Example Transformation and Quality Strategy (TQS)

This document provides examples of potential TQS strategies addressing each of the TQS components. The level of detail needed will vary for each specific project or program your CCO submits, depending on the component(s) it addresses, the type of project or program it is, its stage of implementation, etc.

Contents

Section 1: Transformation and Quality Program Details

A. Project 1: Increasing maternity care access

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

i. Component 1: Health equity: Data
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 for the component(s) selected with CCO- and region-specific data

ExampleCCO wanted a deeper dive into maternal health outcomes for ExampleCCO members. Through discussion with clinical leadership and population health teams, ExampleCCO determined a need for a maternal health care dashboard. In development of the dashboard, ExampleCCO identified population stratifications needed to assess member's maternal needs and health outcome disparities and inequities. The REALD and SOGI standards allow ExampleCCO to identify and address health inequities. Example CCO understands that accurately identifying disparities and subpopulations that may benefit from targeted interventions requires data collection with more granularity.

Additionally, as part of the work on developing the maternal health care dashboard, ExampleCCO recognizes the importance of qualitative data and engaged with key community stakeholders with experience in maternal and child health in the service area, including health care providers, doulas, Head Start, Migrant and Seasonal Head Start, and others. Stakeholders shared their concerns about the effects of food insecurity among pregnant members in our service area. Based on a 2018 survey data from the Behavioral Risk Factor Surveillance System (BRFSS), among Oregon women ages 18-44, about 16 percent reported that in the 12 months before the survey their household cut the size of meals or skipped meals because there was not enough money to buy food. Of those women, about 31 percent reported this happened almost every month. Pregnancy, infancy and toddlerhood are sensitive times in which families are particularly vulnerable to household food insecurity. In partnership with local WIC and Public Health, ExampleCCO surveyed pregnant WIC clients who are ExampleCCO members on food insecurity. Food insecurity was reported on 43.9% of the ExampleCCO pregnant members. Women that identified as Hispanic/Latino and Black/African American had the highest rates of food insecurity. Food insecurity will be added to the maternal health dashboard. ExampleCCO will work with the two primary care practices and the women's health clinic participating in this TQS project to start screening of the household food security status during the primary prenatal care to identify high-risk pregnant members to improve the quantity and quality of their diet.

D. **Project context:** Include justification for the chosen or continued project with CCO- and region-specific data, and progress to date for continued projects

Evaluation analysis: When reviewing ExampleCCO client demographics, maternal and infant health contributes to XX% of our total membership. ExampleCCO believes that connecting pregnant members early in their maternity care will improve health outcomes for the infant and provide pregnant members in our community with ease of access that meets their needs for right care at right door. Upon analysis of the data that has been gathered since the project started, data indicated that in addition to the maternal health care access, support was needed in meeting social determinants of health needs such as access to food and that access to food was a considerable gap that needed to be addressed.

ExampleCCO will continue utilizing population health data with a health equity lens and segmenting by region (county), age groupings, race, ethnicity and service delivery, and language (and disability, sexual orientation and gender identity where data available). The goal of the project was initially to develop programs that will address gaps in care for maternal care through access points in local public health WIC sites and PCPCH Tier 4 practices for ongoing case management. During the first steps of this work, population health data and collaboration with community stakeholders indicated that areas such as food insecurity should also be assessed and addressed.

E. **Project or program brief narrative description**

Ensuring women's health in ExampleCCO region is integral to our healthy community. ExampleCCO will build upon maternal health care for ensuring timeliness to prenatal care through increasing maternity care access points in the community and identifying data metrics related to certain social determinants of health such as food insecurity (because of the significant impact food insecurity has in maternal and child health).

Target population: Mother and babies; no specific age group defined.

Key community stakeholders: Local public health, WIC, two primary care practices and one women's health clinic.

The CCO will identify key metrics, track key indicators and trends, and compare results to goals and targets by race, ethnicity, language, disability, sexual orientation and gender identity.

Allocation of resources to support the program include items aligned with CLAS standards compliance.

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

Activity 1 description: Develop monitoring dashboard for maternal health care with health equity data lens.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Metrics and segmentation determined (for example, timeliness to prenatal care, low birth weight and food insecurity)			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Timeliness on prenatal health metric identified and segmented by	Food insecurity assessment metric identified, and segmentation completed	3/2023	Full metrics list and segmentation completed	3/2023

REALD and SOGI categories				
Monitoring measure 1.2	Metrics tested and dashboard developed			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No dashboard	Metrics tested and dashboard developed	6/2023	Metrics tested and dashboard developed	6/2023

Activity 2 description: Determine gaps in care for maternal health and engagement

☒ Short term or ☐ Long term

Monitoring measure 2.1	Two gaps in health care prioritized for intervention and work plans developed to address each			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Two gaps identified: Timeliness on prenatal health and access to food	Gaps identified and interventions developed	6/2023	Work plans developed	9/2023
Monitoring measure 2.2	Health outcome metric for each gap identified and improved			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No metric identified	Metric for each gap identified by REALD and SOGI categories	9/2023	Metric improved by X% by REALD and SOGI categories	12/2023

Activity 3 description: Develop maternal care team

☒ Short term or ☐ Long term

Monitoring measure 3.1	Culturally and linguistically responsive maternal care team identified, trained and intervention implemented			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No maternal care team in place	Maternal care team identified	9/2023	Maternal care team trained and implementing intervention	12/2023

Activity 4 description: Develop referral system for identified populations in need of maternal care from WIC sites and community organizations to PCPCH sites.

☐ Short term or ☒ Long term

Monitoring measure 4.1	Referral system developed and tested			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No referral system	Referral system developed	12/2023	Referral system tested	6/2024

Monitoring measure 4.2	Referral system implemented			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No referral system	Referral system implemented	8/2024	60% of referrals are being scheduled and members attending appointments 80% of referrals are being scheduled and members attending appointments	12/2024 12/2025

A. Project 2: Using grievance and appeal data to remove barriers for members

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

i. Component 1: Grievance and appeal system
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 for the component(s) selected with CCO- and region-specific data

ExampleCCO strives to encourage the reporting of all grievances, and ensure all members know their right to appeal, which helps the CCO identify issues that need to be addressed.

Grievance and Appeal (G&A) reporting across ExampleCCO follows standard practice and relevant rules for member engagement and rights. ExampleCCO has consistent reporting from XX% of our provider networks. Consistency is defined by providers' G&A reporting amongst provider networks. While ExampleCCO has some

providers not reporting G&A, ExampleCCO is in connection to ensure policies and procedures are in place. G&A are not consistently reported using a standard approach for XX% of our provider networks. It's necessary to identify continued opportunities in the oral health and behavioral provider networks for regular reporting.

Of reported G&A to ExampleCCO, data of grievances per 1000 members show a decline across the past year with the highest numbers of grievances recorded in Qtr 1. Over the course of the year, the top three categories of grievances were interactions with provider/clinic, access and client billing. ExampleCCO will be reinforcing contract language with providers who are not consistently reporting G&A as part of our operational standards. For improvement areas in G&A, ExampleCCO will embark on an access issue of non-emergent medical transportation.

In addition to reviewing grievance and appeal data, it is clear certain populations may not be comfortable filing complaints. Example CCO will begin stratifying the grievance data using race, ethnicity, language and disability (REALD) data to show the demographics of who files complaints. In compiling the data ExampleCCO learned that 46% of the total enrolled members in ExampleCCO did not disclose their race; 24% did not disclose their ethnicity; and 2% did not disclose their preferred language. Of those who did report their race and ethnicity we are able to see the demographics of those members who filed complaints:

- Western European: 78%
- Eastern European: 6%
- Slavic: 4%
- African American: 4%
- American Indian: 3%
- Afro-Caribbean: 1%
- Mexican: 1%
- Chinese 1%
- Korean .5%
- Japanese .5%
- Other Hispanic or Latino/a/x: .5%
- Native Hawaiian: .5%

D. **Project rationale and progress**: Include justification for the chosen or continued project with CCO- and region-specific data, and progress to date for continued projects

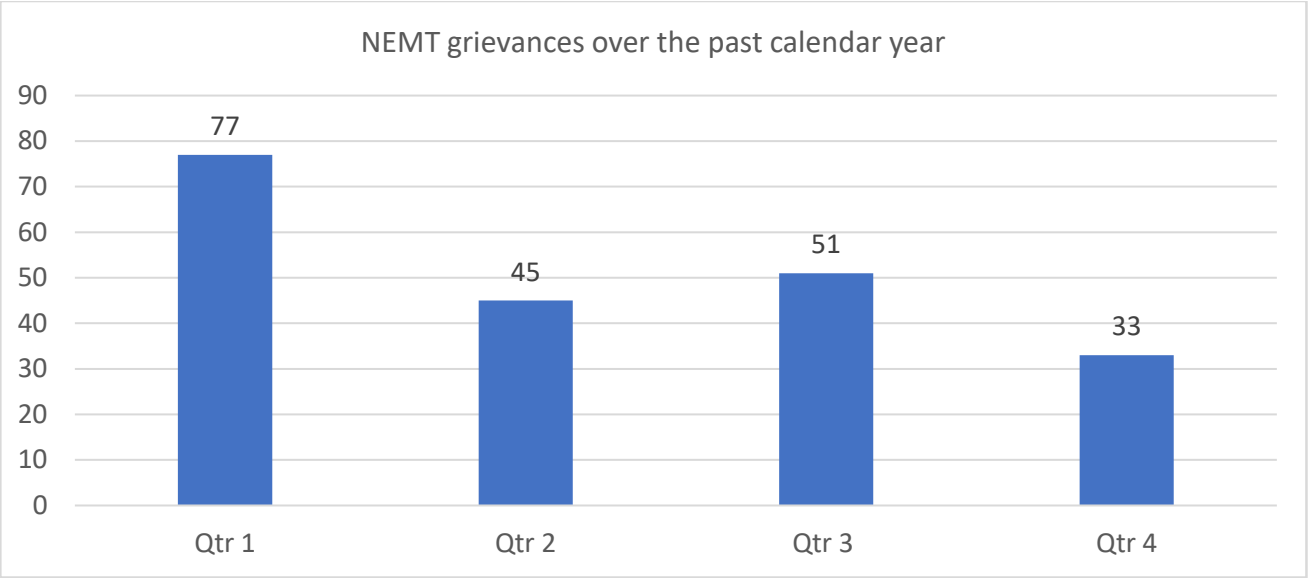
Grievance, NOABD, appeals and hearings disaggregated data revealed useful information about specific problem areas and barriers experienced by members with NEMT services. CCO grievance and appeal data shows that NEMT grievances were the highest number of grievances filed each quarter this last year.

