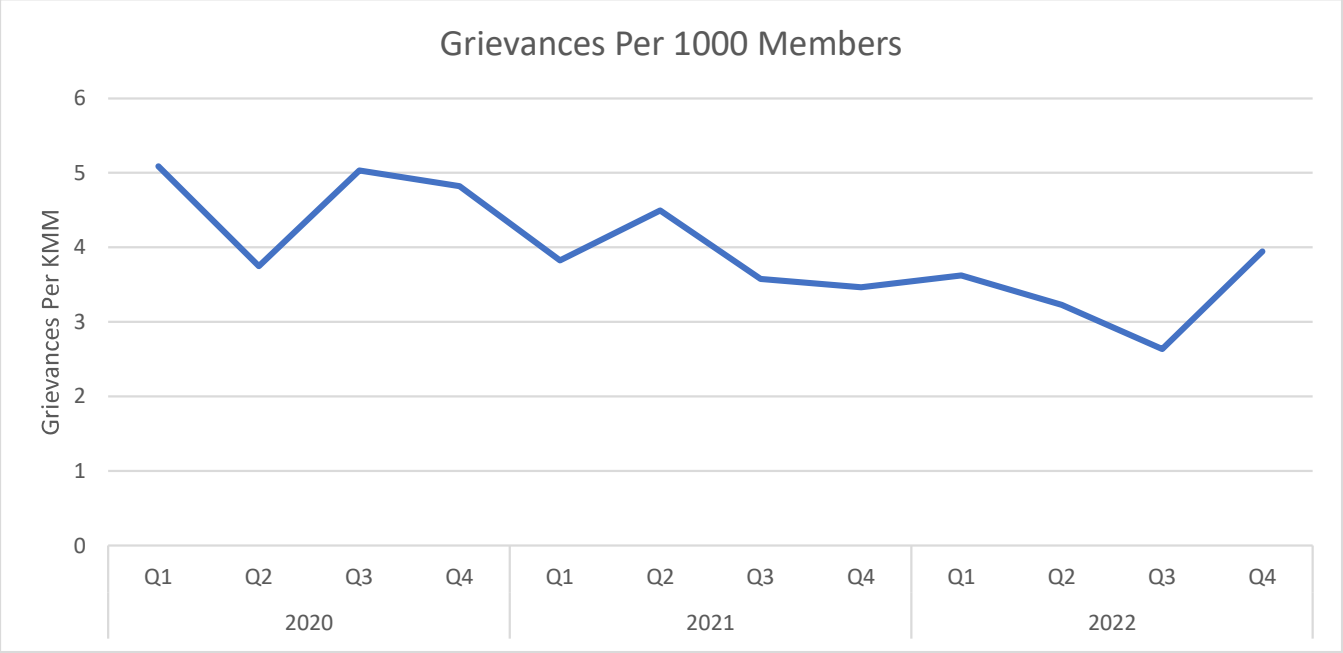
2023 Workplan: See the project description and monitoring activities included in the 2023 TQS project entitled Improved Coordination of Care and Increased Depression Screening and Follow Up for LTSS Members with SCHN.

Report on the Grievance System

Advanced Health monitors data from the Member Grievance System closely for trends that can be addresses through systemic quality improvement efforts.



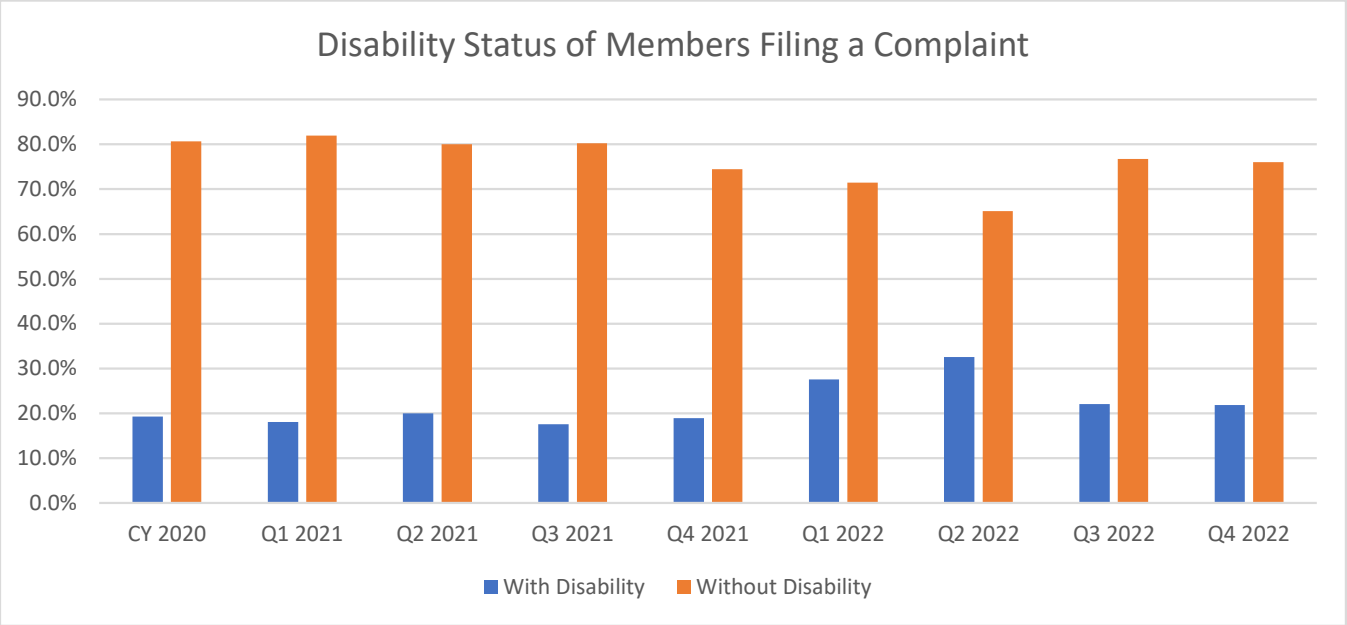
Total complaint volumes decreased slightly in 2022, despite increasing enrollment due to the suspension of the redetermination process while the public health emergency remains in effect. The rate of grievances per 1000 members declined to 3.35 in 2022, from 3.8 in 2021.



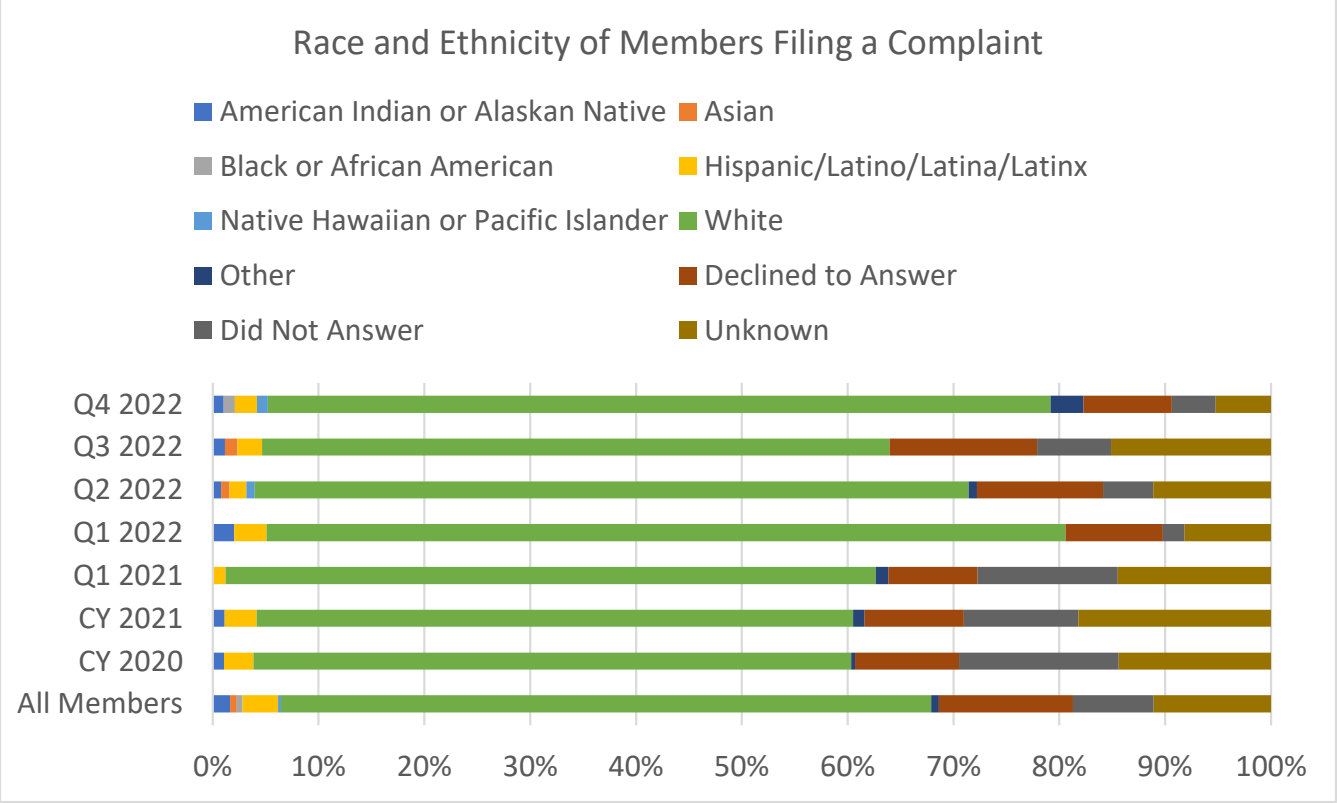
Advanced Health tracks grievances related to cultural sensitivity by both the provider and the plan. We have had no grievances related to cultural sensitivity in the past 12 quarters. We will continue to work to maintain low complaints in this category. These complaints are categorized as IP.h: Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.

With 12% of our member population experiencing disability, they represented 39% of our member complaints in Q1 2022 through Q3 2022. We had 99 complaints from members with documented disabilities. Of those 99 complaints, 12% were related to a disability, but not necessarily the disability listed in the REALD data from the enrollment files, and 88% of those 99 total complaints were not related to the member disability. The complaint process remains accessible

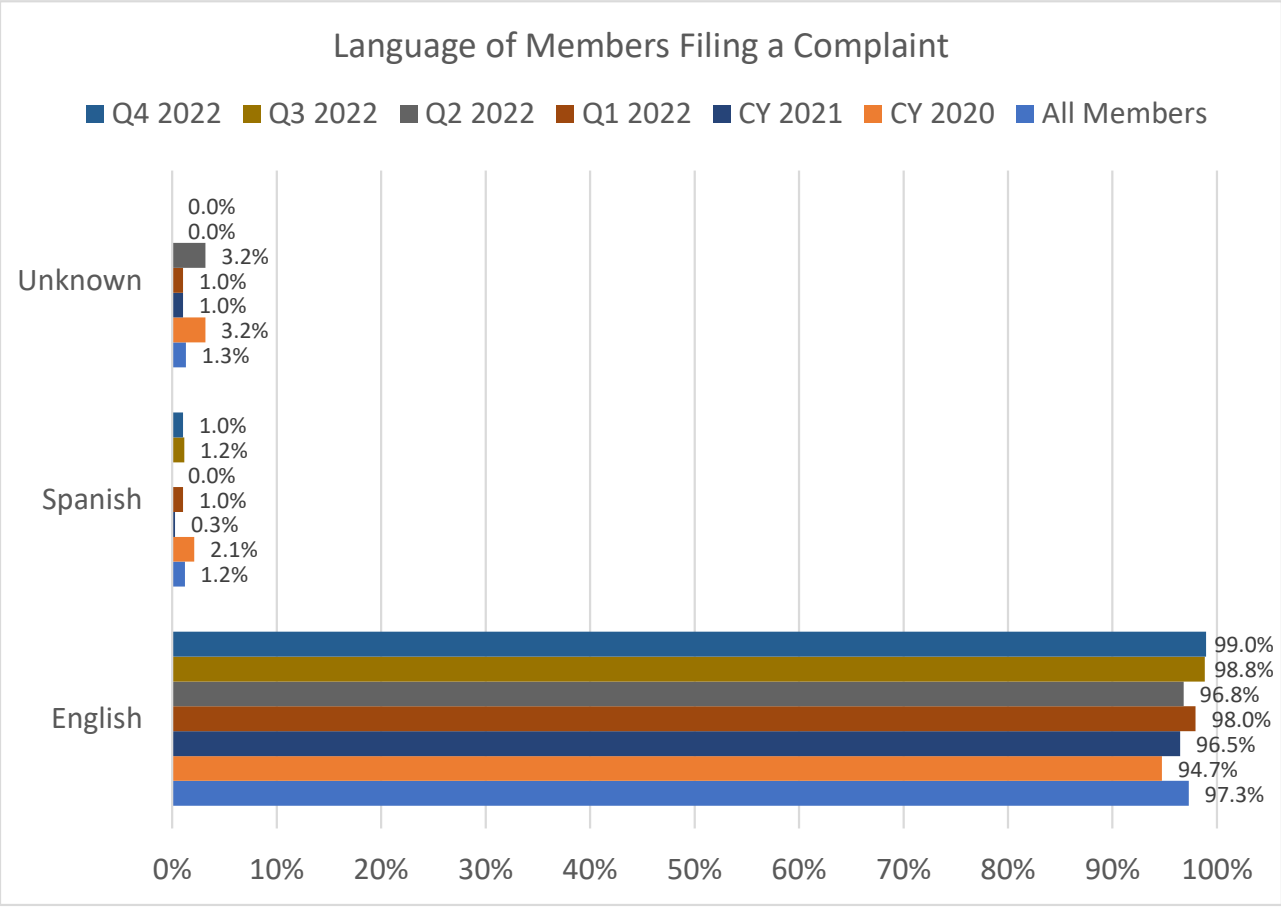
to our members, and we are happy that nearly 88% of those complaints were not related to their disabilities. Two complaints stood out that required corrective action or escalation, but no noted trends were identified.



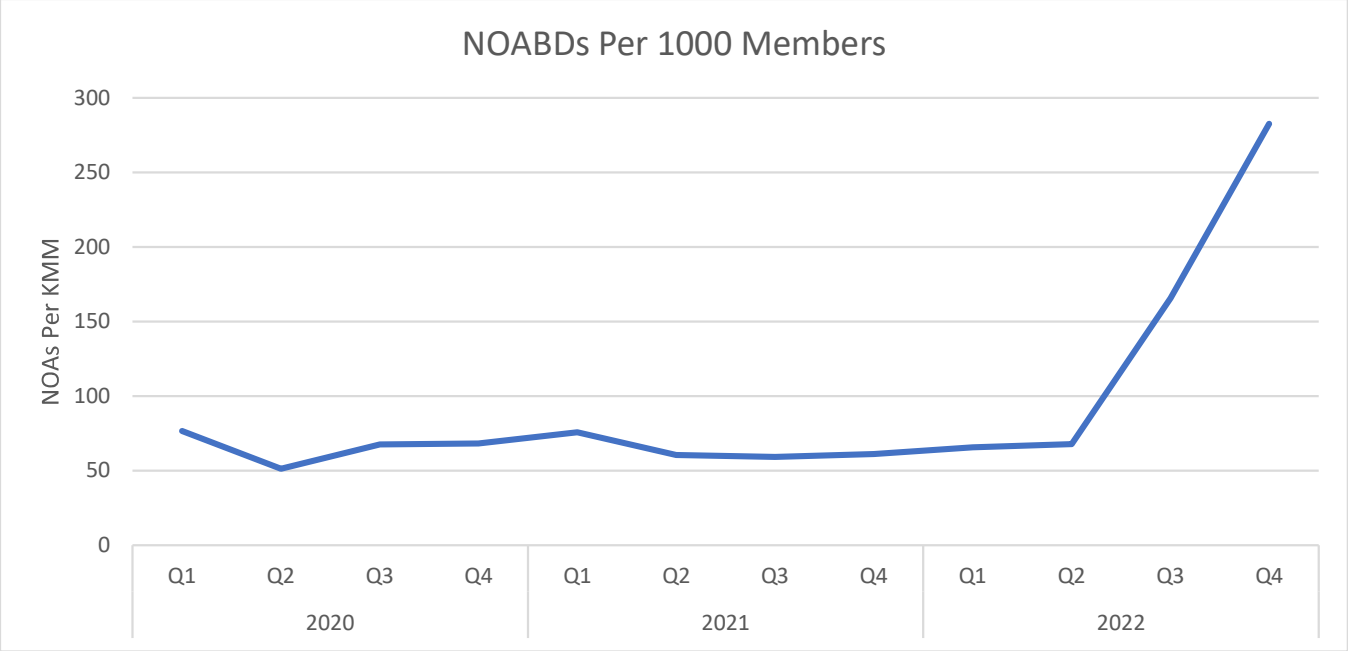
Race and ethnicity data from the 834 enrollment files is matched by member ID to data from the grievance tracking system, allowing for an analysis to better understand whether our grievance system is being accessed equitably by all members. In the chart below, we compare the data for all members to calendar year 2020 and 2021, and 2022 by quarter. We aggregate the data quarterly, so we have a large enough sample of information to give some confidence in the proportions and still have shorter-term check-ins to be able to watch for trends throughout the year. In 2021, this data analysis became part of the grievance data reviewed by the Interagency Quality Committee. There were no notable trends observed in 2022 compared to the two prior calendar years.

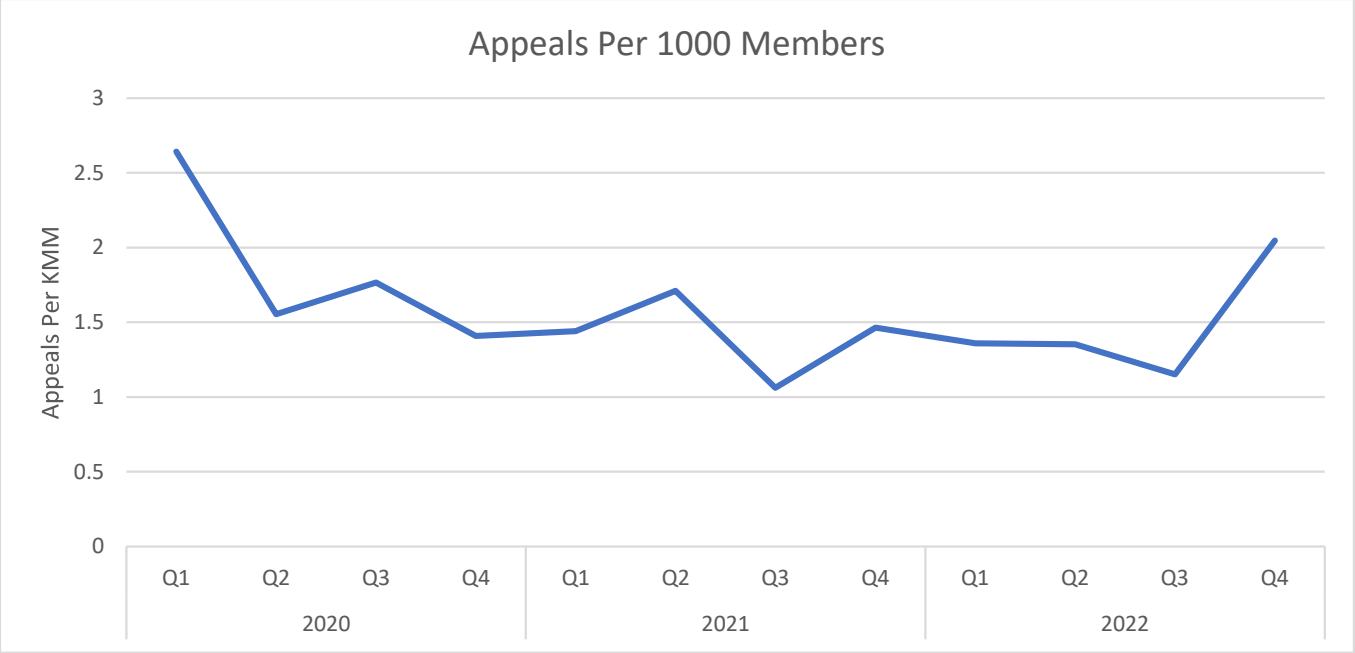


In a similar fashion as described above, the spoken language of members who filed complaints was also analyzed in 2022 and reviewed by the Interagency Quality Committee. Improving language access is an initiative at Advanced Health and it is important to use the data we have available to monitor for equitable access to health care services, but also for access to systems that support member rights, such as the grievance system. In 2021 we see only a small number of complaints from Spanish-speaking members. It is possible that we are missing an opportunity to hear from these members, or it is possible that due to small sample sizes (approximately 30 complaints per month) and the relatively small population, that we can expect to see some months with 0 complaints for Spanish-speaking members. In 2022 we observed a more expected proportion of approximately 1% of complaints coming from Spanish-speaking members. However, this is an area that will require more investigation in 2023 to ensure we identify any unknown barriers

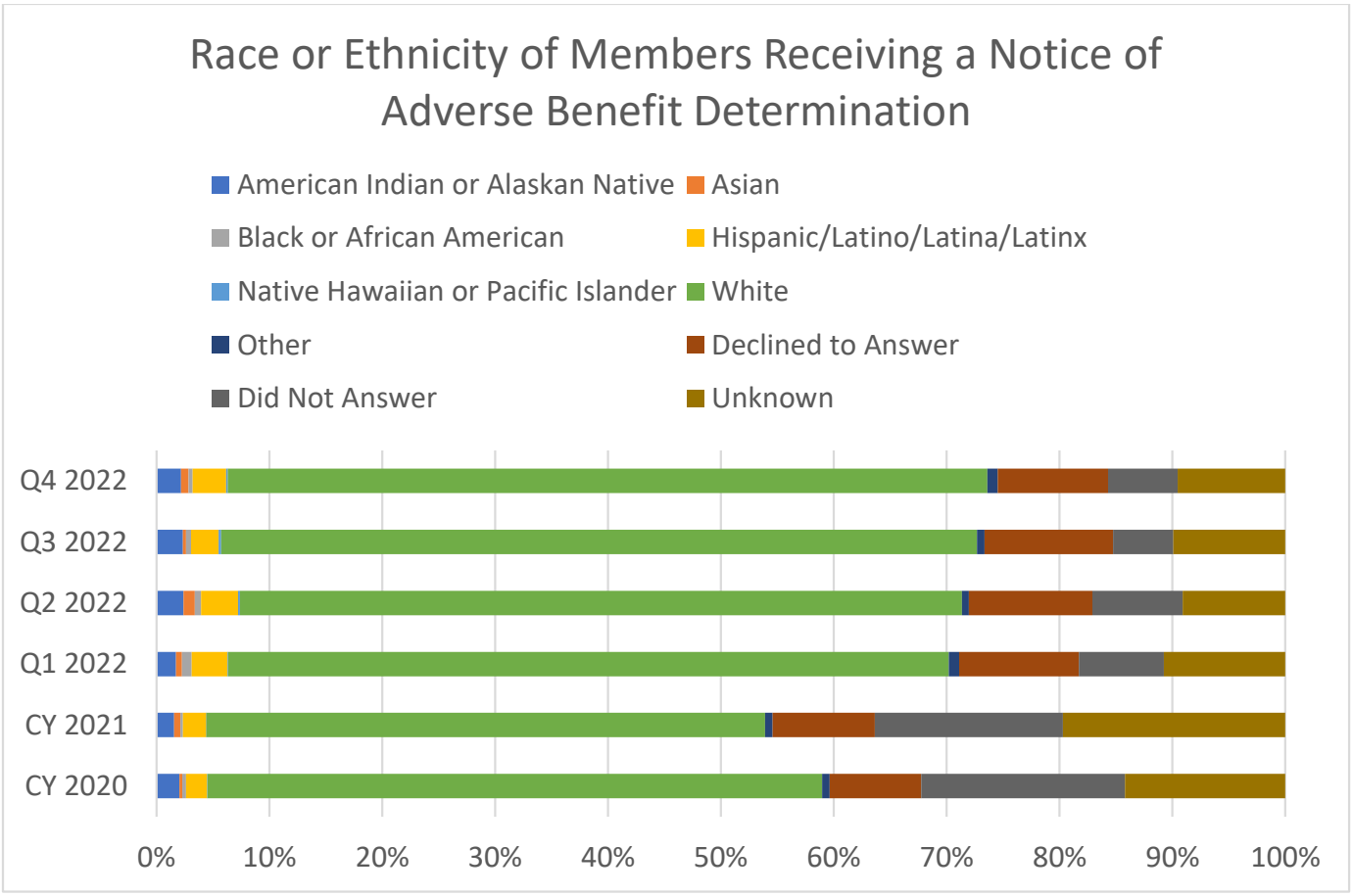


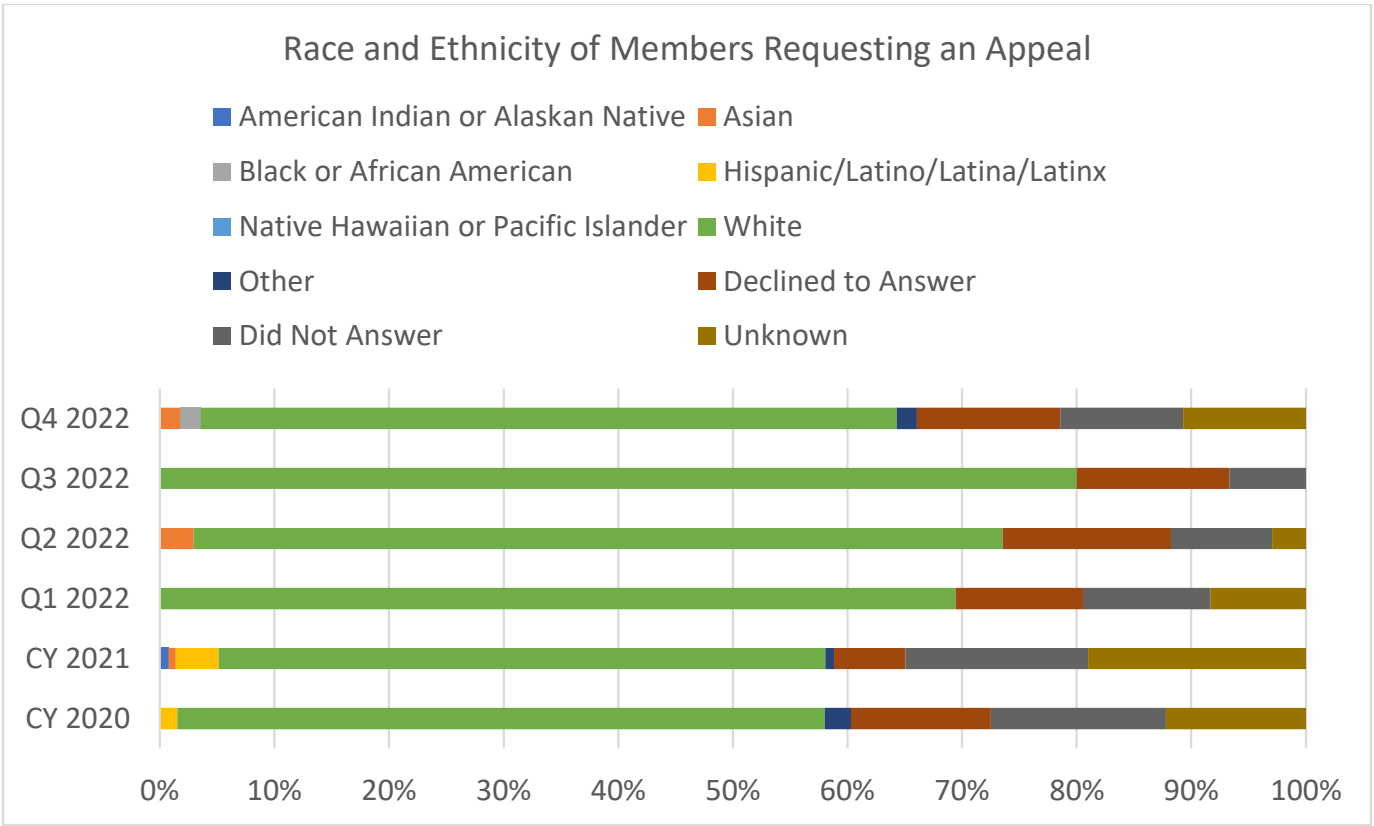
The rate of Notices of Adverse Benefit Determination (NOABDs) per 1000 Members stayed the same the first two quarters of 2022. The rate per 1000 members more than doubled the remaining two quarters with the implementation of mailing member claims NOABDs. Appeals per 1000 Members increased slightly from 1.41 in 2021, to 1.48 in 2022. An increase in appeals was expected with the increase in NOABDs, but is still a decline from 1.84 per 1000 members in 2020.