Of the 105 total grievances received during the 4th quarter, 31.4% were related to NEMT issues. Within the NEMT grievances, 63.3% were related to issues with scheduling, pickups or no coordination of services. 27% of the NEMT grievances were from Company A Transport. No appeals related to NEMT were filed. See charts below for examples of data analysis.

ExampleCCO will identify the sources of where REALD data is collected and review the collection process. ExampleCCO will provide training to provider offices and clinics on how to use culturally and linguistically appropriate methods to ensure all members have an opportunity to self-report their REALD information.

ExampleCCO will develop a report that compares the grievance data with REALD data for ongoing review and analysis. This report will identify where improved education can be provided to increase members' awareness and understanding of when and how to file grievances.

(Note to CCO) Using grievance and appeal data that has been disaggregated, review the data across all areas – grievances, NOABDs, appeals and hearings – on a monthly basis and determine one specific area to focus on (such as non-emergency medical transportation [NEMT], as this is an area that is visible to the public and in many areas creates a high number of grievances). Determine where the highest number of grievances, NOABDs, appeals and hearings are happening, research root causes and develop processes to alleviate the issues.



E. Project or program brief narrative description

ExampleCCO will begin a quality improvement project to improve NEMT services for our members. The project will include assessing barriers through root cause analysis, further development of data monitoring of G&A, NOABD data specific to NEMT, development of member rights for NEMT services communications, and additional interventions based upon root cause analysis.

F. Activities and monitoring for performance improvement

Activity 1 description: Using existing REALD and SOGI data, ExampleCCO will develop a report to compare data with Grievance data.

☒ Short term or ☒ Long term

Monitoring measure 1.1	Review the sources of REALD and SOGI data for use in the report.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Data sources not identified	REALD and SOGI data identified	03/2023	Same as target	03/2023
Monitoring measure 1.2	Develop report to compare Grievance data against REALD and SOGI data			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No Grievance/REALD and SOGI report available	Grievance/REALD and SOGI report created	3/2023	Same as target	03/2023

Monitoring measure 1.3	Develop a plan to improve education to members in population groups that have low numbers of complaints filed.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No plan available	Grievance/REALD and SOGI data report developed and being reviewed on a regular basis. Plan being developed.	03/2023	Plan developed using newly created report	03/2024

Activity 2 description: Review grievances, NOABD, appeals and hearings data to determine first level where high numbers are reported. Drill down using the service code data to determine specific areas that may be seeing higher numbers of grievances. Choose the specific area of concern and work with the quality committee and others to determine root causes.

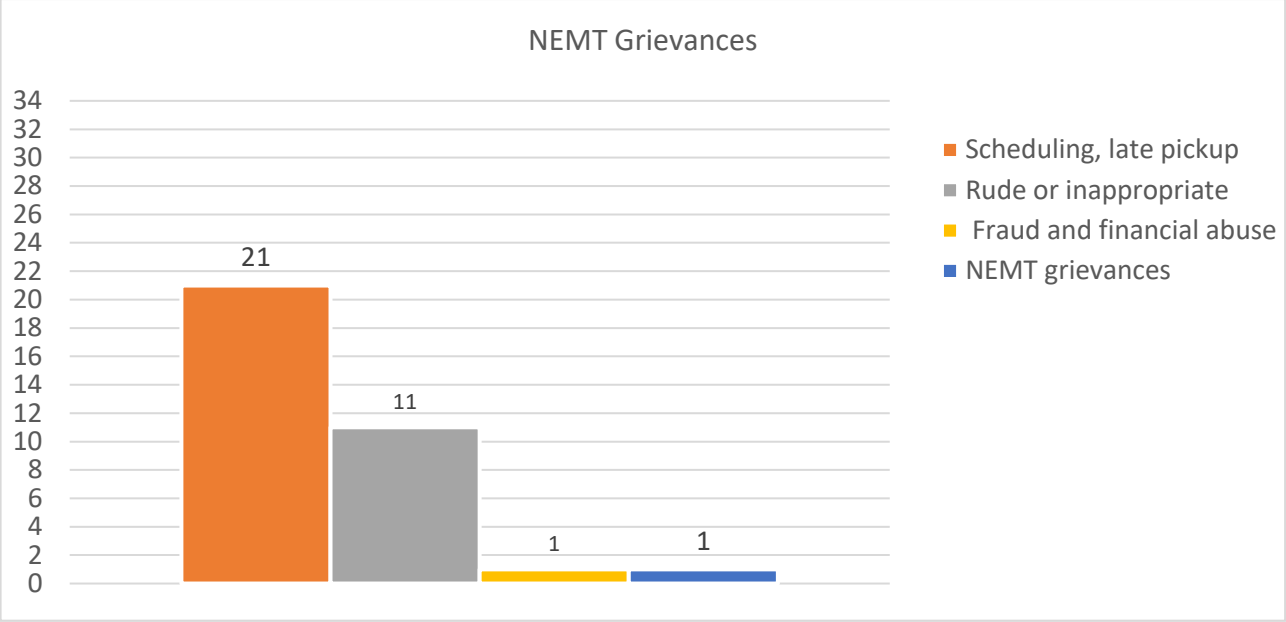
☒ Short term or ☐ Long term

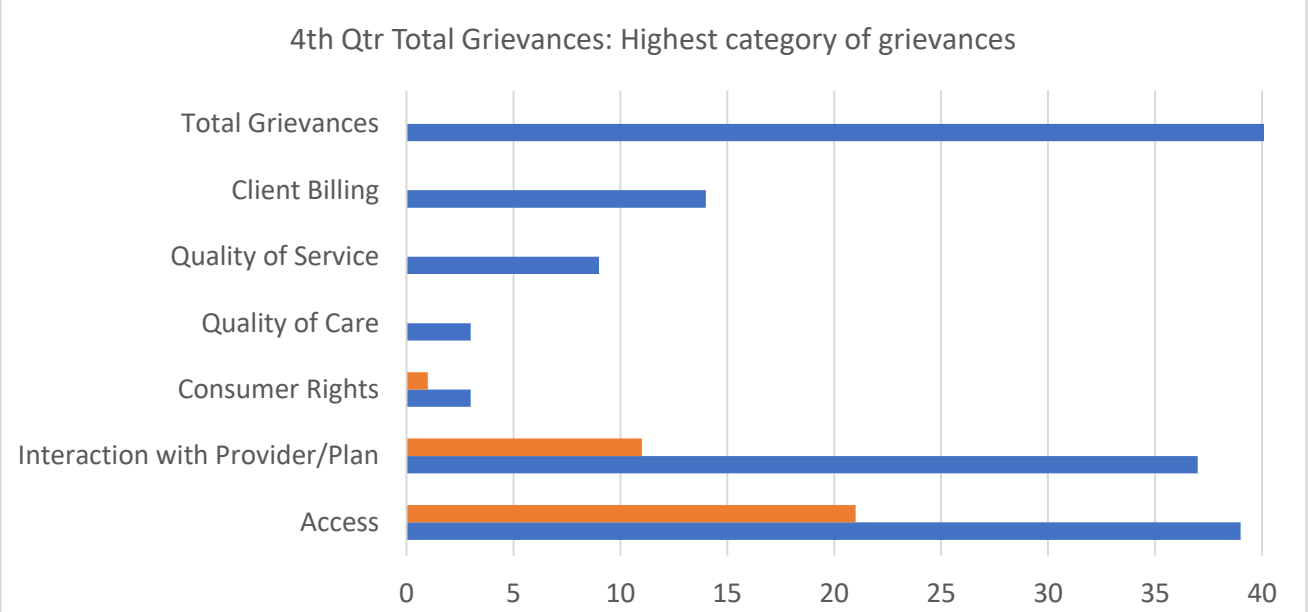
Monitoring measure 2.1	Identify specific concern and root causes.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Identify area of highest level of grievances, identify patterns (provider/clinic/brokerage), and research root causes	Root cause analysis completed	03/2023	Root cause analysis completed	03/2023