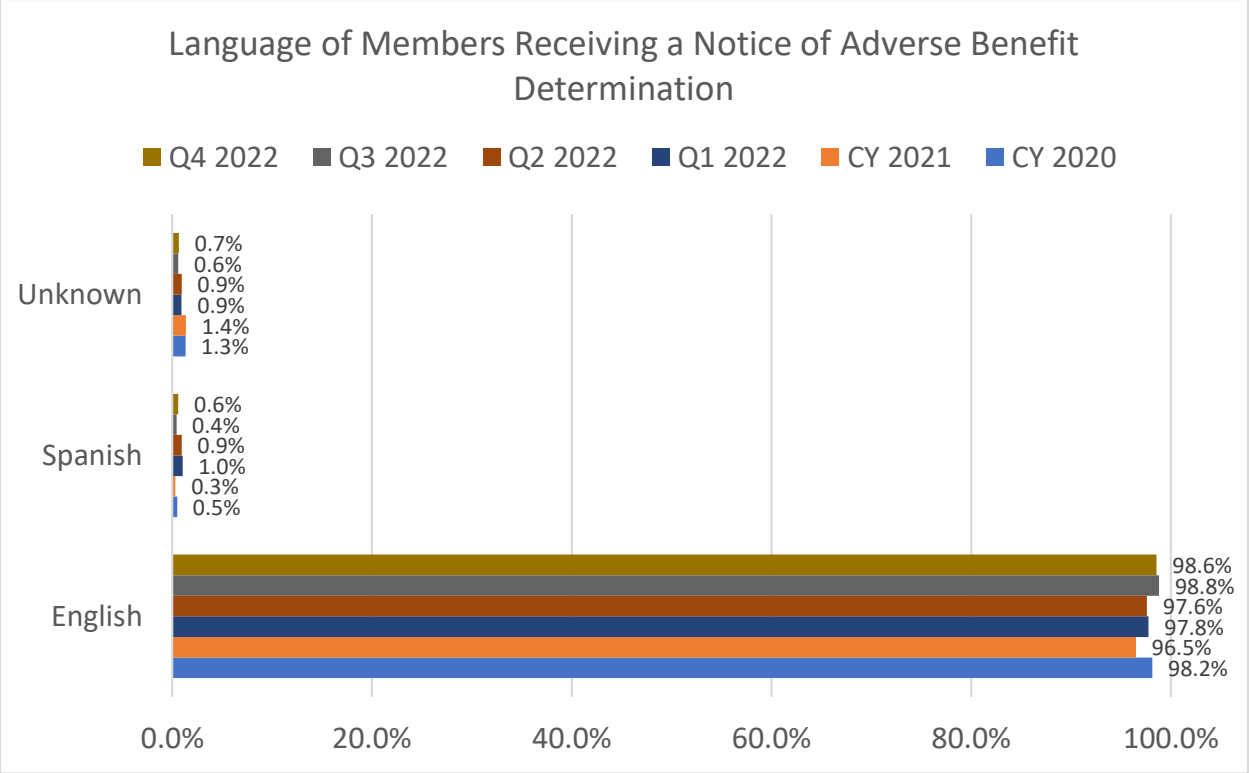




Below is an analysis of member race and ethnicity for NOABDs and for appeals. Similar to the analysis discussed above for grievance data, this information is monitored and reviewed quarterly by the Interagency Quality Committee.


Race or Ethnicity of Members Receiving a Notice of Adverse Benefit Determination
American Indian or Alaskan Native
Asian
Black or African American
Hispanic/Latino/Latina/Latinx
Native Hawaiian or Pacific Islander
White
Other
Declined to Answer
Did Not Answer
Unknown
Q4 2022
Q3 2022
Q2 2022
Q1 2022
CY 2021
CY 2020
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Race and Ethnicity of Members Requesting an Appeal
American Indian or Alaskan Native
Asian
Black or African American
Hispanic/Latino/Latina/Latinx
Native Hawaiian or Pacific Islander
White
Other
Declined to Answer
Did Not Answer
Unknown
Q4 2022
Q3 2022
Q2 2022
Q1 2022
CY 2021
CY 2020
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%



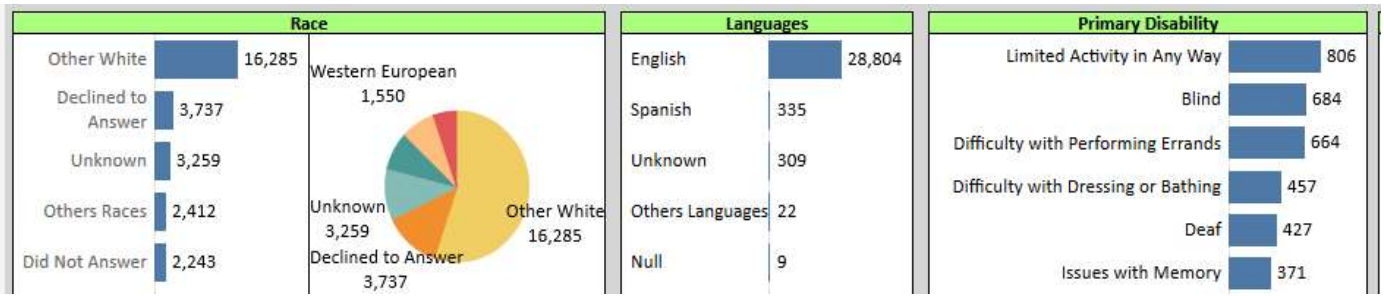
2023 Workplan: See the project description and monitoring activities included in the 2023 TQS project entitled Member Grievance System Improvements.

Health Equity Data

Advanced Health currently serves over 29,000 Oregon Health Plan Members in Coos and Curry Counties on the Southern Oregon Coast. 52% of Advanced Health Members are female, and 48% are male. 12% or, approximately 3,565 members, have one or more disabilities. A report was prepared for the Interagency Quality Meeting following Q3 2022, with the results of a focused review of complaints by members with one or more reported disabilities.

Advanced Health's primary and most complete source of data related to linguistic and cultural needs of members is the OHA 834 enrollment data. Advanced Health finds the REALD demographic data from OHA to be the most comprehensive data set available at this time. Using this REALD data, Analytics Department staff have developed a REALD demographic dashboard in Tableau to summarize the race, ethnicity, language, disabilities, and interpreter needs of Advanced Health members. The dashboard also includes a query feature to allow staff to find REALD data for a specific member. This function is used by the Grievance System Coordinator when reviewing grievance and appeal data to ensure we are offering materials in the member's language and to monitor for any trends related to equitable access to health care or the grievance system. Customer Service and other staff are able to use the feature as well.

These Tableau dashboards are updated daily to weekly, and enrollment and encounter data is updated daily.



Current demographic data identifies the following enrollee characteristics:

All Members Race and Ethnicity	
American Indian or Alaskan Native	1.6%
Asian	0.6%
Black or African American	0.6%
Hispanic/Latino/Latina/Latinx	3.4%
Native Hawaiian or Pacific Islander	0.3%
White	61.4%
Other	0.7%
Declined to Answer	12.7%
Did Not Answer	7.6%
Unknown	11.1%

While there are still gaps in the race and ethnicity data set available through the 834 enrollment files, the completeness of the data improved over the course of 2022 and is continuing to improve in Q1 2023. At the beginning of 2021, nearly 41% of race and ethnicity data was not provided. As of mid 2022, 35% was unknown. And as of Q1 2023, the categories "unknown," "did not answer," and "declined to answer" account for only 31%. This is an encouraging trend in closing the gaps in available race and ethnicity data.

All Member Language Data	
Unknown	1%
Other	<1%
English	97.6%
Spanish	1.1%

*Note languages reported by fewer than 20 members are suppressed from this report

Spanish is the most common non-English language spoken by Advanced Health Members, with 1.1%, or about 335 Members, indicating that their primary language is Spanish. While the language data has long been more complete than the race and ethnicity data, we have noted improvements in this data set as well in 2022 and now show only 1% of language data is listed as "unknown."

Advanced Health analytics staff have used the REALD data available in the 834 enrollment files to stratify data and reporting for quality metrics, performance improvement projects, grievance and appeals system data (including NOABDs), and improving language access. Other areas where REALD data is leveraged is in implementation of the Health Equity Plan across the eight focus areas.

In addition to the 834 enrollment REALD data, Advanced Health has other mechanisms for collecting REALD and SOGI data for some focused populations and analysis. The annual CAC demographic report uses a questionnaire to collect data from CAC members and compares the membership of the CACs to the make-up of the community at large to ensure the CACs are truly representative of the communities in Advanced Health's service area. In 2022 Advanced Health began planning for an updated Community Health Assessment (CHA). The community questionnaire to be launched in 2023 includes REALD and SOGI data collection along with the health information to be included in the analysis published in the 2023 CHA. Advanced Health also has a policy and procedure for collecting REALD data from employees, subcontractors, board, and committee members. This data is analyzed and monitored for several initiatives related to the Health Equity Plan, embedding Culturally and Linguistically Appropriate Services (CLAS) standards within the organization, and for improvements to recruitment, hiring, and retention practices.

Advanced Health does not currently have a comprehensive source of SOGI (Sexual Orientation and Gender Identity) data for its full membership. In 2022, Advanced Health has supported implementation of Reliance, a health information exchange (HIE) that would allow for some visibility into the REALD and SOGI data collected by clinics and hospitals connected to the HIE. Advanced Health has also been following OHA's developments in finalizing a data set for SOGI data and the efforts to develop a REALD and SOGI data repository that will allow CCOs a comprehensive data set gathered from multiple sources throughout the agency's programs.

2023 Workplan: See the project description and monitoring activities included in the 2023 TQS project entitled Member Grievance System Improvements.

EQR Results and Improvement Plan

The External Quality Review in 2022 was performed by HSAG and focused on Confidentiality, Enrollment and Disenrollment, Quality Assessment and Performance Improvement, Health information Systems. Advanced Health received and overall compliance score of 83% with the lower performing standard being Enrollment and Disenrollment due to gaps in nondiscrimination policy notifications and lack of evidence of staff training.

Advanced Health received a score of 75% in the QAPI standard dur to failure to establish and implement a comprehensive and descriptive program description and workplan that met applicable federal, State, and contractual requirements. In addition, Advanced health failed to demonstrate appropriate oversite of the QAPI program, which impacted the MCE's ability to monitor and evaluate the quality and appropriateness of services furnished to its members consistent with the needs and priorities of the MCE's member population.

Advanced Health will revise the Quality Assessment and Performance Improvement program structure to align with federal and State requirements and will demonstrate implementation and appropriate oversight of this program.

2023 Workplan: The full improvement plan to correct findings identified in the 2022 EQR compliance monitoring review report can be found in the 2022 Improvement Plan document submitted to HSAG.

Assessment of Performance on PIPs

Detailed quarterly reports for below outlined projects are conducted and submitted to OHA at least annually. For more information, please refer to the quarterly PIP reports.

OPEN-Statewide PIP- Mental Health Access Monitoring Integration

This statewide PIP was opened in mid-2022 with the first quarterly report submitted in October 2022. Advanced Health has worked with local community partners and groups to implement tailored interventions aimed at increasing the number of members with a mental health need who received a mental health service. Interventions focus on provider recruitment and retention to improve access including secondary focus on the underserved populations in Curry County and understanding barriers to care specific to transportation and member education.

Advanced Health has analyzed member level data to understand the population including where they are living versus where they are accessing services to identify gaps in access as well as transportation barriers that could exist. Member education materials are in draft to assist members in better understanding their mental health benefits as well as intentional support of members seeking mental health services in Curry County during the transition in mental health service organizations.

NEW- Statewide PIP- Initiation, Engagement and Treatment of Alcohol and Other Drug Use Disorders

This is a new statewide PIP with validation completed in late 2022 and quarterly reporting starting in early 2023 with an aim to evaluate the impact of targeted interventions on the rate of members who initiate and receive SUD treatment. This PIP leverages the Initiation and Engagement incentive measure for performance with a target population of members 13 years and older with a newly identified SUD episode in the previous 12-month period.

Interventions for this statewide PIP are still in development through collaboration with our addiction's treatment providers as well as primary care providers in our network to determine the most impactful areas of focus. In 2021, Advanced Health met the improvement target for the initiation aspect of this measure but missed the engagement piece. Through the process of this PIP, Advanced Health hopes to continue to strengthen relationships between primary care and addition and recovery agencies by improving the referral and loop closure aspects of care.

OPEN-CCO PIP-Diabetes Care

This PIP was established in 2019 with the aim to improve the rate of Oral health evaluations for members with Diabetes. Advanced Health has worked with Advantage Dental and primary care practices to build interventions that bring dental care into the primary care setting, improve communication and coordination of care for members with diabetes, and improve provider education with member focused materials highlighting the importance of oral health and chronic disease management.

In collaboration with Advantage Dental, Advanced Health has successfully integrated oral health at six primary care practices. Each location hosts an expanded practice dental hygienist a few days a month to offer services. Care coordination teams at the primary care practices conduct outreach to members to fill the 12-18 spots available on the schedule. This outreach has been very successful as these days are booked at 100% capacity with very low no-show rate. This program has been received well by all parties involved and members find the process easy and comfortable.

Continuous monitoring of Oral health evaluations for members with diabetes reflects the work to increase access to oral health evaluations in the primary care setting is being offset slightly by the remaining impact that Covid-19 has had on utilization of oral health services and clinic partner bandwidth. Advanced Health has experienced a decrease in oral health utilization since the pandemics onset and we anticipate a slow return to normal utilization in the coming years.

OPEN-CCO PIP- Meaningful Language Access

This PIP was established in 2021 with the aim to improve the rate of members who received interpreter services in the healthcare setting. Advanced Health has worked closely with the Interagency Quality and Accountability Committee to identify interventions to improve the identification of patients who require interpreter services, workflows to capture the use of interpreter services and the number of OHA qualified/certified healthcare interpreters working in our local provider network.

In 2022, clinic partners received resources to help members self-identify as Limited English Proficient including "I speak" materials for the clinical setting. A direct member mailing was done to inform members of their right to no-cost interpreter services as well as an "I speak" card to aid in receiving the interpreter services they need. Advanced Health also established and widely promoted a Health Care Interpreter certification scholarship to aid clinical staff who are serving as interpreters to become OHA qualified/certified with more than 6 awardees in 2022. Advanced Health reviewed the language accessibility of our website including the provider look up tool adding any non-English spoken language to the provider information.

Member level Real-D data was analyzed to better understand the prominent non-English languages in our population and the Health Risk Assessment was updated to include the top six non-English languages prevalent in our population for the member to self-identify their primary language. Advanced Health's in-house interpreter services program was enhanced to include not only in person interpretation for Spanish speaking members, but video interpretation services for over 240 languages through Language Line. This program is widely promoted to our provider network and tracked internally to capture the language and modality of interpreter services offered.

Performance on the selected metric for this PIP improved in Q4 of 2021 and has since hovered around the baseline for the reported quarters in 2022. With continued focus on identifying members with interpreter needs we hope to see performance reach the 10% above baseline goal.

OPEN- CCO PIP- ED Utilization

This PIP was established in 2019 with the aim to reduce ED utilization for Advanced Health members. In coordination with the Interagency Quality and Accountability Committee and internal Intensive Care Coordination team interventions were designed to promote the coordination of care with Emergency Department providers, primary care intervention aimed at identifying SUD and providing navigation to treatment and the analysis of member level data to better understand the drivers of Emergency Department Utilization, including those with Sever and Persistent Mental Illness (SPMI).

Advanced Health's Intensive Care Coordination (ICC) utilizes Activate Care to coordinate care with Emergency Department staff as well as managing care plans for those ICC eligible members with chronic conditions like Asthma and Diabetes. This platform allows the ICC team to put in alerts for members who utilize Emergency Department services at higher rates as well as their care plan to assist those Emergency Department providers in coordinating services. This allows all members of the care team to understand the current condition and goals of the member when providing services.

Advanced Health has experienced lower than usual rates of Emergency Department utilization since the onset of Covid-19 and we expect this to continue in the coming years. This PIP will be closed with the first quarterly reporting of the new Statewide PIP around Substance Use Disorder.

Assessment of Performance on Quality Incentive Measures

Advanced Health expects to earn 90% of its quality pool payment for 2022. The following is a brief discussion of Advanced Health's performance on each quality incentive measure and the primary reasons for success or failure. Each measure is marked with either a ✓ indicating expected attainment of either the Benchmark or the Improvement Target, or a O indicating Advanced Health is not certain of the measure outcome or does not expect to achieve the target performance.

- ✓ **Assessments for Children in DHS Custody:** The FEARsome Clinic, which coordinates physical, dental, and mental health assessment for children in DHS custody, continued its work in 2022. This clinic has been held out as a model for achieving this metric. We expect to see a large improvement in performance on this measure and will surpass our improvement target for 2022.Despite having to change its main modality to telehealth due to the pandemic, this clinic continued to function and provide timely assessments for children in DHS custody.
- ✓ **Childhood Immunization Status (Combo 3):** Advanced Health continues to collaborate with primary care practices to promote well visits and immunizations for children and provides monthly gap lists to clinics for outreach. The delayed impact of the pandemic continues to decrease utilization of primary care services including well visits and immunizations.
- o **Cigarette Smoking Prevalence:** Advanced Health continues to promote standardized data collection practices with primary care practices in our network. The delayed impact of the pandemic continues to decrease utilization of primary care services including well visits and appropriate screenings.
- o **Depression Screening and Follow Up:** Advanced Health continues to promote standardized data collection process with primary care practices in our network. The delayed impact of the pandemic continues to decrease utilization of primary care services including well visits and appropriate screenings.
- ✓ **Diabetes: HbA1c Poor Control:** Preliminary data shows Advanced Health meeting this measure in 2022 due in large part to the strategies employed. Strategies for improvement include promoting the use of standing A1c orders for members in primary care case management as well as health coaching and pharmacy programs aimed at reducing A1c. In 2022 the Integrated Clinical Pharmacist program was established at our largest primary care practice; this program leveraged a full- time pharmacist who saw members based on referral for medication adherence, optimization, and member education. Preliminary data from this program shows a vast reduction in A1c over 6 months and we hope to see this reflected in our overall CCO population. In addition, the "A1 See Ya later" project had its pilot phase in 2022 with roughly 12 members identified through our Intensive Care Management team to undergo a 12-week intensive course that included health coaching, food and nutrition guidance and physical fitness tailored to the needs of the member. This program also produced a reduction in A1c for the participants and the member experience spoke to more health outcomes than just A1c reduction. We hope to see the work of these interventions in the final metric performance.

- ✓ **Health Equity- Meaningful Language Access:** In 2022, Advanced Health received 82 points via the attestation process and expects to meet the 80% data collection rate for the hybrid measure sample. Advanced Health has many interventions to ensure members who communicate in languages other than English or are hard of hearing are provided with certified and qualified health care interpretation services. These interventions are outlined in the PIP as well as the Improved Language Access TQS project highlighted above.
- ✓ **Health Aspects of Kindergarten Readiness:** Advanced Health expects met the attestation requirements for this measure in 2022 with 65 total points. In collaboration with our local early learning hub and Allcare Health in Curry County we successfully held community meetings to review the REACH data, the asset map and build interventions. The voice of our community partners was prevalent in the identification of priority populations and the building of innovative interventions for improved access to care for the 0-5 year old population.
- o **Immunizations for Adolescents (Combo 2):** Advanced Health does not anticipate meeting the improvement target for this measure based on the current data available. Barriers for this measure include continued reduction in utilization of primary care services due to the Covid-19 pandemic as well as vaccine hesitancy specifically for HPV. Historically Advanced Health has worked with local pediatricians to stress the importance of having the HPV vaccine discussion with parents around the age of 9, when this vaccine can first be given instead of waiting until the patient turns 12. This strategy has proved effective however the vaccine rate stays below the goal based on the reduced utilization of well visits and vaccine appointments.
- ✓ **Initiation and Engagement of Alcohol and other Drug Treatment- Initiation and Engagement:** Advanced Health expects to meet the engagement aspect of this measure but not the initiation aspect. Collaboration with SUD partners and primary care has been the focus of 2022 specifically around navigating positive screenings in the primary care setting with navigation to treatment by Integrated Behavioral Health staff. These efforts are in the beginning stages however we anticipate improved performance in the coming measurement years.
- ✓ **Oral Evaluation for adults with Diabetes:** Advanced Health anticipates meeting this measure in 2022 due to the collaboration with our local Dental Care Organization (DCO), Advantage Dental. This collaboration focused on outreach for members with Diabetes and integration with primary care. In 2022, Advanced Health and Advantage Dental paired with primary care offices in our community to establish "dental days" which hosted an advanced practice dental hygienist for the purpose of oral health evaluations for all patients of the clinic. Primary Care Case Management (PCCM) and primary care providers at the clinic were the main source of referrals for this program. Utilization of these services was consistent throughout 2022 and the member experience was very positive. See additional information listed in the DM Care PIP report above.
- ✓ **Preventive Dental or Oral Service Utilization age 1-5 and age 6-14:** Advanced Health anticipates meeting this measure for both age groups in 2022 largely due to an increase in utilization of oral health services and collaboration with Advantage Dental our local DCO for member outreach.
- ✓ **Screening, Brief Intervention and Referral to Treatment (SBIRT) for drug and alcohol use:** Advanced Health anticipates meeting this measure in 2022. The processes used to capture this screening for our clinical partners is well established however, a new community wide Electronic Health Record (EHR) has made data reporting somewhat challenging.
- ✓ **Timeliness of Postpartum Care:** Advanced Health anticipates meeting this measure in 2022 largely due to the well-established scheduling processes of our clinic partners. Historically Advanced Health has worked with providers to encourage the use of administrative codes that capture not only the first prenatal visit but also the first postpartum visit. This practice has reduced the chart review burden over the past few years.
- o **Well Care Visits (age 3-6):** Advanced Health does not anticipate meeting this measure in 2022 due to sustained decrease in primary care utilization since the onset of the pandemic in 2020. Our primary care provider network continues to utilize outreach tools for well visits and vaccines.

The table below lists all of the 2022 Quality Incentive Measures, an estimate of the potential Advanced Health member population included in each measure, as well as targets and performance trends.

2022 Quality Incentive Measure	Approximate Denominator	2022 Benchmark	2022 Improvement Target	2022 Estimated Performance	2021 Performance	2020 Performance
***Assessments for children in DHS custody**	Age 0-17 in DHS custody	90.0%	90.0%	91.7% [1]	90.3%	78.8%
Child immunization status (combo 3)	Age 0-2	71.1%	56.3%	64.4%[1]	66.4%	75.6%
Cigarette smoking prevalence (lower is better)	Age 13 +	25.0%	N/A	39.5%[2]	39.0%	29.0%
Depression screening and follow up	Age 12 and up	64.6%	45.0%	19.7%[2]	42.6%	48.9%
Diabetes: HbA1c poor control (lower is better)	Age 18-75 with diabetes	27.5%	39.5%	31.0%[2]	40.8%	39.7%
Health Aspects of Kindergarten Readiness- Social Emotional Health Metric	Age 0-5	Attestation, asset map, action plan	Attestation, asset map, action plan	Met: 65 Points	N/A	N/A
***Immunizations for Adolescents (Combo 2)**	Age 13	36.9%	26.7%	23.2%[1]	25.6%	36.3%
***Initiation and Engagement of Alcohol and other Drug Treatment**	Age 13+	43.0% 13.9%	43.0% 11.3%	34.4%[1] 13.1%[1]	31.6% 9.4%	37.8% 10.0%
Oral Evaluation for adults with Diabetes	Age 18+	20.4%	18.6%	21.3%[1]	18.4%	16.1%
Preventive Dental or Oral Service Utilization age 1-5 and 6-14	Age 1-5 and 6-14	43.1% 52.0%	43.1% 48.2%	49.9%[1] 52.5%[1]	44.9% 47.8%	33.2% 40.1%
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Age 12+	68.2% 53.5%	46.2% 8.1%	59.4%[2] 17.0%[2]	43.5% 2.5%	50.6% 2.6%
Timeliness of postpartum care	Women who have given birth	80.9%	76.6%	N/A (Chart Review)	76.1%	84.2%
***Well Child Visits (age 3-6)**	Age 3-6	64.1%	63.2%	58.9%[1]	64.2%	62.8%

*Challenge Pool Measure

[1] OHA current Rolling data through September 2022

[2] Preliminary internal EHR data report

[3] Preliminary internal report from administrative data

2023 Quality Improvement Strategy and Work Plan

The *Quality Improvement Strategy and Work Plan* is the third and final component of Advanced Health's overall Quality Assurance and Performance Improvement Program. It is a forward-looking plan for quality improvements over the coming year and is informed by the results of the *Quality Program Evaluation* in section 2.

Advanced Health maintains an array of strategies across a number of quality improvement efforts with work plans specific to each project. These projects arise from a variety of sources including contractual requirements for performance improvement projects and transformation benchmarks, quality incentive measures, quality performance measures, and other internal quality improvement efforts.

Performance Improvement Projects and Focus Areas (PIPs)

PIPs and Focus Areas are selected by Advanced Health from a menu of options defined by OHA in the CCO contract Exhibit B, Part 10, #6. PIP reports are conducted and reported to OHA at least annually. For more detail on the PIPs, see the quarterly progress reports submitted to OHA.