Activity 3 description: Develop processes to remove barriers

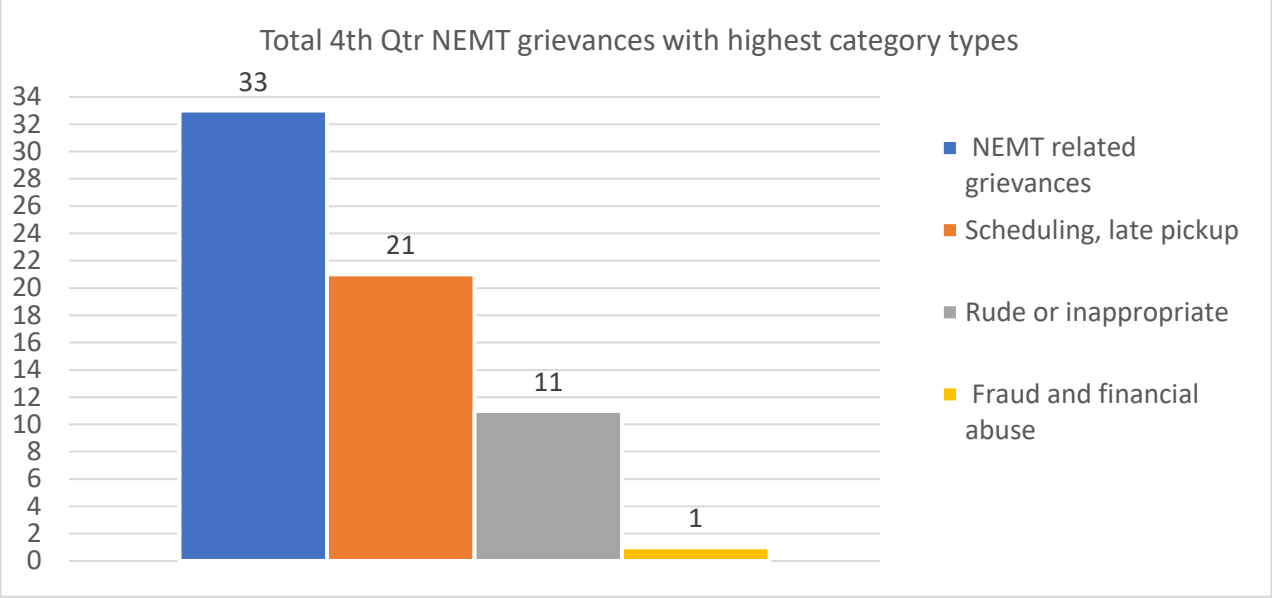
☐ Short term or ☒ Long term

Monitoring measure 3.1	• Identify staff/committees, etc. who will be involved in developing processes to alleviate the barriers. • Set timelines to develop processes that will be used to alleviate barriers. • Identify what types of processes are needed for improvement.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Number of current grievances in area identified through monitoring activity 1	Number of grievances reduced by 25%	06/2024	Number of grievances reduced by 50%	12/2024





	Access	Interaction with Provider/Plan	Consumer Rights	Quality of Care	Quality of Service	Client Billing	Total Grievances
NEMT	21	11	1				
Grievances	39	37	3	3	9	14	105



A. Project 3: Communication and language assistance services implementation plan

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

i. Component 1: Health equity: Cultural responsiveness
ii. Component 2 (if applicable): CLAS standards
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?
☐ Economic stability ☐ Education
☒ Neighborhood and build environment ☐ Social and community health
vi. If this is a CLAS standards project, which specific standard does it primarily address? 6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing
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 for the component(s) selected with CCO- and region-specific data

As Oregon's population becomes ever more diverse, health care providers serve increasing numbers of members with disabilities and from diverse genders, sexual orientations cultures and linguistic backgrounds and the intersections within those identities. Disability, gender identity, sexual orientation, culture and language play a crucial role in how effectively health services are delivered and received. Issues such as patient activation and engagement, health care literacy and English language proficiency are all factors that providers must consider when providing responsive care and services. The provision of quality language services to individuals with limited English proficiency (LEP) and individuals who are Deaf or Hard of Hearing is a key component of health equity. REALD and SOGI data play a critical role in the shaping our health care system to meet the needs of our members.

As we reviewed available data regarding language for members, it became clear that we continue to struggle with the limitations of the MMIS data and work toward increased outreach and engagement with members on their language access needs to improve our services and engagement with current and potential members. We are eager to receive Repository Data from OHA to help improve the quality of the language data we currently receive. We are also working internally on developing our own strategies to reduce missing data with our members and potential members by educating members, call center staff and our network of providers about the importance and availability of language access supports and why it is critical for us to understand who needs language access support. We also want their help in documenting language access needs on member profiles to create a more accurate picture of our membership and their needs. We also continue to monitor county wide data and information from our community partners to ensure we are also monitoring for changes in demographics and opportunities to serve potential members. We continue to work on reducing the volume of unknown data elements based on what we can control.

2022 ACS Census data shows us that in the three counties we serve, approximately 1,819 identify as primarily speaking Spanish (self-evaluation in the census indicating ability to speak English as "less than very well"). No other language was specifically identified in the 2022 ACS data map. However, our own MMIS data does show a population of Romanian, Vietnamese and ASL speakers.

D. **Project context**: Include justification for the chosen or continued project with CCO- and region-specific data, and progress to date for continued projects

While the REALD data is still not fully absorbed into the MMIS system, we do have a starting point. Current REALD data shows that our CCO membership is comprised of approximately 1,347 individuals whose primary language is Spanish. Approximately 245 members speak primarily in Romanian and approximately 62 members speak primarily in Vietnamese. Total known CCO members likely needing spoken language interpretation is approximately 1,654. In addition, CCO data indicate 27 individuals use ASL to communicate. The REALD data does show a gap of approximately 237 members whose language is in the other/undetermined category and 70 members declining to answer.

There are currently gaps in availability and access to quality health care interpretation, with less than 15% of LEP or Deaf/Hard of Hearing members accessing a qualified health care interpreter during their appointments. It is not known why we have low utilization at this time.

The CCO will create a Communication and Language Assistance Services Implementation Plan (LA Plan). We will be prioritizing online recorded trainings in English, Vietnamese, Spanish, ASL and Romanian with on-screen captioning and a written checklist for staff, in-network providers and members to ensure all individuals are aware of the availability of language assistance services. Our plan has also been updated to reflect the needs of interpretation and information about interpretation in a telehealth environment.

This project is relevant and critical to the mission and work of this CCO. As such we are committed to continuing our work on improving our demographic data, member outreach and communication materials into Spanish, Romanian, Vietnamese and ASL to best meet the needs of our current and potential members. As our data collection standards improve, we will update the LA Plan along with our communication plan to reflect our changing member landscape as additional information is received.

E. **Project or program brief narrative description**

Communication and Language Assistance Services Implementation Plan (LA Plan)

CCO will develop a plan that will allow the CCO and our network health care providers to meet the requirements of the following CLAS Standards:

1. Provide and track mandatory training to CCO staff and all in-network providers on the CCO interpreter services reimbursement policy in accordance with CLAS Standard #6 on an annual basis.
2. Inform CCO members of the availability of language assistance services in their primary language, orally and in writing through a strategic marketing campaign, which will include at least communication online, within our handbook and with all significant communication sent to members in accordance with CLAS Standard #6.
3. Develop a process with Care Coordination to ensure that complex case members are appropriately screened for any language access needs.
4. Conduct a telephone survey with at least 20% of all known members who speak languages other than English to ask about their experiences accessing health care within our network
5. Develop a training plan for CCO staff and network providers to develop understanding of state and federal laws regarding language and disability (Title VI Civil Rights, ACA 1557, ADA, etc.) and knowledge of CCO's interpreter services polices and process for existing and new staff in accordance with CLAS Standard #6.
6. Track network providers and CCO interpreter utilization to meet CCO contractual requirements and include measurement for timely access in accordance with CLAS Standard #5.
7. CCO and network providers provide easy-to-understand print and multimedia materials and signage in the languages commonly used or anticipated by the populations in the service area in accordance with CLAS Standard #8.
8. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided in accordance with CLAS Standard #7.

F. Activities and monitoring for performance improvement

Activity 1 description: The Communication and Language Assistance Services Implementation Plan is developed based on the CLAS framework along with consumers and community members, in addition to plan and clinic leadership. It includes the allocation of funds for language services and guidance on the provision of such services that include:

- Create a training development plan and an implementation plan for existing and new CCO staff and providers within our network on interpreter services policies and procedures
- Create a training on how to choose and use qualified and/or certified health care interpreters and what to do if there are concerns about quality
- Create a training and toolkit on using telephonic or video interpreting and contracting with agencies that employ qualified/certified interpreters
- Create a training on understanding how to use interpreter services and the different modalities (with the interpreter present or via phone or video) and considering patient/members preferences
- Create a communication plan on how to engage members and provide members information on the right to interpreter services and how to request interpreter services and what to do if interpreter services are denied or the member experiences issues with interpretation
- Create a communication plan for members and providers on the provision of language services at no cost to members and what it means to facilitate timely access
- Create a policy on the utilization of bilingual staff and when it is or is not appropriate

- Create a tool for providers and members to be able to provide feedback on the quality of language services provided by the interpreter

☒ Short term or ☐ Long term

Monitoring measure 1.1	Development of plan			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No current plan	Plan is developed	07/2023	Same as target	Same as target

Monitoring measure 1.2	Implementation of the training and written materials plan.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No current plan	20% of the plan elements are implemented	03/2024	Same as target	Same as target

Activity 2 description: Monitor implementation of the language plan:

- Ensure data on ethnicity, race, language and disability as well as sexual orientation and gender identity are gathered using REALD and SOGI standards and used to determine language access needs and develop appropriate plans and services such as the use of interpreter services, provider cultural responsiveness training, engagement with community-based organizations and recruitment of a workforce that reflects the culture and language of the communities being served.
- Include the ongoing assessment of characteristics and needs of the population including race/ethnicity, cultural health beliefs and practices, preferred languages, health literacy, vision and hearing limitations and other communication needs.
- Include interpreter services utilization tracking mechanisms.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Member data is consistently updated or collected in alignment with REALD&SOGI standards.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
30% of members have complete demographic fields per REALD and SOGI standards	40% of members have complete demographic fields per REALD and SOGI standards	12/2023	50% of members have complete demographic fields per REALD and SOGI standards	12/2023

Monitoring measure 2.2	Percent of members who have identified a primary language other than English and have LEP who have accessed a health care interpreter.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
14.2%	25%	12/2023	35%	12/2024

A. Project 4: Increasing the uptake and adoption of MAT services in integrated settings

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this 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) for the component(s) selected with CCO- or region-specific data.

Behavioral integration for ExampleCCO focuses on three areas: 1) Clinic integration (for example, BH embedded in primary care, primary care embedded in BH); 2) electronic health record sharing for care coordination (for example, PreManage, CareEverywhere utilization, integrated electronic health records, community health information exchange); and 3) population health quality initiatives (for example, ED/SPMI, care transitions of SPMI, addictions treatment in multiple health settings, suicide prevention in multiple settings). The current state for each three areas, based on a 2022 analysis, is as follows:

1. Clinic integration: 45% of primary care providers have embedded BH providers; 35% of BH clinics have embedded primary care providers
2. EHR sharing for care coordination: PreManage deployed in 35% of BH clinics; integrated EHRs implemented in 45% of BH clinics and 60% of primary care providers; CIE in deployment across community, but not yet widespread adoption
3. Population health quality initiatives: 30% of participating clinics will use an opioid use disorder disease registry; 27% of participating clinics screen for substance use/misuse using the AUDIT or DAST validated screening tools. The population health measures will use REALD and SOGI data to track service equity.

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

Oregonians experience one of the highest rates of substance use and substance use disorders (SUDs) in the nation, and the personal and financial costs are enormous. National estimates placed the number of Oregonians who needed but did not receive addiction services at somewhere between 266,000 and 362,000 (or 7.6% to 10.4% of all Oregonians) in 2016–2017 (Oregon Statewide Strategic Plan 2020–2025). To meet the growing demand for SUD services that promote treatment and recovery, this project continues to build on the behavioral health integration efforts to expand medication assisted treatment (MAT) in primary care settings. More specifically, the opioid epidemic in Oregon has had a devastating toll. However, MAT is a demonstrably effective medical response that is tragically underutilized. The use of medication in combination with counselling and behavioral therapies provides a whole-person approach to the treatment of substance use disorder in an integrated setting. MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce OUD-associated morbidity and mortality, improve health, productivity and social outcomes and reduce health care spending. In Oregon, X% of adults do not have access to adequate addiction services,

which mirrors ExampleCCO's region of Y% in 2022. In addition, this project will implement the use of REALD and SOGI data to track service equity in all process and outcome measures.

To build on the community conversation, the state priorities, and ExampleCCO's strategic plan, we are going to focus on a population health project for MAT. Project activities in 2022 resulted in five additional primary care providers that incorporated MAT and met key process measures through ExampleCCO's value-based payment (VBP) model. This included an increase of 20% of members who were eligible for and subsequently engaged in treatment through MAT.

E. Brief narrative description

ExampleCCO will expand the current VBP model that pays for performance to ten additional voluntarily participating primary care providers to incorporate MAT and achieve benchmarks on process measures. The VBP model requires participating primary care providers achieve benchmarks on key process measure to increase uptake and adoption of MAT, member engagement in MAT, uptake and adoption of team-based psychosocial support as an adjunct to MAT, adoption of adequate EHR infrastructure supporting care coordination, and use of REALD and SOGI data to track and mitigate service inequities.

F. Activities and monitoring for performance improvement

Activity 1 description: Care coordination by primary care MAT providers

☐ Short term or ☒ Long term

Monitoring measure 1.1	Percent of members stratified by REALD and SOGI who meet DSM V criteria for SUD and OUD and are engaged in treatment through expanded MAT provider networks.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/ future state**	**Benchmark met by (MM/YYYY)**
# of patients who initiate pharmacotherapy (MAT) with at least one prescription within 30 days of index visit and with appropriate diagnosis	25% of patients	6/2023	50% of patients	1/2024
# of patients with one prescription with appropriate pharmacotherapy at any given time during the measurement year	30% of patients	6/2023	60% of patients	1/2024
Duration of MAT - length of treatment # of patients who had two or more visits after initiation of MAT within 30 days (engagement)	25% of patients on MAT	6/2023	50% of patients on MAT	1/2024
# patients enrolled in MAT using REALD data	25% of patients	6/2023	50% of patients	1/2024

Activity 2 description: Participating providers receive enhanced payment if MAT is offered and benchmark is met on length of member engagement in treatment.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Increase MAT provider networks through increasing participating clinics with ExampleCCO's VBP model; increase providers with waivers in the VBP model participating clinics.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Measure of VBP model uptake: 8 primary care clinics participating in VBP model	10 additional clinics participating	6/2023	25% of primary care clinics participating	1/2024
Measure for network adequacy and access: # of waivered primary care providers	20% of primary care providers are waivered	6/2023	75% of primary care providers are waivered	1/2025
Measure of uptake and adoption: # of waivered providers at participating clinics who wrote a prescription for MAT	25% of providers	6/2023	50% of providers	1/2024

Monitoring measure 2.2	Increase team-based/multi-disciplinary care providing psychosocial support as an adjunct to MAT.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
# referrals for team-based care by REALD and SOGI categories	20% of patients by REALD and SOGI categories on MAT	6/2023	40% of patients by REALD and SOGI categories on MAT	1/2024
# of service providers who are co-located and or integrated	15% of staff are co-located and or integrated	6/2023	30% of staff are co-located and or integrated	1/2024
# of clinics with disease registry for OUD	20% of clinics have an OUD disease registry ; disease registries use REALD and SOGI data to mitigate service inequities	1/2024	50% of clinics have an OUD disease registry; disease registries use REALD and SOGI data to mitigate service inequities	1/2025
# of preventive health services received	25% of patients on MAT by REALD and SOGI categories received preventive health services using	6/2023	60% of patients on MAT by REALD and SOGI categories receive preventive health services	1/2024

Monitoring measure 2.3	HIT elements: EHR meets meaningful use criteria for care coordination (inter-operability)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

Timely exchange of information on demographic data, problem list, medication list, diagnosis, tests and notes	15% meet meaningful use criteria for care coordination	6/2023	40% meet meaningful use criteria for care coordination	1/2024

A. Project 5: Improving access to SDOH-E supports for high-risk populations

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

If continued, insert unique project ID from OHA: ##

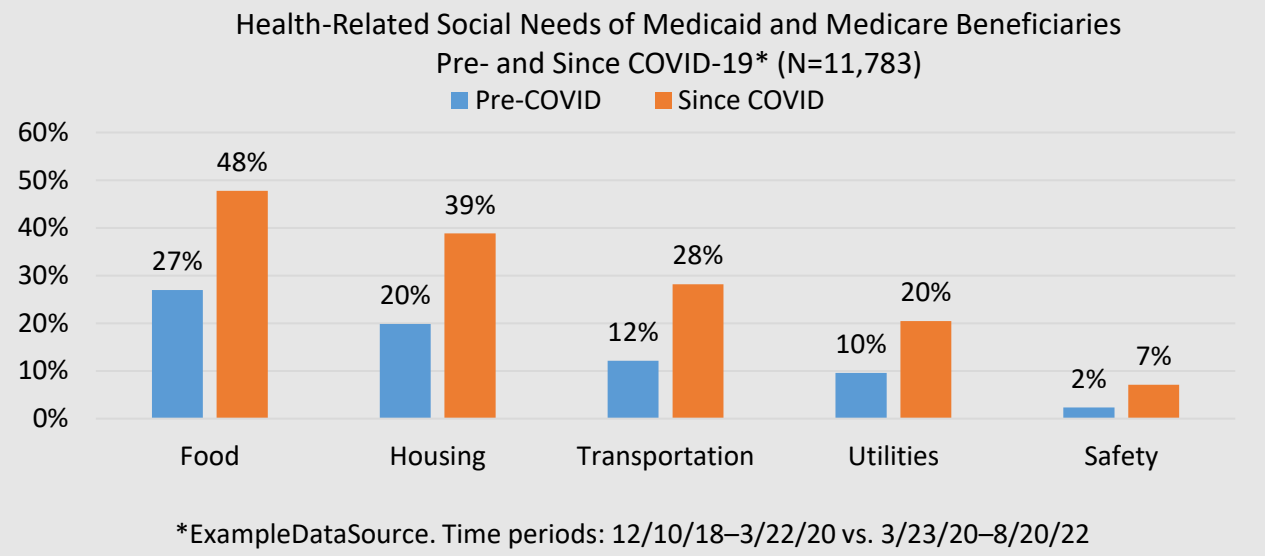
B. Components addressed

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

Unmet social needs have a significant impact on health outcomes, and we know OHP members are at increased risk for food insecurity, housing instability and other factors based on income level alone. In a prior year ExampleCCO member survey, members indicated that social needs are a driving factor for poor health and that meeting social needs is their top priority for improving their community's health. These needs have only been exacerbated from the economic impact of COVID-19. The ExampleDataSource, which includes Medicaid members statewide, shows social needs have increased across areas, including food, housing, transportation, utilities and safety. Chart 1 details the needs prior to and since the beginning of COVID-19. Medicaid members that identified as Hispanic/Latino had the largest increase in housing related needs as well as the highest housing need. Within the Hispanic/Latino community, disparities were even greater for families including individuals who identify as LGBTQIA2S+.