Project	Team	Overview of Goals, Strategies, and Work Plan
Mental Health Access Monitoring. ****State-wide PIP****	Advanced Health's COO, Kent Sharman, Advanced Health's CMO, Kera Hood, Advanced Health's Behavioral Health Director, Amanda McCarthy, Advanced Health's Quality Manager, Lisa Castle, Quality Improvement Specialist, Pamela Huntley, Systems of Care Coordinator, Clinical Advisory Panel, and Interagency Quality and Accountability Committee.	**Goal**: Increase the rate of members with a mental health service need who received mental health services. Advanced Health will continue to collaborate with internal and external stakeholders to identify potential barriers to mental health care including access, geographical location, transportation, and member education. Initial interventions have been developed and submitted to OHA and HSAG via the validation form and include specific collaborations with mental health service organizations in Curry County as well as data analysis to better understand the population receiving services stratified by RealD data and geographical location. Quarterly OHA provided data is consumed by an internal dashboard that allows Advanced Health to monitor service rates and the demographic location of members in the denominator compared to the BH provider location. Ongoing monitoring of this dashboard in addition to efforts on interventions will continue and be reported throughout 2023.

Project	Team	Overview of Goals, Strategies, and Work Plan
Reducing preventable Emergency Department Utilization ****CCO PIP****	Advanced Health's COO, Advanced Health; Kent Sharman, MD, Medical Director, Advanced Health; Amanda McCarthy, Quality Manager, Advanced Health; Lisa Castle Quality Improvement Specialist, Advanced Health; Advanced Health's Clinical Advisory Panel, and Interagency Quality and Accountability Committee.	**Goal**: Reduce the rate of Emergency Department visits per 1000 member months for Advanced Health members by at least 2 percentage points over the previous year's rate. The use of care management platform Collective Medical to manage emergency room discharge data to identify members with Severe and Persistent Mental Illness (SPMI) and those who could benefit from Intensive Care Coordination (ICC) services. The focus of this intervention has been to promote the adoption of Collective Medical at our largest hospital, clinics, and our public health/behavioral health partner. The development of an internal data dashboard to monitor Emergency Department utilization per 1000 member months. This dashboard allows for analysis of data by date of service, age, facility, primary diagnosis code, and assigned primary care provider. Additional filters for the SPMI and Substance Use Disorder (SUD) populations were added in 2022. Advanced Health plans to add additional filters for the LTSS population in early 2023 for better visualization of the ED utilization for that subset of members. Advanced Health as partnered with a local primary care office who is piloting the ANTECEDENT program through OHSU and ORPRN to identify SUD in primary care. This pilot involves primary care providers and the integrated behavioral health team to aid in patient navigation from positive screening and brief intervention to treatment. This PIP gauges performance using the rate of emergency department visits per 1000 member months. **This PIP will be closed with the first quarterly report of the second statewide PIP.**
Meaningful Language Access ****CCO PIP****	Advanced Health's COO, Advanced Health; Kent Sharman, MD, Medical Director, Advanced Health; Amanda McCarthy, Quality Manager, Advanced Health; Lisa Castle Quality Improvement Specialist, Advanced Health; Advanced Health's Clinical Advisory Panel, and Interagency	**Goal**: Increase the number of members who receive appropriate interpreter services in the healthcare setting by 10% by the end of 2023. Continued focus on interventions that can increase performance on this incentive measure in advance of the completion of its three-year glide path. These interventions include surveying the current healthcare interpreter landscape, provider education around interpreter services, increasing the number of certified/qualified interpreters in our provider network, member education and resources for finding providers who speak non-English languages and to self-identify primary language, as well as data visualization of Advanced Health's members to better understand our population. This PIP gauges performance using the rate of members who received interpreter services in the health care setting as well as those who received services by an OHA qualified/certified

Project	Team	Overview of Goals, Strategies, and Work Plan
	Quality and Accountability Committee.	interpreter. Both metrics align with the OHA incentive measure and allow us to understand the impact of our chosen interventions. Continued promotion of the Health Care Interpreter Scholarship aims to increase the rate of OHA Qualified/Certified interpreters working in our provider network.
Improving Oral Health Care for Patients with Diabetes ****CCO PIP****	Advanced Health's COO, Advanced Health; Kent Sharman, MD, Medical Director, Advanced Health; Amanda McCarthy, Quality Manager, Advanced Health; Lisa Castle Quality Improvement Specialist, Advanced Health; Advanced Health's Clinical Advisory Panel, Interagency Quality and Accountability Committee, Bay Clinic, North Bend Medical Center, Waterfall Community Health Center, Advantage Dental, DCO.	**Goal:** Increase rate of oral health evaluations for patients with diabetes by at least eight percentage points by the end of 2022. This PIP includes interventions that can increase performance on this incentive measure by improving communication to coordinate care, provider education, and improve access through co-location. Each intervention leans on collaboration between clinics and our local Dental Care Organization (DCO) Advantage Dental to orchestrate "dental days" in the primary care setting. The care coordination teams at both the primary care offices as well as at Advantage Dental work diligently to outreach and schedule oral evaluations for patients identified with Diabetes with high utilization of the co-location days with primary care. Provider education interventions include co-branded patient education documents that highlights the collaboration between the DCO, CCO and primary care offices. These documents are aimed to highlight to correlation between chronic physical health conditions and oral health. This PIP gauges performance using the rate of Oral Evaluations for adults with Diabetes. Continued promotion of co-located dental days with primary care offices with the aim to increase the rate of members with Diabetes who receive an oral health evaluation.
Initiation, Engagement, and Treatment of Alcohol and Other Drugs Use Disorders ****Statewide PIP 2023****	Advanced Health's COO, Advanced Health; Kent Sharman, MD, Medical Director, Advanced Health; Amanda McCarthy, Quality Manager, Advanced Health; Lisa Castle Quality Improvement Specialist, Advanced Health; Advanced Health's Clinical Advisory Panel, and Interagency	**Goal:** to determine if targeted interventions increase the percentage of targeted members who initiate and receive SUD treatment. In 2022, this second statewide PIP completed its HSAG validation process and CCO's are awaiting validated baseline data prior to its first quarterly submission, which includes interventions. When the first quarterly report is submitted the CCO will close out a CCO specific PIP to retain the number of active PIP reports outlined in contract. Continued work on outlined interventions in 2023 to increase the rate of initiation and engagement of treatment of alcohol and other drug use disorders.

Project	Team	Overview of Goals, Strategies, and Work Plan
	Quality and Accountability Committee	

Utilization Review

2023 Workplan: see project description and monitoring activities included in the 2023 TQS report for the following projects:

- Community Collaborative – Initiation and Engagement in SUD Treatment
- Integrated Clinical Pharmacist
- Asthma Medication Adherence and Optimization

Availability of Services, Second Opinions, & Timely Access

Advanced Health has engaged with a consulting firm to assist in improving procedures for monitoring timely access to care through data collection strategies. In Q1 2023 new procedures will be finalized, along with a data collection plan, data templates for provider offices, and a member survey. Data collection will begin in Q2 2023 with a first quarterly analysis report to be produced by the compliance department in early Q3 2023.

Health Equity Cultural and Linguistic Considerations

2023 Workplan: See the project narrative and monitoring activities and measures included in the 2023 TQS for the project entitled Improve Language Services Access.

Behavioral Health Integration

2023 Workplan: see the project description and monitoring activities included in the 2023 TQS project entitled Community Collaborative – Initiation and Engagement in SUD Treatment.

Serious and Persistent Mental Illness (SPMI)

2023 Workplan: See the project description and monitoring activities included in the 2023 TQS project entitled Roadmap to Improved Behavioral Health Access.

Quality and Appropriateness of Care for Members with Special Health Care Needs

2023 Workplan: See the project description and monitoring activities included in the following 2023 TQS projects

- Medical Shelter Program
- Improved coordination of care and increased depression screening and follow up for LTSS members with SCHN

Quality and appropriateness of care for LTSS members

2023 Workplan: See the project description and monitoring activities included in the 2023 TQS project entitled Improved Coordination of Care and Increased Depression Screening and Follow Up for LTSS Members with SCHN

Grievance System

2023 Workplan: See the project description and monitoring activities included in the 2023 TQS project entitled Member Grievance System Improvements.

Health Equity Data

2023 Workplan: See the project description and monitoring activities included in the 2023 TQS project entitled Member Grievance System Improvements.

EQR Results and Improvement Plan

2023 Workplan: The full improvement plan to correct findings identified in the 2022 EQR compliance monitoring review report can be found in the 2022 Improvement Plan document submitted to HSAG.

Strategies to Improve Performance on Quality Incentive Measures

The overall theme for Quality in 2023 is “back to basics”. This will include engaging our Interagency Quality and Accountability committee in the detailed review of each incentive measure and their strategies consistently throughout the year. A deep dive into Epic, its functionality, process, and data reporting capabilities as well as working with clinic quality partners on specific interventions for improvement on low performing metrics. Direct provider communication regarding metric education and performance updates will resume in 2023 with the aim to keep data flowing for real time improvement with targeted efforts with compassion and understanding of our current and future healthcare landscape.
Childhood Immunization Status (Combo 3)

- • Promote clinic outreach to schedule well visits where immunizations are addressed
- • Review assigned patients and schedule due well visits
- • Gap Lists

Immunizations for Adolescents (Combo 2) ***challenge pool***

- • Promote clinic outreach to schedule well visits where immunizations are addressed
- • Review assigned patients and schedule due well visits
- • Gap Lists

Children and Adolescent well-care visits (ages 3-6) ***challenge pool***

- • Promote clinic outreach to schedule well visits
- • Review assigned patients and schedule due well visits
- • Gap Lists

Prenatal and Postpartum care -postpartum care ***challenge pool***

- • Schedule timely postpartum care appointments
- • Bill using administrative code to reduce chart review burden

Screening for Depression and follow-up plan

- • Promote clinic outreach to schedule annual well visits where this screening is standard workflow

Health Aspects of Kindergarten Readiness: CCO system level social emotional health

- • CCO attestation
- • CCO lead asset mapping

Cigarette Smoking Prevalence

- • Promote clinic outreach to schedule annual visits where this is a standard workflow

Alcohol and Drug Misuse: Screening, Brief Intervention and Referral to Treatment (SBIRT)

- □ Promote clinic outreach to schedule annual visits where this is a standard workflow
- • Promote efficient referral loop closure workflows

Members Receiving Preventive Dental or Oral Health Services (Ages 1-5 and 6-14) ***challenge pool***

- • Promote dental screening and discussion of oral health during well visits
- • Utilize integrated dental services when possible (Bay Clinic, NBMC, Waterfall Community Health Center and Coos Health & Wellness)
- • Promote efficient referral loop closure workflows

Oral Evaluation for Adults with Diabetes

- • Cobranded member education for use by primary care providers
- • Utilize integrated dental services when possible (Bay Clinic, NBMC, Waterfall Community Health Center and Coos Health & Wellness)
- • Promote efficient referral loop closure workflows
- • Gap lists to Advantage Dental for member outreach

Mental and Physical Health and Oral Health Assessment Within 60 days for children in DHS Custody

- • FEARsome clinic coordinated by Advanced Health staff
- • Strong relationship with local DHS field office

Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)

- • Promote clinic outreach to schedule annual visits
- • Promote clinic outreach to schedule A1c tests
- • Promote the adoption of clinical care guidelines and standing orders
- • Gap lists

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

- • Promote clinic outreach to schedule annual visits where screening for SUD is standard workflow

- • Promote efficient referral loop closure
- • Collaborate with community partners on the use of Integrated Behavioral Health staff as navigators for patients referred to treatment in the primary care setting.

Meaningful Language Access too Culturally Responsive Health Care Services

- • CCO Attestation
- • Quarterly chart review by clinic partners
- • Healthcare Interpreter Certification scholarship
- • Clinic data to more accurately reflect the population

Social Determinants of Health: Social Needs Screening & Referral ***New***

To build system capacity, this measure requires CCOs to (1) prepare for equitable, trauma-informed, and culturally responsive screening and referrals; (2) work with community-based organizations to build capacity for referrals, and meeting social needs, and (3) support data sharing between CCO's, providers, and community-based organizations. Later, CCO's start reporting social needs screening and referral data.

- • CCO Attestation
- • Unite Us Connect Oregon (Health Information Exchange) will aid in the screening, referrals, network capacity and loop closure aspects of this measure
- • Glide path (just like HAKR)

Attachment A: 3 months of IQAC meeting minutes.