Chart 1



D. **Project context**: Include justification for the chosen or continued project with CCO- and region-specific data, and progress to date for continued projects

Year one of the project focused on determining the greatest need of the member population in relation to the social determinants of health and equity through the needs assessment conducted with community-based organizations. Year two of the project focused on stakeholder engagement and the creation of a community-based steering committee, which undertook three main activities. The overall goal of these activities was to understand the existing support network, identify opportunities for better linkage to these supports, identify gaps for at-risk populations and explore ways to strengthen the safety net for at-risk populations, including recommendations for possible future SHARE initiative or other CCO investments.

The community-based steering committee brought together local community-based organizations, community action agencies, housing authorities and other partners included in the CHP planning process with the goal of creating a resource for providers detailing referral pathways in each county ExampleCCO serves to local housing supports. These pathways were identified and gaps in supports determined, and the steering committee was asked to recommend a year three SHARE initiative.

In 2022, ExampleCCO partnered with five local culturally specific community-based organizations to conduct an updated needs assessment related to social determinants of health. Given the impact of convening in person due to COVID-19 restrictions, sessions were held virtually, over the phone, and through a survey administered at flu shot clinics. Each of the organizations determined housing resources as the primary need in their communities. ExampleDataSource also demonstrates that in ExampleCCO's service area, X% of families experienced housing instability in 2020 and X% in 2021 compared to X% in 2022. This represents an X% increase in two years. Disaggregating the data by REALD and SOGI categories demonstrated that housing resources are disproportionately needed within the region's Hispanic/Latino community. While they represent Y% of the population, Hispanic/Latino families accounted for X% of the population who had experienced housing instability in 2022. Within the Hispanic/Latino community, disparities were even greater for families including individuals who identify as LGBTQIA2S+. While only XX% of the Hispanic/Latino respondents identified as LGBTQIA2S+, this group accounted for YY% of the Hispanic/Latino population who had

experienced housing instability. While the assessment didn't fully address why families experienced housing instability, we assume the disparity is at least in part due to systematic and historic racist housing practices.

Many clinicians are aware that housing supports exist for their patient population, but specific needs often remain undetected and unaddressed. In addition, resources within the community are underutilized due to lacking infrastructure for coordinating across organizations. Integrating housing support program referral into ExampleCCO's primary care settings, and connecting patients with community organizations (especially culturally responsive organizations) that provide needed resources, can significantly impact health outcomes for both individuals and families.

E. Project or program brief narrative description

In year three, ExampleCCO will determine SHARE initiative feasibility and possible funding levels to provide community-level support to address gaps identified in year two. Year three will also look at integrating SDOH-E housing support referral into community information exchange, developing a plan for updating information with organizations represented on the steering committee, and bi-directional tracking of OHP patients.

F. Activities and monitoring for performance improvement

Activity 1 description: Review identified gaps in funding levels and determine proportion of SHARE initiative and other CCO funding to culturally responsive community partners to address gaps.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Steering committee to identify funding level needs to address identified gaps from systems integration report and recommendations			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Funding level needs not identified	Gaps reviewed and prioritized ability to address disproportionate impact to the Latino community	03/2023	Funding level needs identified to address prioritized gaps	04/2023

Monitoring measure 1.2	Propose SHARE initiative and other CCO spending to culturally responsive community partners to meet identified funding level needs that will address prioritized gaps			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No funding allocated	Proposal to CAC and CCO leadership	05/2023	Funds allocated	07/2023

Activity 2 description: Develop systems integration report with recommendations

☒ Short term or ☐ Long term

Monitoring measure 2.1	Create systems integration report and recommendations

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No report	First draft of report submitted by steering committee	10/2023	Final draft of report submitted	11/2023

Activity 3 description: Implement housing-related questions in community information exchange (CIE) based on prior review of tool questions and available housing supports. Support community-based organizations and local agencies in CIE implementation and closed loop referrals, especially culturally responsive organizations serving Hispanic/Latino and LGBTQIA2S+ families.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Steering committee social needs screening tool review			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No housing question incorporated into CIE	Housing tool questions incorporated into CIE	06/2023	Same as target	Same as target
No CBO and local agencies receiving housing support and service referrals through CIE	X CBO and local agencies provided CIE access and technical assistance to implement CIE closed loop referrals; with at least X that primarily serve Hispanic, Latino and LGBTQIA2S+ families	09/2023	X additional CBO and local agencies provided CIE access and technical assistance to implement CIE closed loop referrals; with at least X that primarily serve Hispanic, Latino and LGBTQIA2S+ families	12/2023
Members not receiving housing supports and services through closed loop referrals	X% of CCO members by REALD and SOGI categories screened for and referred to housing supports and services	06/2024	X% of members by REALD and SOGI categories who are referred to housing supports and services show housing needs are met	12/2024

A. Project 6: Increase acute psychiatric hospital care coordination and Oregon State Hospital diversion

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

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

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

Care coordination for SPMI clients at acute psychiatric hospitals has largely been through authorization of services and collaboration with community behavioral health contractors. ExampleCCO has worked closely with these community service providers to monitor the continued need for hospitalization and discharge readiness, as well as ensuring other community health providers are established, especially physical health and specialty care.

In 2022, data from REALD and SOGI identifies the lack of clinicians who reflect the community of the client is a central barrier in client continued engagement. Pilots have indicated that crisis services are less effected by community engagement than ongoing supports, either through peer supports, clinical services or both. Comparing REALD and SOGI data with staffing within the ExampleCCO service area indicates a shortage of 58% in matching clinicians to population served and 64% in peer supports. Service data shows that the Community Mental Health Program (CMHP) lead acute hospital discharges in 87% of the cases with SPMI patients and facilitated 93% of Oregon State Hospital (OSH) diversions. Readmissions have been inching up from 2021, from 3% to 4.1%.

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

The current CCO contract emphasizes that CCOs cannot delegate behavioral health responsibility to contracted entities, even if those behavioral health contractors facilitate the services directly. To improve coordination of care, the CCO has become and will continue to become more centrally involved with oversight of patient coordination at the acute psychiatric hospital level, focusing on discharge planning and readmission prevention. Relating readmission to REALD and SOGI factors will be critical in preventing readmission.

ExampleCCO has been increasing its monitoring of behavioral health treatment needs in partnership with the CMHPs in the region, which is fueling a plan to bolster community services through Assertive Community Treatment (ACT) (currently serving 54 clients in 2021 but population need indicates 80) and developing protocol for transitioning clients from mental health residential treatment programs to supported housing (from a facility-based service to a system-based process beginning in Q3 of 2022). Previous to 2021, this responsibility of treatment development largely fell to the CMHP, which was effective to meet the needs but not progressive to curb the trajectory of the SPMI population. Extended stays in acute hospitals were 26 days average in 2021 and 19 days average in 2022. Diversion from OSH admission was a focus in 2022 for the civil population.

E. Brief narrative description

This project will continue to focus on identifying all admissions into acute psychiatric hospitalization, monitoring the progress of stabilization, assessing the need for LTPC referral, and coordinating diversion planning from OSH admission. The baseline and 2022 improvement targets/benchmarks were based on a study of 2019-2022 acute psychiatric hospitalizations, including: length of hospitalization, numbers placed on the waitlist for LTPC, time on the waitlist before OSH admission, numbers of diversions after being placed on the waitlist, and readmissions to acute psychiatric hospitalization. The goals are to: 1) increase, beyond 2020 improvements, direct involvement of coordinated care by Intensive Care Coordinators (ICCs) of SPMI patients at acute psychiatric hospitals to 95%, and 2) significantly increase, beyond 2021 improvements, appropriate diversions from OSH admission by at least p=<0.05.

F. Activities and monitoring for performance improvement

Activity 1 description: Increase direct involvement of coordinated care by ICCs of SPMI patients at acute psychiatric hospitals.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Improve upon 2022 progress for acute psychiatric hospitalizations based on data sources including those from the CCO, OSH and involved CMHP.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Length of acute psychiatric hospitalizations for SPMI members is at X	Decrease length of hospitalizations for each SPMI member by Y%	6/2023	Decrease length of hospitalizations for each SPMI member by additional Z%	12/2023
Readmissions to acute psychiatric hospitalization is X	Reduce numbers of readmissions compared to date of acute psychiatric hospital discharge by Y%	6/2023	Reduce numbers of readmissions compared to date of acute psychiatric hospital discharge by additional Z%	12/2023
The ratio of peer staff and clients by REALD & SOGI categories compared to the % of readmissions, then measure the changes in the REALD & SOGI ratio over time and compare to % changes in readmissions	Percentage of peer staff matching the community of the client is increased by 5%	6/2023	Percentage difference between clients of peer staff matching the community of the client vs peer staff who do not as it relates to readmission into psychiatric hospitalization.	12/2023
Length of stabilization for those with psychiatric	Increase length of stabilization between hospitalizations by 5%	6/2023	Increase length of stabilization between hospitalizations by an	12/2023

hospital history is an average of X	from last calendar year's accumulated data.		additional 5% from last 6 month accumulated data.	