Interagency Quality Committee Minutes

October 6, 2022

Attendance			
X	Amanda McCarthy, Quality Manager, Advanced Health		Jim Gardner, Chief Operating Officer, Advanced Health
	Anna Warner, Executive Program Director, Advanced Health		Jerry O'Sullivan, ADAPT
	Belle Shepherd, Innovator Agent, OHA		Marla Smith, Compliance Officer, Advanced Health
	Lindsey Tyner, Quality Improvement Coordinator, NBMC		Rosie Revelle, Office Manager, Dr. Mike & Friends
	Tim Novotny, Bay Cities Brokerage/Ambulance	X	Dawn Gray, Chief Operating Officer, Coast Community Health
X	Laresa Rowden, Quality Improvement Coordinator, Bay Clinic	X	Lisa Castle, Quality Improvement Specialist, Advanced Health
X	Debbie Standridge, Adapt		Nicole Norris, CQO, Waterfall Community Health Center
	Rebecca Meszaros, Clinic Manager, Coast Community Health-Bandon		Tami Graziano, Coquille Valley Hospital Manager Quality/Risk/Patient Satisfaction
	Jamilah Mooney, Coos Health & Wellness		Jessica Foster, QI Specialist, Coast Community Health
	Amanda Saunders, Clinic Manager, Coast Community Health-Port Orford		Alyssa Kelley, Trainer, NBMC
	Molly Johnson, Advantage Dental		Karen Stafford, Southern Coos
	Nina, Bay City Brokerage/Ambulance	X	Kent Sharman MD, Chief Medical Officer, Advanced Health
	Dee Roberson, Dr. Mike & Friends		Brandie Feger, Director of Pharmacy, Advanced Health
	Ross Acker, Advanced Health Director of Care Coordination		Holly Oltman, QI Compliance Officer, ADAPT

X	Heather Garrett, Bay Clinic	**X**	Lisa Frischkorn, Director of Member Services, Advanced Health
X	Kelli Dion, Chief Quality Officer, Bay Area Hospital	**X**	Sierra Spencer, Quality, Standardization and Training, NBMC
	Dr Tedd McDonald, Chief Community Health Officer, Waterfall Community Health Center	**X**	Doris Kiragu, Health Equity Policy Analyst, Advanced Health
X	Kaitlyn Dubisar, Quality Improvement, Bay Clinic		Lela Well, Grievance System Coordinator, Advanced Health
	Martina Rodman, Quality, Standardization and Training, NBMC		Selia Coven, Customer Service Representative, Advanced Health
			Valeria Torres, Customer Service Representative, Advanced Health

TOPIC	**DISCUSSION / INFORMATION**	**ACTION REQUIRED Person Responsible**
1.0 Call to Order / Introductions	• The meeting was called to order at 10:30 am. • Introductions and roll call via Microsoft Teams/phone ensued. • Reviewed and passed the September 2022 Minutes at 10:34 am	There were no action items brought forward from September 1, 2022 meeting.
2.0 2022 Metrics update • Gap Lists • MedInsight	• Amanda McCarthy gave an update on the Gap lists and to expect the Well Child Visit and Immunization Gap Lists to go out by the following week. Shared it will be around the first of the New Year before we will have the data to send out the Diabetic Oral Health gap lists. • Amanda spoke to how 2022 has been a year of transition for Advanced Health regarding data as Advanced Health transitioned from former claims software EZCap to Quantum Choice, and from Milliman to MedInsight, which is a part of the Milliman software family. Most recent update from the MedInsight team is positive as the clinical measures data have been built and verified from 01/01/2022 through August 31, 2022. They are currently working on the EHR measures for Bay Clinic, NBMC and Waterfall and they project they will have the entire EHR measures updated in November. • Amanda acknowledged it has been a very challenging year for everyone to make process improvement plans with no access to the related data and looking forward to the New Year when we will have access to all the data and able to report out in a timelier fashion. • Dawn asked if Coast Community could integrate their data now, they are on OCHIN Epic, and Amanda	Amanda will keep everyone updated regarding MedInsight and upcoming access for our clinical partners & MedInsight training

<table>
<tr><td></td><td>believed they could as Waterfall is reporting their data securely with OCHIN Epic files.</td><td></td></tr>
<tr><td>3.0
Language Access Quarterly report
• Updated template to capture member refusal reason.</td><td>
• Lisa Castle gave a quick update on the quarterly Language Access reports to alert those who receive them for chart review of the new allowable reasons for a member flagged as needing interpretive services refusal. The new reason codes for when a member refuses interpreter services will be added to the next quarters chart review requests. Please see OHA changes to the Language Access measure below:
<table>
<tr><td>Did the member refuse interpreter service?</td><td>Yes
No</td><td></td></tr>
<tr><td>Reason for Member Refusal</td><td>Enter reason code 1-4:
1. Member refusal because in-language visit is provided
2. Member confirms interpreter needs flag in MMIS is inaccurate
3. Member unsatisfied with the interpreter services available
4. Other reasons for patient refusal</td><td>Scenario 1: The member confirms the provider for the visit can perform in-language service and therefore no interpreter service is needed. To note, if the in-language service provider is OHA certified or qualified, it could be a numerator hit for the metric.
Scenario 2: OHA recommends initiating correction of the interpreter flag in MMIS.
(Visits with refusal reasons 1 or 2 can be excluded IF the CCO attests collecting corresponding information in the CCO self-assessment survey question#11).
Scenarios 3 and 4 do not quality for denominator exclusion</td></tr>
</table>
• Discussion ensured regarding the “dirty” data on the Language Access reports which inappropriately flags patients/members as needing interpretive services when they do not, such as English speaking (not requiring ASL), OHA is now fully aware of the scope of this problem and Lisa Frischkorn, Director of
</td><td></td></tr>
</table>

	Member Services, shared about a new tool from OHA which, as of September 26th, 2022, allows the CCO's to now update contact information and Language Preferences of their members. Advanced Health is hopeful, over time, both the member contact information and Language Preferences will become more dependable, and we will see less and less of our members inappropriately flagged. Being able to correct the contact information will also assist in making the member contact information more accurate on the monthly gap lists as well. Lisa Frischkorn also shared about the updates to the Advanced Health TTY line, letters being sent out to members requesting them to update their Language Preferences along with "I speak" cards for members to fill out and keep with them to use when presenting for care, and information on the use of the available Language Line.	
4.0 Health Aspects of Kindergarten Readiness • Community meetings happening in October	Amanda spoke to the work being done regarding the newer Kindergarten Readiness CCO measure and presented the data OHA has provided to us. She let committee members know she will be meeting with community members in both Coos and Curry counties, starting with Curry County in a few weeks, to come together and create interventions to do better for our kids. Amanda believes they have identified everyone who should be "sitting at the table" who impact children 0-5 years of age such as DHS, schools, Head Start, and Native American Tribes but could have missed an organization or individual whom should be included so asks to please let her know if there is anyone whom should be included in this work as we go forward and she will reach out and send them an invite to join with the other community providers. The community work plans these groups create and implement will be included as our Kindergarten Readiness Process Improvement Project (PIP) reported out to OHA. Amanda will keep us updated as this work continues.	
5.0 Community Updates	• Dawn from Coast Community shared they are opening two school-based clinics in Brookings Harbor and Gold Beach 2.5 days a week at each site and will include primary medical care, family planning, as well as Behavioral Health, and staff outreach to include SNAP benefits and OHP sign up. Question was asked regarding how care is to be provided, such as prescriptions for medication, without parents. Noted that if 14 years or older parent consent is not needed but noted by Dr. Sharman how it is careful ground to walk upon. Discussed how Waterfall had developed strict guidelines/protocols around operations for their embedded school sites and would be a great resource and suggested/asked if Dr. Sharman could connect with Dr. Kellogg. • Lisa Frischkorn discussed the FAQ documents which have been created to assist the providers and they have gone to print. Dani, Advanced Health Provider Relations Representative, will be sending them out as well as Language Line information to those who have requested it. • Keli Dion shared updates from Bay Area hospital letting the committee know they had a new Chief Nursing Officer, Jen Collins as well as an interim CFO. Thankfully, they also have new hire RNs coming onboard, as travelers have been too expensive to maintain, which will allow them to re-expand their inpatient	

	capabilities again and med/surg unit is now reopened. Kelli also noted the Emergency Room boarding will be going away and how the majority being held in the emergency room are intermittent care patients. Bay Area, which is in region three of the state, along with other hospital facilities in the state, are in constant communication with each other regarding capacity and available beds in case they need to divert patients or transfer to higher care. • Jamie from CH&W spoke to Dr. Sharman regarding their urgent need for Behavioral Health Assessments, citing they have 7 patients today, and spoke to the Qualified Mental Health Professional (QMHP) gap, there is no one to take the patients from them, how this is an ongoing problem and the assessments need to be done in the hospital, but we have a Psych hold unit, not a Psych unit at Bay Area Hospital. Dr. Sharman acknowledge the issue and shared how Kari Hood, Advanced Health Director of Behavioral Health is aware and concerned and in meetings regarding this issue.	
6.0 Adjourn	• Meeting adjourned at 11:30 am.	

NEXT MEETING: November 3rd, 2022

Location: Plan on it being a Teams Meeting

Interagency Quality Committee Minutes

November 3rd, 2022

Attendance			
X	Amanda McCarthy, Quality Manager, Advanced Health		Jim Gardner, Chief Operating Officer, Advanced Health
	Anna Warner, Executive Program Director, Advanced Health		Jerry O'Sullivan, ADAPT
	Belle Shepherd, Innovator Agent, OHA		Marla Smith, Compliance Officer, Advanced Health
	Lindsey Tyner, Quality Improvement Coordinator, NBMC		Rosie Revelle, Office Manager, Dr. Mike & Friends
	Tim Novotny, Bay Cities Brokerage/Ambulance		Dawn Gray, Clinic Manager, Southern Coos Hospital & Health Center
X	Laresa Rowden, Quality Improvement Coordinator, Bay Clinic	X	Lisa Castle, Quality Improvement Specialist, Advanced Health
	Debbie Standridge, Adapt		Nicole Norris, CQO, Waterfall Community Health Center
X	Rebecca Meszaros, Clinic Manager, Coast Community Health-Bandon		Tami Graziano, Coquille Valley Hospital Manager Quality/Risk/Patient Satisfaction
	Jamilah Mooney, Coos Health & Wellness	X	Jessica Foster, QI Specialist, Coast Community Health
	Amanda Saunders, Clinic Manager, Coast Community Health-Port Orford		Alyssa Kelley, Trainer, NBMC
X	Molly Johnson, Advantage Dental		Karen Stafford, Southern Coos
	Nina, Bay City Brokerage/Ambulance		Kent Sharman MD, Chief Medical Officer, Advanced Health
	Dee Roberson, Dr. Mike & Friends		Brandie Feger, Director of Pharmacy, Advanced Health
	Ross Acker, Advanced Health Director of Care Coordination		Holly Oltman, QI Compliance Officer, ADAPT
X	Heather Garrett, Bay Clinic		Lisa Frischkorn, Director of Member Services, Advanced Health

	Kelli Dion, Chief Quality Officer, Bay Area Hospital	**X**	Sierra Spencer, Quality, Standardization and Training, NBMC
	Dr Tedd McDonald, Chief Community Health Officer, Waterfall Community Health Center		Doris Kiragu, Health Equity Policy Analyst, Advanced Health
X	Kaitlyn Dubisar, Quality Improvement, Bay Clinic		Lela Well, Grievance System Coordinator, Advanced Health
	Martina Rodman, Quality, Standardization and Training, NBMC	**X**	Shayla Stidham RN BSN, Triage/Chronic Care/Medicare Wellness, Coquille Valley Hospital

TOPIC	**DISCUSSION / INFORMATION**	**ACTION REQUIRED Person Responsible**
1.0 Call to Order / Introductions	• The meeting was called to order at 10:30 am. • Introductions and roll call via Microsoft Teams/phone ensued. • Reviewed and passed the October 2022 Minutes at 10:35 am	There were no action items brought forward from October 6, 2022 meeting.
2.0 2022 Metrics update • Gap List • MedInsight Update	• Amanda McCarthy gave an update on the Gap lists and confirmed the Diabetic Oral Health gap lists will go out in January as previously reported. Lisa will be sending out the December gap lists by the end of next week. • Amanda spoke to some of the data issues MedInsight team has been working on resolving and stated they are still on track to have all data issues resolved by the first of the New Year having now successfully pulled everything over from the old Milliman platform to the MedInsight platform. • Amanda did a quick update on our status CCO incentive measures stating she still believes we will meet at least 6 of the measures based on the 1st 6 months data which speaks to how the current hardwired processes are working as we have been data blind for most of the 2022 measurement year. She stated she has been most concerned with the well child visit measure but believes we may pass it based on what internal data we now have. Molly Johnson from Advantage Dental shared she believes we are currently a	Amanda will continue to keep everyone updated regarding MedInsight and access for our clinical partners & MedInsight training

	little higher than 17.5% and closer to 20.4% for the Diabetic Oral Health measure, which is also great news.	
3.0 Diabetes Care PIP • Aim statement • Referral loop closure	• Lisa Castle spoke regarding the Diabetes Care Performance Improvement Project (PIP) and discussed the original AIM statement which was to improve upon our 2018 baseline rate of oral health evaluations for patients with diabetes by at least 8% points by December 2020 with the final goal rate of 22.9%. We were set to meet this goal, only 0.02% short of reaching it, when the pandemic hit. Decided to vote whether to keep it as is or revise it in 1st quarter of 2023. • Lisa Castle spoke regarding the subcommittee meeting to work on closing the referral loop and how to measure the percentage of the patients/members being seen by the Advantage Dental team on dental days onsite at the participating clinics. It is challenging work as it has been hard to pull the subcommittee together on a day when everyone can participate. It has also been challenging for the embedded advanced practice dental team to assist in identifying whom is a diabetic member or not as they do not always do the scheduling and are not always made aware of the patient status. Lisa will attempt to pull the subcommittee team together again before the end of December, if possible, and/or meet again in January of the New Year. Noted when last met only a few could attend but they determined a measure of success to monitor would be the number of patients with a dental referral (denominator) with confirmation of these same patients with dental referrals having been seen and chart notes received (numerator) to appropriately close the referral per PCPCH guidelines. Discussed how participating clinic with dental days need to work to find a way to flag diabetic patients when scheduling them on their dental days so we can better track and report the percent of diabetics being seen at the embedded clinic sites. Possible solution may be to cross reference a list of assigned diabetic members with a list of patients seen on dental days to be able to identify this subpopulation. Noted we need to be able to report out percent of diabetics seen at embedded clinic sites by the end of 1st quarter of 2023. • Molly spoke regarding Advantage Dental trauma informed care training and was asked if it would be possible to share this training or do an onsite training with providers and caregivers at interested clinics. Molly said they offer the training on certain days, and it may be possible for interested caregivers to attend.	Will vote whether to keep the current AIM statement or revise it during 1st quarter of 2023. Need additional clarification and information on dental trauma informed care training from Advantage Dental.

5.0 • Community Updates	• No community updates given, and meeting ended giving back a little time to committee members.	
6.0 Adjourn	• Meeting adjourned a little early at 11:20 am.	

NEXT MEETING: December 1, 2022

Location: Plan on it being a Teams Meeting

Interagency Quality Committee Minutes

December 5th, 2022

Attendance			
X	Amanda McCarthy, Quality Manager, Advanced Health		Jim Gardner, Chief Operating Officer, Advanced Health
	Anna Warner, Executive Program Director, Advanced Health		Jerry O'Sullivan, ADAPT
	Belle Shepherd, Innovator Agent, OHA		Marla Smith, Compliance Officer, Advanced Health
X	Lindsey Tyner, Quality Improvement Coordinator, NBMC		Rosie Revelle, Office Manager, Dr. Mike & Friends
	Tim Novotny, Bay Cities Brokerage/Ambulance	X	Dawn Gray, Clinic Manager, Southern Coos Hospital & Health Center
X	Laresa Rowden, Quality Improvement Coordinator, Bay Clinic	X	Lisa Castle, Quality Improvement Specialist, Advanced Health
	Debbie Standridge, Adapt		Nicole Norris, CQO, Waterfall Community Health Center
	Rebecca Meszaros, Clinic Manager, Coast Community Health-Bandon		Tami Graziano, Coquille Valley Hospital Manager Quality/Risk/Patient Satisfaction
	Jamilah Mooney, Coos Health & Wellness		Jessica Foster, QI Specialist, Coast Community Health
X	Amanda Saunders, Clinic Manager, Coast Community Health-Port Orford		Alyssa Kelley, Trainer, NBMC
X	Molly Johnson, Advantage Dental		Karen Stafford, Southern Coos
	Nina, Bay City Brokerage/Ambulance		Kent Sharman MD, Chief Medical Officer, Advanced Health
	Dee Roberson, Dr. Mike & Friends		Brandie Feger, Director of Pharmacy, Advanced Health
	Ross Acker, Advanced Health Director of Care Coordination		Holly Oltman, QI Compliance Officer, ADAPT
X	Heather Garrett, Bay Clinic		Lisa Frischkorn, Director of Member Services, Advanced Health
X	Kelli Dion, Chief Quality Officer, Bay Area Hospital		Sierra Spencer, Quality, Standardization and Training, NBMC

	Dr Tedd McDonald, Chief Community Health Officer, Waterfall Community Health Center	**X**	Doris Kiragu, Health Equity Policy Analyst, Advanced Health
X	Kaitlyn Dubisar, Quality Improvement, Bay Clinic	**X**	Lela Well, Grievance System Coordinator, Advanced Health
X	Martina Rodman, Quality, Standardization and Training, NBMC		Shayla Stidham RN BSN, Triage/Chronic Care/Medicare Wellness, Coquille Valley Hospital

TOPIC	**DISCUSSION / INFORMATION**	**ACTION REQUIRED Person Responsible**
1.0 Call to Order / Introductions	• The meeting was called to order at 10:30 am. • Introductions and roll call via Microsoft Teams/phone ensued. • November 2022 Minutes to be reviewed and approved during January meeting.	
2.0 2022 Metrics update • Gap Lists MedInsight/Language Access Chart Review	• Amanda McCarthy gave a quick update on Kindergarten Readiness. The planned community meetings in Coos and Curry Counties, held with those identified as being vested in the care of our community little ones, were both well attended, and attendees were highly engaged. • MedInsight is still working to address issues identified with the data files. Gap lists will be going out next week and starting in January the Diabetic Oral Health Assessment gap lists will also be going out. • Lisa Castle alerted members the third quarter Language Access chart review requests would be going out regarding interpretive services for members flagged as needing them. She asked they be returned no later than Friday, December 23rd to give us time to format the results and report out to OHA on time.	

3.0 Grievance & Appeals	• Lela Wells, Advanced Health Grievance Systems Coordinator informed committee members the good news that Tammy Wagner from Customer Service had excepted the position as the newest Grievance Coordinator at the end of September. • Lela reviewed the Grievance System Report for Quarter 3, 2022 (the full report is attached for your review) and shared how she had to amend the report she had submitted to OHA as they required us to use their newly updated template. She shared our current enrollment for third quarter was 26, 921 members and we had processed 6, 515 prior authorizations (PA). Our rate of complaints was at 2.63 per 1,000 members (down from the last 3 quarters), and the top three complaint categories were Access to Care, Interaction with Provider and Quality of Care. • Lela shared how pharmacy was receiving increased PAs without required documentation which is delaying them from being processed and requiring them to be resubmitted with the missing documentation. • There were thirty-one appeals third quarter, but Lela stated she anticipates there will be an increase next quarter although we have been on a downward trend. • Lela explained the appeal process and how they try and call and explain to the member why an appeal was denied and answer questions so the member can better understand, as well as using plain language when sending out the Notice of Adverse Benefit Determination (NOABD). Effective communication when communicating NOABDs helps to reduce appeals.	
5.0 • Community Updates	• Kelli Dion from Bay Area Hospital shared they were experiencing a bed shortage and saturated with currently 12-13 patients being held in the ER waiting for open beds and an entire department designated as an influenza A and/or Covid unit. They have had to implement crisis staffing guidelines, but on a positive note some of the travelers are onboarding as permanent hires and additional new hires coming onboard. • Doris Kiragu, Health Equity Policy Analyst at Advanced Health, shared an update regarding a project called Beet which has partnered with the Coos Bay Public Library and opened a community fridge. If you can not make it to the main food pantry site can go to the library and get fresh foods. • Amanda shared a quick update on what the committee would be working on in 2023 and stated we would be focusing on getting back to the basics with a focus on Performance Improvement Projects (PIPs), Transformation and Quality Strategy (TQS) projects, conduct a deep dive every month on one incentive measure, examine our workflows and how we can better leverage our data and supplemental data to advance our projects. • Dawn Gray from Southern Coos Hospital & Health Center shared she thought it was a good idea to get back to a focus o the basics and shared their current EMR is extremely difficult to navigate and access	

	quality metrics, it takes a lot of mining to get to the data. She shared they want to have access to Southern Coos data and their goal is to be a multispecialty PCPCH recognized clinic which obtaining the quality data would be critical to meet the quality portion of the PCPCH standards. Epic a much better EMR for monitoring quality metrics.	
6.0 Adjourn	• Meeting adjourned at 11:25 am.	

NEXT MEETING: January 5th, 2023

Location: Plan on it being a Teams Meeting

Inter-Agency Quality Committee Charter

Title:	**Interagency Quality Committee**
Date Chartered:	September 2014
Time Line:	Standing Committee
Purpose:	The Interagency Quality Committee exists to provide a platform for collaboration and coordination between Advanced Health's leadership, provider network, and community partners purposed at achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care; and, cost efficacy.
Goals:	1. Work collaboratively to build relationships and systems that support Advanced Health members and providers by designing, measuring, evaluating, and improving the effectiveness of quality management systems; 2. Work collaboratively to achieve OHA metrics; 3. Identify opportunities for practice/agency level health system transformation and improvement; 4. Identify barriers and gaps to achieving transformation and improvement; 5. Identify and implement actions to promote improved processes within the service delivery system; 6. Participate in the development and implementation of Advanced Health's annual Quality Improvement Strategy and Work Plan; 7. Advise, evaluate, and support Advanced Health's strategic initiatives and goals related to quality, access, and process improvement. Evaluation may include monitoring with the following actions: • Clinical record keeping/documentation review • Utilization review including in and out of network, and emergency services • Referrals • Comorbid conditions • Prior authorizations and medication review • Encounter data regarding member disenrollment and access to care and services

	8. Recommend standards and strategies for quality review of the following delegated services: • Mental Health Services • Public Health Services' Home Visiting Programs • Addictions Services • Oral Health • Transportation Services 9. Oversee implementation of Advanced Health's quality review of delegated services; grievance and appeals 10. Monitor Non-Medical/Flexible Fund expenditures for compliance with established policy and procedure and recommend changes as needed;
Committee Chair:	The committee will be chaired by Advanced Health's Director of Quality
Committee Membership	Advanced Health's Medical Director, Director of Behavioral Health, Quality Manager, Quality Improvement Specialist, Coos Health and Wellness, ADAPT, Advantage Dental, Bay Area Hospital, Waterfall Community Health Center, Coast Community Health Center, North Bend Medical Center, Bay Clinic, Coquille Valley Hospital, Southern Coos Hospital, Curry Health Network/Curry General Hospital, Community Advisory Council representatives, when invited, and other community providers as invited or interested.
Committee Members' Responsibilities	• Actively participate both in and out of meetings to achieve the committee's goals • Work effectively with other committee members • Act as role models to inspire their organization's engagement • Participate in External Quality Review processes when requested
Meeting Frequency:	Full committee will meet monthly for 1 hour or more often if necessary to accomplish the purpose of the committee Time framed work groups may be convened to focus on a particular objective or project
Term	Ongoing
Review Charter:	Annually
Date(s) Revised:	March 2016, May 2017, February 2018, November 2019, May 2020, May 2021, April 2022, January 2023

Quality Assurance and Performance Improvement (QAPI) Policy and Procedures

Company: Advanced Health CCO	Approved by: Anna Warner Title: Executive Program Director Current Revision Date: March 10, 2023
Department: Quality	

Table of Contents

1. PURPOSE

1.1. Advanced Health members are best served by a Quality Assurance Program designed to provide robust methods for process measurement and analysis to assure early detection of discrepancies and continual performance improvement.

2. SCOPE

2.1. Advanced Health is a Coordinated Care Organization, contracted with the Oregon Health Authority to administer the benefit for Oregon Health Plan members in Coos and Curry Counties. Advanced Health maintains a network of providers and contractors for primary physical health, behavioral health, dental health, specialty services, hospital services, chemical dependency services, and transportation services.

3. ACRONYMS AND DEFINITIONS

3.1. Unless otherwise defined, all uppercase words will be defined the same as in the CCO Contract.

4. POLICIES

4.1. Management provides evidence of its commitment to the development, implementation, and continual improvement of the Quality Assurance Program by:

4.1.1. Communicating to the organization the importance of meeting member needs for effective, equitable, understandable, and respectful services, as well as statutory and regulatory requirements;

4.1.2. Ensuring that member needs and expectations are determined and fulfilled in a manner that is responsive to cultural beliefs, preferred languages, health literacy, and other communication needs with the aim of improving member satisfaction;

4.1.3. Planning the processes and activities needed for the Quality Assurance Program;

4.1.4. Conducting an annual Quality Program Evaluation;

4.1.5. Establishing an annual Transformation and Quality Strategy and Work Plan;

4.1.6. Ensuring availability of resources;

4.1.7. Defining organizational roles, responsibilities, and authorities; and,

4.1.8. Planning actions to address risks and opportunities

5. PROCEDURES

5.1. Performance Evaluation and Improvement

5.1.1. Advanced Health has planned and implemented the following monitoring, measurement, and analysis activities in order to demonstrate that services provided to members conform to requirements and that the Quality Assurance Program, including the Transformation and Quality Strategy and Work Plan, performs as expected. The results of the monitoring, measurement, and analysis activities are used to improve the effectiveness of the Quality Assurance Program.

5.2. Participation as a Member of the OHA Quality and Health Outcomes Committee (QHOC)

5.2.1. Advanced Health is committed to participation and attendance at the monthly Quality and Health Outcomes Committee. Advanced Health's Executive Program Director and Quality Manager regularly attend the meetings held in Salem. Other CCO employees, contractors, and providers may participate, either in-person or by phone, depending on the topic of the meeting or the learning collaborative session.

5.3. External Quality Review and Corrective Action

5.3.1. Advanced Health participates in annual External Quality Reviews (EQRs) conducted by an External Quality Review Organization, as required by the Oregon Health Authority. Any findings from the EQR generate corrective action or improvement plans to eliminate the cause or causes of the problem and prevent recurrence. The corrective action or improvement plan includes a determination of the root cause, actions to address the root cause, and verification that the actions taken were effective.

5.4. Utilization Review

5.4.1. A robust program of Utilization Review is in place to ensure that high quality, Medically Appropriate services are delivered to all members, including those with special health care needs. A number of mechanisms are in place to monitor for both under- and over-utilization of services.

5.4.1.1. Medical Management Department Activities

5.4.1.1.1. The Medical Management Department includes Utilization Review functions. This team reviews prior authorizations to ensure that treatments follow the clinical practice guidelines, the Prioritized List of Health Services and the associated guidelines to assure that services are medically appropriate and evidence-based. The list of services requiring prior authorization is reviewed at least annually for opportunities to reduce administrative burden on providers while still ensuring that care is delivered locally when possible, in a cost-

effective manner, and consistent with medical evidence. The authorization process ensures that members have access to second opinions when desired, and all members (including those with special healthcare needs) may have direct access to a specialist when medically appropriate.

5.4.1.1.2. The Medical Services Department monitors performance to ensure that requests are handled in a timely and consistent manner. A data dashboard is in place to allow monitoring of number of authorization requests received, average and individual time to completion, percent approved or denied, and the types of requests seen. This data is used to inform staffing decisions and prior authorization requirements. Attention is focused on high risk, high dollar interventions.

5.5. Grievance and Appeal System

5.5.1. Advanced Health maintains a comprehensive Member Grievance System policy and procedure, including robust processes addressing Grievances, Notice of Adverse Benefit Determination, Appeals, Contested Case Hearings, requests for expedited Appeals or Expedited Contested Case Hearings, continuation of benefits, documentation requirements, and quality improvement review. Advanced Health reviews the policy and procedure annually, revising as needed to ensure the document accurately reflects the implemented process and meets all federal, state, and contract requirements. The Advanced Health policy and procedure are submitted annually to OHA for review and feedback. The Grievance and Appeal System is also part of the regular External Quality Review cycle and is reviewed at least every three years through that process.