Monitoring measure 1.2	Increase ICC directly involved in care coordination oversight to 95%			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
X number of meetings with acute psychiatric hospital staff to identify patient stabilization	Identify coordination meetings by date and complete Y meetings	6/2023	Attending at least one coordination meeting per patient per episode at 95% of all members	12/2023
X number of meetings with community behavioral health care coordinators over aftercare plans for each patient	Identify community meetings by date and complete Y meetings	6/2023	Attending at least one community meeting per patient per episode at 95% of all members	12/2023
Aftercare services needed for acute hospital discharge are not identified	Develop and regularly update list of aftercare services to pursue	6/2023; Ongoing throughout the project	Develop, share and update list of options for at least 95% of all members	12/2023
When an LTPC referral is needed is not defined	List of conditions requiring LTPC is defined and refined	6/2023; Ongoing throughout the project	Develop, share and update list of conditions for at least 95% of all members	12/2023
Diversion plans from OSH admission are not identified	Develop and regularly update list of diversion options considered and pursued	6/2023; Ongoing throughout the project	Develop, share and update list of options for at least 95% of all members	12/2023

Monitoring measure 1.3	Increase appropriate diversions from OSH admission by at least p=<0.05.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
X total diversions as defined in Activity 1.1	Increase by Y% number of diversions facilitated once a member was placed on the waitlist by date and diversion type of community services	6/2023	Increase numbers of diversions by p=<0.05 while not increasing number of readmissions	12/2023

A. Project 7: Building collaborative treatment plans for members with dementia in collaboration with affiliated Medicare Advantage DSNP and LTC/LTSS providers

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

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

The CCO community health needs assessment identified access to medical care for CCO members over 65 as one of several community issues related to access. To follow up and better understand this issue, our CCO's Quality Improvement Committee (QIC) developed new utilization review reports to look at both under- and over-utilization of services and to take a deeper dive into care patterns for dual eligible members with two or more chronic and/or behavioral health conditions. Our QIC also conducted a survey of primary care providers (60% response rate) to identify areas where providers felt they needed more support from our CCO QIC for complex patients with two or more chronic and/or behavioral conditions. We also evaluated data for members with dementia diagnosis by REALD data to identify health inequities in care delivery and advanced care planning for those with dementia diagnosis.

Based on data from both of these activities, including limited cognitive assessments and early identification of dementia in primary care, our QIC identified a need to focus on building a more comprehensive collaborative approach to dementia for services aimed at improving detection, diagnosis and care planning and coordination for patients with Alzheimer's disease and related dementias (ADRD) and their caregivers. This led us to focus on a project across our CCO network and representative partners using the Alzheimer's Association Cognitive Impairment Care Planning Toolkit to develop a new CCO approach that included: addressing assessments as part of workflows in primary care; ensuring referrals for accessing available behavioral health services upon diagnosis; need for understanding for specialty consultation value and referral process; and developing shared checklists and collaborative treatment plans within HIE systems. This process also created clarity around Medicaid and Medicare billing codes, providers available for referrals, CCO intentions to monitor HIE completed checklists, and plans as a quality improvement project.

D. **Project context**: Include justification for the chosen or continued project with CCO- and region-specific data, and progress to date for continued projects

Full benefit dual eligible (FBDE) members have higher rates of hospitalization overall compared to non-dual eligible members. In a high percentage of these hospitalizations for over 65 members, diagnoses may include identification of cognitive declines that contributed to the need for hospitalization. Our CCO has chosen to build increased assessment of cognition with primary care to prevent unnecessary hospitalizations through earlier identification of needs. Educational outreach to primary care providers and specialists on the lack of care planning for those with dementia diagnosis, especially for populations of color, was determined as a need to improve provider development of advanced care plans under CPT code 99483. Non-white populations (by REALD categories) were far less likely to have advance care plans and more likely to have unnecessary ER and hospital admissions, and less likely to have received referrals to LTSS or specialists. FBDE members

transitioning to home settings have complex needs that require involvement and planning by primary care, specialists, long-term care providers and the CCO and Medicare Advantage DSNP plan. CCO 2.0 goals target created shared care planning for members that ensure elements of quality transition care and follow-up. Our HIE system allows us to track follow-up appointment referrals and attendance so we can ensure members are receiving timely follow-up. Medicare prevalence of dementia is about 14.4% overall and Alzheimer's disease accounts for 60-80% of cases. Vascular dementia, which occurs after a stroke, is the second most common dementia type. Care planning needs to address social determinants of health, potential behavioral health side effects members may be experiencing, coordination of home and community supports to ensure successful transition, and family/caregiver wellness. Our data showed that when not identified early, CCO members and their family caregivers had difficulty accessing appropriate care and were more likely to have adverse outcomes such as added ER visits, hospital readmissions, and limited access to supportive behavioral health services. Year two of this project aims to track this newly CCO-wide implemented standardized care coordination pathway for dementia.

E. Project or program brief narrative description

The CCO ICC team and Medicare Advantage DSNP care coordination team will coordinate with contractors and subcontractors to analyze processes and care planning formats, checklists and medication reconciliation checklists that can be shared via the regional HIE to reduce duplication and ensure quality and appropriateness of care. A project team has been established to develop a coordinated care planning approach with local dementia specialists, primary care, APD case managers, and the respective CCO and our partner MA plan (for example: Alzheimer's Association Cognitive Impairment Care Planning Toolkit). The CCO QM team will use data collected to monitor readmissions and hospitalizations, as well as completion of follow-up monitoring tasks and appointments within the initial 30 days post-transition. The CCO QM team will monitor the development of dementia advance care plans by billing code by population, including analysis of increase in percentage of members receiving advance care plans by REALD, using direct claims data. The goal is to reduce hospitalizations and hospital readmissions, and improve care referrals, coordination, and information sharing among all care team members. Updates to our HIE system allow the CCO tracking of follow-up appointment scheduling from referrals and follow-up appointment attendance. Provider contracts support primary care provider tracking of cognitive assessments and depression screenings in our FBDE population.

F. Activities and monitoring for performance improvement

Activity 1 description: Coordinate with Medicare and Medicaid providers/care coordinators, Part D Medication Management teams, and DHS LTSS programs as necessary to implement the established coordinated cognitive impairment care planning approach for comprehensive assessment and coordination of dementia care. This includes HIE implementation to support the coordinated care planning approach and establishing an HIE workflow.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Develop dementia coordinated care planning workflow in HIE.			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No internal HIE workflow for dementia care	Implement the new HIE workflow and policy for coordination pathway to	7/2023	100% of providers and MA partners trained in use of coordination pathway; CCO	10/2024

coordination and planning	share with providers and MA partners Providers will receive educational outreach that includes a focus of current status of advanced care planning in dementia and how to appropriately provide services and bill for CPT 99483.	7/2023	and MA Care Management reviews shared checklists and care plans within HIE CCO sees a 50% increase in populations identified at disproportionate risk by REALD and SOGI categories receiving advance care planning based on claims data.	12/2023

Monitoring measure 1.2	Track use of care coordination pathway by providers			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Cognition assessments are incorporated into primary care workflow	Primary care providers report each quarter on number of cognitive assessments completed for FBDE population over 65 Primary care providers report each quarter on cognitive assessments for their patient population by REALD categories	9/2023 9/2023	80% of FBDE members over 65 receive a cognitive assessment within a 2-year period Increase by 50% non-white FBDE members receiving cognitive assessments, verified through claims data analysis.	12/2024 12/2024
No coordinated dementia care planning in use	Document percent of members with dementia who have documented dementia care coordination in HIE by REALD and SOGI categories, to identify inequities in access and establish whether reaching populations equitably	12/2023	100% of members with dementia have documented dementia care coordination in HIE Increase by 50% any FBDE populations identified as being at higher risk (by REALD and SOGI categories) for dementia care coordination in HIE, verified through claims data analysis.	12/2024
ICP plans for members with dementia are not shared via HIE	Establish baseline and increase by 30% the members with dementia who have ICP plans shared via HIE; review whether	12/2023	60% the members with dementia who have ICP plans shared via HIE; verify breakdown (REALD) of members	12/2024

	this increase is happening across all populations by breaking down data by REALD		with dementia ICP plans shared via HIE to determine progress for all population groups	
MA plan does not document members receiving medication management monitoring in line with coordinated dementia care planning	Partner with MA plan to develop HIE document plan for members with dementia receiving medication management monitoring; track improvement in medication management by REALD to ensure care improvements occurring in all population groups	12/2023	60% of members have medication management documentation in HIE; MA plan is able to stratify such data by CCO and MA duals; verify percentages of members by REALD and SOGI with improvements compared to overall to track improvements across REALD groups	12/2024
Members with dementia are not routinely referred for diagnostic testing based on coordinated dementia care planning	Use HIE to establish referral baseline and increase referrals to diagnostic testing for dementia by 25% Increase referrals for populations with disproportionate access (as determined by REALD and SOGI) by 25% and provide outreach to support follow-up to referrals for non-English speaking populations to increase follow-through on referral appointments	12/2023 12/2023	Use HIE to track 100% of referrals. Referrals are documented in HIE as closed loop referral (referral to completed diagnostic testing, behavioral health services or specialty consultations ongoing); breakdown referral tracking by REALD data to further ensure equity in referral follow-through	7/2024
Members with dementia diagnosis receive annual depression screening	75% of members with dementia diagnosis receive depression screening in CY2023 Track depression screening with dementia diagnosis through REALD breakdown	Track depression screening by PCPs in CY2023	90% of members with dementia diagnosis receive depression screening in CY2024; breakdown depression screening data by REALD to further ensure equity in screening follow-through	12/2024

Activity 2 description: Reduce unnecessary hospital readmissions, unnecessary ER visits, or long-term care readmissions for members with dementia through coordinated care pathway with local dementia specialists, primary care, APD case managers, the CCO and our partner MA plan.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Long term care (LTC), unnecessary ER visits, and hospital readmission rates for members with dementia			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No standardized HIE transition care planning and discharge transition process for FBDE members with dementia completing transitions of care	Develop standardized HIE transition care planning and discharge transition process for FBDE members with dementia Track equity in transition care and discharge planning through stratifying data by REALD breakdowns	12/2023 1/2024	Implement standardized HIE transition care planning and discharge transition process for all FBDE members with dementia; provide breakdown of data by REALD to track equity across population subgroups for care provision Develop additional strategies for populations that continue to lag in receiving equitable care.	06/2024 12/2024
Document improvement in follow-up post hospital time for appointments	Use new HIE appointment referrals and tracking to document improvement from CY 2021 post hospital appointment data with CY 2022 Analyze data by REALD to determine inequities in care and follow-up for population subgroups and develop additional feedback to providers where inequities persist	12/2023 12/2023	Continue data tracking on appointment post-hospitalization tracking with targeted 20% improvement over CY2022 Analyze improvement tracking by REALD to determine whether improvements are occurring equitably across population groups	12/2024 12/2024
Unnecessary LTC admissions for members with dementia: X%	Reduce LTC admissions by 15% Track current LTC admissions by REALD to	12/2023 12/2023	Reduce LTC admissions by 10% over prior year; breakdown by REALD to track equity in target goal for all populations	12/2024

	determine where discrepancies may exist Increase HCBS assessments for in-home support care for dementia-diagnosed populations; analyze by REALD to track referrals to LTSS assessments across all sub-populations to ensure equity in care approaches	12/2023		
Unnecessary ER visits admission for members with dementia: x%	Reduce unnecessary ER visits by 25% Track current ER visits by REALD to determine where discrepancies may exist	12/2023 12/2023	Reduce unnecessary ER visits by additional 5% over prior year; breakdown by REALD to track equity in target goal for all populations	12/2024
Unnecessary hospital readmissions for members with dementia: X%	Reduce unnecessary hospital readmissions by 15% Track current hospital admissions by REALD to determine where discrepancies may exist; determine where feedback to providers and additional care triggers may be valuable for increasing equitable approaches	12/2023 12/2023	Reduce unnecessary hospital readmission by 10% over prior year; breakdown by REALD to track equity in target goal for all populations	12/2024

A. Project 8: PCPCH VBP Model

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

i. Component 1: PCPCH: Tier advancement
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) for the component(s) selected with CCO- or region-specific data.

ExampleCCO had a goal to improve the PCPCH tier level of all PCPCHs in our network. Approximately **XX#** distinct PCPCHs are in the network with **YY#** PCPs. Of these, **ZZ#** PCPCHs are tier 2 or higher. ExampleCCO recognizes that a robust PCPCH network is required to fully serve the community health goals. Many PCPCHs in the area do not have the resources to achieve increases in tier level on their own. ExampleCCO's goal is to provide financial, educational and technology support to achieve our PCPCH goals.

PCPCH clinics	***Associated PCPs***	***PCPCHs ≥ Tier 2***
XX	YY	ZZ

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

ExampleCCO recognizes that higher tier level PCPCHs typically can provide more robust services to patients, such as having an integrated behavioral health therapist, offering alternative visit types to in-person visits or screening and providing interventions for health-related social needs. ExampleCCO understands robust services such as these are difficult for a PCPCH to develop and implement without additional financial and educational resources. In the past year, ExampleCCO, had developed a value-based payment (VBP) model and technical assistance to support clinics to either achieve PCPCH recognition or PCPCH tier advancement. This resulted in **EE#** additional PCPCH recognized clinics. Currently, there are **BB#** PCPCH Tier 3 clinics, but only **CC#** Tier 4 and **DD#** Five Star clinics. The enhanced focus for 2021 will be to increase Tier 3 clinics to Tier 4, in addition to the current PCPCH VBP model and TA.

PCPCH Tier 2	***PCPCH Tier 3***	***PCPCH Tier 4***	*PCPCH Five Star*
AA	BB	CC	DD

E. **Brief narrative description**

CCOs are required per contract to pay all PCPCHs a per-member-per-month (PMPM) payment based on tier level (PCPCHs with a higher tier level receive a higher PMPM). Currently, ExampleCCO PCPCHs receiving a tier-based PMPM VBP are also eligible to request practice coaching and technical assistance, and non-PCPCHs are eligible for practice coaching and TA to achieve initial PCPCH recognition.

ExampleCCO has ***BB#*** of Tier 3 PCPCHs in its network. To provide additional support to these PCPCHs to advance their tier level, the CCO will pay the Tier 4 PMPM rate to these Tier 3 PCPCHs for 18 months. Tier 3 PCPCH must be interested in advancing their tier level and participate in technical assistance support. Further, the CCO will provide practice coaching and technical assistance around the PCPCH standards to the PCPCHs receiving these additional payments. At the end of 12 months, the PCPCH will be prepared to re-apply for PCPCH recognition at a Tier 4 level, and will continue to receive the Tier 4 PMPM until recognition or for a total of 18 months.

F. Activities and monitoring for performance improvement

Activity 1 description: Promote and provide an increased PMPM to PCPCHs to support tier level advancement

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of Tier 3 PCPCHs receiving a PMPM for Tier 4			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Increased PMPM for Tier 3 clinics promoted across provider network	Existing provider network communication channels targeted for promotion	3/2023	Same as target	Same as target
Tier 3 PCPCHs receiving the Tier 3 PMPM	Tier 3 PCPCHs receiving the Tier 4 PMPM for 18 months	6/2024	Same as target	Same as target

Activity 2 description: Practice coaching and technical assistance to PCPCHs receiving a higher PMPM payment.

☒ Short term or ☒ Long term

Monitoring measure 2.1	Assign a CCO staff person to provide practice coaching and technical assistance			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No practice coach assigned	Practice coach assigned	3/2023	Same as target	Same as target

Monitoring measure 2.2	Check-in progress meetings with PCPCH at 6-month intervals.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Launch of PCPCHs receiving technical assistance and additional PMPM	Two, 6-month interval check-ins completed	12/2023	Three, 6-month interval check-ins completed	6/2024

Activity 3 description: Tier 3 PCPCHs advance to Tier 4 PCPCH recognition

☐ Short term or ☒ Long term

Monitoring measure 3.1	Tier 3 PCPCHs apply for and receive Tier 4 PCPCH recognition			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
XX# Tier 3 PCPCHs	XX# Tier 3 PCPCHs apply to Tier 4	3/2024	XX# Tier 3 PCPCHs advance to Tier 4	6/2024

Monitoring measure 3.2	20% of the plan is implemented			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No current plan	Training and written materials plan elements are implemented	03/2024	Plan is implemented	03/2024

A. Project 9: Patient-Centered Primary Care Home (PCPCH) Member Enrollment

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

i. Component 1: PCPCH: Member enrollment
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) for the component(s) selected with CCO- or region-specific data.

ExampleCCO has a membership of ###, of which XX% are assigned to PCPCH clinics. Achieving a coordinated care model in our community will require the CCO to continue increasing member assignments with PCPCH clinics. While there are only ### PCPCH certified clinics within ExampleCCO's region, there is room for improved member assignment to those clinics.

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

ExampleCCO assigns members to primary care clinics at the time of enrollment. Currently, 60% of members are assigned to a PCPCH and this percentage has decreased from 62% of members the previous year. This is likely due to PCPCH capacity issues as well as a need to update the process for member assignment. Given the evidence to support improved outcomes for members receiving care at a recognized PCPCH that has demonstrated high quality care, ExampleCCO aims to increase the percent of members assigned to PCPCHs in its network.

Prior activities have focused on member assignment, which has resulted in an improved member assignment algorithm that prioritizes assignment to a PCPCH, but this year the project will focus on the member assignment to the highest PCPCH tier possible. This project is complemented by ExampleCCO's PCPCH value-based payment model to incentivize additional PCPCH providers and tier advancement in the region.

E. Brief narrative description

Although members are assigned to primary care clinics at enrollment, with a priority on assigning to PCPCH clinics, the CCO acknowledges its assignment process needs improvement. This project will improve the CCO's internal process for assigning members to PCPCHs. Additionally, the transition of members between plans (FFS and/or CCO) and/or clinics requires re-assignment of members to primary care clinics. CCO staff will coordinate with member enrollment, the population health team and case management teams to build a process and algorithm to prioritize member assignment to a PCPCH at the highest tier possible, as well as to prioritize PCPCH over non-PCPCH assignment. Further, the CCO will consider known member needs and preferences, such as language or physical setting, in member assignment to a PCPCH.

F. Activities and monitoring for performance improvement

Activity 1 description: Increase percentage of members assigned to a Tier 4 or Five Star PCPCH, based on an updated process and algorithm for member assignment.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Monitor member assignment among both PCPCH and non-PCPCH provider offices by tracking monthly assignment reports.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
60% of members assigned to PCPCH	70% of members assigned to PCPCH	12/2023	80% of members assigned to PCPCH	12/2024

Activity 2 description: Monitor member assignment among PCPCH Tier 4, Five Star, and ≤ Tier 3. Improve % of members assigned to ≥ Tier 4 and to Tier 3, if capacity ≥ Tier 4 is exhausted.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Monitor member assignment to PCPCH provider offices at Tier 3 and ≥Tier 4.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
X% ≥ Tier 4	Increase by 10%	12/2023	Increase by additional 10%	12/2024
Y% at Tier 3	TBD based on capacity of clinics ≥ Tier 4	12/2023	TBD based on capacity of clinics ≥ Tier 4	12/2024

Activity 3 description: Monitor member assignment among PCPCH Tier 4, Five Star, and ≤ Tier 3. Improve % of members assigned to ≥ Tier 4 and to Tier 3, if capacity ≥ Tier 4 is exhausted.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Analyze (at 6-month intervals) progress toward assignment at higher tiers (Activity 2) and ExampleCCO membership to adjust assignment algorithm and increase promotions of ExampleCCO's PCPCH value-based payment model (incentivizes additional PCPCH providers and tier advancement in the region).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No analysis completed	Develop and test analysis of progress (activity 2) and ExampleCCO membership	6/2023	Complete 3 analyses (6-month intervals) of progress (activity 2) and ExampleCCO membership	12/2024
No algorithm adjustment	Adjust algorithm up to 3 times, based on analyses, at 6-month intervals	12/2023	Same as target	Same as target
Standard level of PCPCH VBP model promotion	Target PCPCH VBP model promotion, at 6-month intervals, at Tier 1-3 clinics that see ≥ ExampleCCO members	12/2024	Same as target	Same as target

A. Project 10: Diabetes: Inter-professional Care Collaboration between Primary Care and Dental Providers

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

If continued, insert unique project ID from OHA: ###

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 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:

One way to achieve oral health integration is to deliver dental services where the patient is receiving their primary care via teledentistry. Teledentistry is the coordination and delivery of dental care (diagnostic, preventative, and some treatment) using electronic, video and audio technologies that transmit patient data to the remotely located treating dentist via a dental hygienist, who is physically with the patient. Using video conferencing and other live communication technologies, a live virtual visit between the patient, hygienist and dentist can occur. Alternatively, dental providers can view patient information later in a “store-and-forward” visit.