5.5.2. Advanced Health works closely with organizations to which portions of the Grievance and Appeal System are delegated to ensure the processes of the delegated entities meet the requirements of the Advanced Health policy and procedure. Delegate Grievance System policies and procedures are reviewed at least annually for compliance with federal, state, CCO contract, and Advanced Health requirements. Grievance System records and data collected from delegated entities are reviewed at the time of collection and all information from delegates is incorporated into the quarterly Grievance System report submitted to OHA. The data and trends noted in the quarterly Grievance System report are also reviewed by the Interagency Quality and Accountability Committee for opportunities for system-level quality improvements.

5.6. Program Evaluation & Improvement Strategy and Work Plan

5.6.1. The entire Quality Assurance and Performance Improvement Program is reviewed and evaluated at least once per year to ensure its continuing suitability, adequacy, and effectiveness in satisfying the requirements of the Oregon Health Authority and Advanced Health's goals and objectives. This evaluation includes assessing opportunities for improvement and the need for changes to the Quality Assurance Program. The Quality Program Evaluation is prepared by the Executive Program Director and Quality Manager in collaboration with key subject matter experts and reviewed by the Interagency Quality and Accountability Committee, the Clinical Advisory Panel, and the CCO Board of Directors.

5.6.2. Input to the Quality Program Evaluation includes, but is not limited to, the following information:

5.6.2.1. Results of External Quality Review

5.6.2.2. Member complaints and the grievance system

5.6.2.3. Status of current improvement efforts and suggestions for new improvement efforts

5.6.2.4. Status of CCO quality incentive measures and other CCO performance measures

5.6.2.5. Quality and appropriateness of care for members, especially those with special health care needs; including those who are aged, blind, or disabled or who have high health care needs, multiple chronic conditions, behavioral health disorders; who receive Medicaid funded long-term

care or long-term services and supports benefits; or who are children receiving Child Welfare services or OYA services;

5.6.2.6. Improvement in an area of poor performance in care coordination for members with SPMI

5.6.2.7. Monitoring and enforcement of consumer rights and protections

5.6.2.8. Compliance of the fraud, waste, and abuse prevention program

5.6.2.9. Utilization data

5.6.2.10. Network contractor and provider monitoring results and findings

5.6.3. Output of the Quality Program Evaluation informs the Transformation and Quality Strategy and Work Plan for the coming year and includes decisions and actions related to:

5.6.3.1. Improvement of the effectiveness of the Quality Assurance Program and its processes

5.6.3.2. Improvement of member services related to requirements

5.6.3.3. Resource needs

5.7. Performance Improvement Process

5.7.1. Advanced Health continually improves the effectiveness of the Quality Assurance Program through review by the Interagency Quality and Accountability Committee and other committees, participation in OHA Quality and Health Outcomes Committee meetings, participation in OHA Transformation Center technical assistance and learning collaborative opportunities, analysis of data, external quality review, and internal quality program evaluation.

5.7.2. OHA determines and/or approves contractual requirements for all CCOs related to Performance Improvement Projects (PIPs), Transformation and Quality Strategy components, Quality Incentive Measures, and other performance measures. Advanced Health conforms to these requirements and incorporates these improvement projects as well as other projects into its annual Transformation and Quality Strategy and Work Plan, conducted and submitted at least annually.

5.7.3. In managing the Transformation and Quality Strategy and Work Plan, Advanced Health employs a variety of process improvement tools, including PDSA, DMAIC, impact analysis, project management, and other lean tools. The process improvement method(s) used depends on the needs of the specific project and the capabilities of the team planning and implementing the improvements.

5.7.4. Process improvement priorities are determined with consideration to a variety of sources, including but not limited to:

5.7.4.1. OHA Requirements: Performance Improvement Project focus areas, Transformation and Quality Strategy components, Quality Incentive Measures, other performance measures, and other contractual requirements

5.7.4.2. Advanced Health's strategic plan and direction from the Board of Directors

5.7.4.3. Community Priorities: input from the Community Advisory Councils, findings from the Community Health Assessments, and priorities identified in the Community Health Improvement Plans

5.7.4.4. External Quality Review results

5.7.4.5. Member complaints and grievance reports

5.7.4.6. Cultural and linguistic needs of Advanced Health members

5.7.4.7. Delegate and provider compliance

5.7.4.8. Delegate, provider, and community partner feedback

5.7.4.9. Annual Quality Program Evaluation

5.7.4.10. Other statutory and regulatory requirements

5.8. Committees

5.8.1. Advanced Health's Quality Assurance and Performance Improvement processes rely on a series of collaborative, yet distinct and well-defined standing committees. Each committee is characterized by a charter that defines the committee's purpose, goals, schedule of meetings, scopes of authority, membership composition, and member responsibilities. The standing committees that participate in Quality Assurance and Performance Improvement processes are described below.

5.8.1.1. Interagency Quality and Accountability Committee

5.8.1.1.1. This committee is chaired by the Advanced Health Director of Quality and attended by representatives of delegate organizations, as well as community partners and providers. The Interagency Committee meets monthly. The purpose of this committee is to provide a platform for collaboration and coordination between Advanced Health's leadership, contractors, network provider organizations, and community partners purposed at achieving the Triple Aim. This committee supports data-driven decision making and development of a culture of quality through the review of data reports that support OHA contract compliance, achievement of Advanced Health's strategic plan, advances in individual and population health, enhancement of the member's experience of care, and cost efficacy. The Interagency Quality and Accountability Committee reports to the Advanced Health Board of Directors.

5.8.1.2. Clinical Advisory Panel

5.8.1.2.1. The Clinical Advisory Panel is chaired by Advanced Health's Chief Medical Officer and membership includes providers representative of behavioral health, physical health, dental health, and substance use treatment. The CAP usually meets twice per month. The CAP provides input on clinical programs and policies with the goal of achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care; and, cost efficacy. The Clinical Advisory Committee provides perspective of practicing clinicians to Advanced Health. The Clinical Advisory Panel reports to the Advanced Health Board of Directors.

5.8.1.3. Pharmacy and Therapeutics Committee

5.8.1.3.1. The Pharmacy and Therapeutics Committee meets at least quarterly. Committee membership includes Advanced Health providers representing various specialties (e.g. family practice, internal medicine, OB/GYN, pediatrics, mental health etc.) and may also include community partners (e.g. Bay Area Hospital) and pharmacists. The Pharmacy and Therapeutics Committee is responsible for maintaining a formulary providing the most cost-effective drug therapies to Advanced Health members and ensuring compliance with DMAP rules and regulations. The Pharmacy and Therapeutics Committee reports to the Advanced Health Clinical Advisory Panel.

5.8.1.4. Community Advisory Councils

5.8.1.4.1. Advanced Health has established two Community Advisory Councils, one in Coos County and one in Curry County. Both councils hold monthly meetings. Membership includes a broad spectrum of representatives, including Advanced Health members and their families, health providers, non-clinical partner organizations, and other key community representation. Over 50% of the councils are consumer representatives. The purpose of these councils is to provide the voice of the consumer to advise Advanced Health and its governing body in its efforts to meet the Triple Aim of better health, better care, and lower costs. The Consumer Advisory Councils report to the Advanced Health Board of Directors.

5.8.1.5. Community Health Improvement Plan Committees

5.8.1.5.1. The Consumer Advisory Council (CAC) provided input and recommendations on priorities of the Community Health Improvement Plan (CHIP). The Coos and Curry CHIP Steering Committees are responsible for setting up appropriate supports and structures to monitor and move the work of the CHIP forward. Each CHIP subcommittee is responsible for developing an implementation plan for achieving the goals and objectives outlined by the CHIP. Progress reports are presented for approval to the respective CAC and then to the Advanced Health Board of Directors.

5.9. Transformation and Quality Strategy (TQS) Development Process

5.9.1. Much of the process for the TQS analysis, development, and planning is described in the above sections regarding the Program Evaluation & Improvement Strategy and Work Plan and the Performance Improvement Process. The Executive Program Director and Quality Manager worked with the key personnel and committees described above beginning in the third quarter of the calendar through January of the reporting year to select the list of projects and programs to be included in the TQS to highlight the work of Advanced Health and that best address the required TQS components. These projects and programs include priorities that align with the Community Health Improvement Plan, CCO quality measures, PCPCH standards, CPC+ program metrics, contract requirements, current and future Performance Improvement Projects, as well as other statutory and regulatory requirements.

5.9.2. The TQS projects and programs are presented for discussion and feedback, beginning in the fourth quarter of the year prior to the reporting year, to the Interagency Quality and Accountability Committee and the Clinical Advisory Panel. The Consumer Advisory Councils work on the Community Health Improvement Plan throughout the year, and that information is incorporated in the presentations to the other committees. The information is presented to the Advanced Health Board of Directors for review and approval prior to the March submission to OHA.

5.9.3. In February and March of the reporting year, additional details, data, activities, and targets are collected from the project or program leaders. Final versions of sections are reviewed by relevant executive leadership and other personnel involved as needed, including those functions discussed below in the Organizational Roles and Responsibilities section.

5.10. Consumer Rights and Protections and Fraud Waste and Abuse

5.10.1. Activities managed through the compliance department and are monitored through comprehensive compliance reports and FWA prevention plans submitted quarterly and annually to OHA for review.

6. REFERENCE SOURCES

6.1. 42 CFR § 438.330 Quality assessment and performance improvement program

6.2. CCO Contract Exhibit B – Statement of Work: Part 10 Transformation Reporting, Performance Measures and External Quality Review

6.3. OAR 410-141-3525

7. RESPONSIBILITIES (Compliance, Monitoring, Review)

7.1. Executive Program Director

The Executive Program Director has the authority and responsibility to make appropriate changes to the Quality Assurance Program and to communicate the requirements to personnel. Every level of management shares the responsibility to ensure proper maintenance and performance of the Quality Assurance Program. A brief overview of key titles and their responsibilities related to the quality assurance program is provided below.

7.2. Board of Directors

7.2.1. Representative of equity partners, community partners, community stakeholders, and the Community Advisory Councils

7.2.2. Guides, controls, and directs the organization through the adoption and review of annual strategic plans, the annual budgeting process, and written policies

7.2.3. Oversees the performance of the organization

7.2.4. Reviews and authorizes the annual Transformation and Quality Strategy

7.2.5. Ultimately responsible for the quality of clinical services provided to members

7.3. Chief Executive Officer

7.3.1. Facilitates business planning and develops appropriate strategies to attain annual strategic objectives

7.3.2. Reviews activity reports and financial statements to determine progress and status in attaining quality, performance, and compliance objectives

7.3.3. Ensures adequate resource availability

7.3.4. Ensures the promotion and awareness of member needs and contract requirements throughout the organization

7.3.5. Reports directly to the Board of Directors

7.4. Chief Compliance Officer

7.4.1. Ensures contractual obligations as well as statutory and regulatory requirements are met

7.4.2. Oversees the development, review, and revision of the compliance plan

7.4.3. Implements the compliance plan

7.4.4. Audits and monitors contractors and providers

7.4.5. Opens and performs preliminary investigations regarding Waste, Fraud, and Abuse and makes referrals to OPI or MFCU as required

7.5. Chief Medical Officer

7.5.1. Ensures services are medically appropriate, high quality, cost-effective, and in accordance with Oregon Health Authority (OHA) Coordinated Care Organization (CCO) contract and related Oregon Administrative Rules (OAR) and the Code of Federal Regulations (CFR)

7.5.2. Reviews member Appeal and Contested Case Hearings requests

7.5.3. Ensures assigned staff adhere to medical policy and member benefits

7.6. Executive Program Director

7.6.1. Directs development, implementation, and improvement of the Quality Assurance and Performance Improvement Program and annual Transformation and Quality Strategy

7.6.2. Develops, implements, and communicates quality improvement strategies throughout the organization as well as to delegate and provider network, community partners, and other stakeholders

7.6.3. Assists with the annual External Quality Review process

7.6.4. Oversees Member Grievance System

7.6.5. Health Equity Administrator

7.7. Directors and Managers

7.7.1. Oversee successful operation of assigned area of responsibility to ensure production efficiency, quality of service, and cost-effective management of resources

7.7.2. Coordinate business practices and procedures to optimize operations

7.7.3. Ensure training of new and existing employees

7.7.4. Support efforts to improve the effectiveness of the Quality Assurance Program

7.7.5. Provide direction to staff

7.7.6. Assist with annual EQR process in areas of assigned responsibility

8. RELATED DOCUMENTS

8.1. Interagency Quality Committee Charter
8.2. Clinical Advisory Panel Charter
8.3. Pharmacy and Therapeutics Committee Charter
8.4. Coos and Curry Community Advisory Council Charters
8.5. Coos and Curry Community Health Improvement Plans
8.6. Coos and Curry Community Health Assessment
8.7. Annual Transformation and Quality Strategy

9. ATTACHMENTS

9.1. None

10. APPROVALS

10.1 – Document Owner	Name: Anna Warner, Executive Program Director Department: Administration
10.2 – Approving Manager	Name: Anna Warner, Executive Program Director Department: Administration Signature Anna Warner Anna Warner (Mar 14, 2023 12:45 PDT)
10.3 – Collaborators	Name(s): Amanda McCarthy
10.4 – Approvals	**Policy Review Committee** Date Approved: 3/13/2023

10.5 – Original Effective Date	**Date: July 29, 2015**
10.6 – Review Period	**How often PnP is reviewed: Annually**
10.7 – Review Date(s)	**Date:**
10.8 – Revision Date(s)	**Date: 3/12/2020, 3/15/2021**

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Final Audit Report 2023-03-14

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