This model has many benefits, such as reducing patient burden, increasing care utilization, and reducing delivery system burden. In Oregon, comprehensive care delivery via co-located teledentistry is still emerging but is delivering promising results at piloted physical health locations treating diabetic patients. Across the

ExampleCCO's service area in 2022, only X% of primary care providers had partnered with dental providers to implement co-located teledentristry, and only Y% of dental providers had implemented non-oral health care screenings and referrals.

Using REALD and SOGI data, ExampleCCO identified three populations of adults with diabetes – X, Y and Z – who receive dental care less frequently within ExampleCCO's service area. To improve access to dental care for these groups, Example CCO prioritized partnerships with primary care clinics that serve these populations. They also convened a series of listening sessions to hear from patients with diabetes who are served by these clinics about their needs and experiences.

While efforts to initiate co-located dental services were not successful due to COVID-19 and other partner/stakeholder challenges, ExampleCCO made progress in expanding provider awareness around teledentistry. ExampleCCO created several assets to facilitate provider awareness and understanding of teledentistry, mobile dentistry, co-location, and integration that include:

- *Teledentistry FAQ for Physicians and Behavioral Health Providers*
- *Mobile Dentistry and Teledentistry Explained – a training slide deck for physicians and other care providers*
- *Oral Health Integration for Physicians FAQ*

In support of oral health integration, ExampleCCO has continued to encourage and support the adoption and use of Reliance's HIE and HIT platforms in area, where Reliance is active. We have achieved this through facilitating platform demonstrations, initiating conversations between the vendor and DCOs, and assisting with clarification and troubleshooting as appropriate. Example CCO made some progress with the DCO's adoption of the Reliance Community Health Record. However, due to the vendor being unable to complete platform updates required by the health information exchange, we could not make progress with adopting and using the eReferrals platform.

D. **Project context:**

Diabetes prevalence and its impact on health is an ongoing concern in the region. Data presented in the 2019 community health assessment indicates that "11% of area adults are diabetic (2% higher than Oregon and Washington state rates)." Optimal disease management and prevention remain a top priority for Example CCO, given the continued impact of diabetes across the state and in the area. One means to achieve this is through oral health integration, specifically co-located teledentistry within primary care. Unfortunately, COVID-19 hindered this work in 2020. Efforts to increase dental care for diabetic members fell significantly short of the 26.8% target, with just 16.9% of diabetic members receiving the qualifying dental exam.

MEASURE	NUM	DEN	RATE	Target	DIFF
Oral Evaluation - Diabetic	341	2,018	16.9	26.8	-9.9

In 2022, ExampleCCO aimed to leverage value-based payment (VBP) strategies, dashboards and monthly monitoring to increase the percentage of diabetic members who receive a comprehensive or periodontal exam. These dashboards include REALD and SOGI data stratifications to help track performance in reducing differential access in care. While ExampleCCO completed the dashboard revision efforts, COVID-19 led to several dental clinic closures, which impeded progress. As a result of COVID-19's impact on all care-related measures, OHA suspended the quality withhold arrangement with CCOs. Despite this, ExampleCCO continued

updating and sharing dashboards with DCOs, discussing the deployment of strategies for resuming care for people with diabetes through teledentistry and co-location and encouraging DCOs to continue member outreach to deliver care via telehealth or in clinic settings.

Other efforts in promoting dental care delivery to the diabetic population via teledentistry and co-location with physical health provider clinics were successful. In 2022, ExampleCCO created and deployed a dental integration activities log, which provided a baseline for current state diabetes co-location efforts. Additionally, ExampleCCO created several informational guides on teledentistry, mobile dentistry, co-location, and oral health integration to facilitate provider awareness and increase understanding. We also received support and commitment from the DCO to implement a co-location program.

However, ExampleCCO was unable to reach its goal of securing one or more co-locations to serve diabetic members in 2022. The barriers arose from both COVID-19 and the ongoing contract negotiations between a DCO and a local physical health clinic system to continue and expand a 2019 pilot program. The DCO is committed and ready to implement the co-location program. However, progress stalled because the physical health care system wants to charge the DCO a daily site use fee that neither the DCO nor ExampleCCO feels is justified. Both parties continue discussions about how best to move forward. As these discussions continue, ExampleCCO continues to prioritize care for three populations of adults with diabetes – X, Y and Z – identified through REALD and SOGI data as receiving dental care less frequently. Decisions about partnerships with other clinics will be based on the extent to which clinics serve these populations. Listening sessions with patients will continue to shape the project's direction.

Lastly, in 2022, ExampleCCO aimed to work with various internal and external stakeholders to encourage further adoption of the Reliance HIE eReferrals platform and the community health record by DCOs and dental clinics. The community health record would enable care coordination and interprofessional collaboration. ExampleCCO made progress with one DCO adopting the community health record. A second DCO has signaled they intend to adopt the platform and are evaluating further connectivity with Reliance HIE. We continued productive discussions with the third DCO. While progress is ongoing with the DCOs, the factors preventing the CCO region from fully utilizing Reliance's eReferrals platform (and to a lesser degree, the community health record) persist. Thus no meaningful progress with the adoption of the eReferrals platform to generate and track referrals has been possible.

E. **Brief narrative description:**

In an effort to implement and improve oral health integration, ExampleCCO will continue using a VBP model to incentivize the delivery of dental care to members with diabetes. This work aligns with the quality incentive measure (QIM) addressing oral evaluations for diabetic members. It also continues tracking with the 2021 TQS strategy to use VBPs to incentivize each DCO to achieve performance improvement targets and, ultimately, the region's performance benchmark on this measure. The VBP strategy, in combination with monthly monitoring and sharing of measure dashboards and gap lists, will help drive continued progress.

ExampleCCO will also promote the establishment and expansion of co-located teledentistry programs within physical health clinics to increase dental care utilization in the diabetic population. We support this endeavor by facilitating regular conversations with DCOs, sharing resources, hosting discussions encouraging integration (including co-location as appropriate) with physical health providers, and connecting interested physical health providers with DCOs to explore further options when needed.

Finally, ExampleCCO will promote community HIE and HIT systems adoption to enable interprofessional collaboration and care coordination between physical and dental providers. ExampleCCO recently entered into

a significant partnership with Unite Us (Connect Oregon) that over time will phase in access to ExampleCCO's entire provider network across all CCO regions.The Unite Us platform offers closed-loop referral functionality to support social determinants of health (SDOH) service coordination. Throughout 2023, ExampleCCO plans to collaborate with Unite Us to evaluate options for provider-to-provider closed-loop referrals. We plan to leverage our investment and partnership with Unite Us to solve provider care coordination and referral needs. Depending on what we discover, ExampleCCO will shift efforts to support the DCOs and dental providers in adopting the Unite Us platform for SDOH and health care coordination referrals. ExampleCCO will also research and evaluate other options such as Fast Healthcare Interoperability Resources (FHIR), Activate care, and Epic's Care Everywhere to best support existing, preferred provider-to-provider communication systems.

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

Activity 1 description: Leverage VBP strategies, dashboards and monthly monitoring to increase the percentage of diabetic members who receive a comprehensive or periodontal exam during the measurement period.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Monitoring will occur via a dashboard that displays year-to-date performance on diabetic members with dental visits, with REALD and SOGI stratifications to track performance in reducing differential access to care. This dashboard (accompanied by a gap list) will be refreshed monthly and shared with each DCO.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The CCO estimated baseline for the region overall: 16.9%	The CCO meets the incentive metric improvement target set by OHA.	12/2023	The CCO meets the incentive metric benchmark set by OHA.	12/2024

Activity 2 description: Promote dental care delivery to the diabetic population via teledentistry, co-located with physical health provider clinics.

☐ Short term or ☒ Long term

Monitoring measure 2.1	ExampleCCO will utilize a regional DCO survey to capture co-located teledentistry programs in each region. Improvements to baseline will be monitored to track growth in teledentistry activities and partnerships.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline availability of co-located teledentistry programs serving the diabetic population is established using the tracking log data.	One or more co-located teledentistry programs are serving the diabetic population, with a focus on serving populations of	12/2023	Two or more co-located teledentistry programs are serving the diabetic population.	12/2024

Currently, there are 0 co-located teledentistry programs serving the diabetic population.	diabetic patients who receive care less frequently.			

Activity 3 description: Work with various internal and external regional stakeholders to research and explore platforms such as Unite Us, FHIR, Epic's Care Everywhere, and Activate Care that enables provider-to-provider care coordination and interprofessional collaboration. Depending on what is discovered, facilitate product awareness and connectivity by arranging demonstrations (as needed) of the platform to DCOs and interested dental providers.

☐ Short term or ☒ Long term

Monitoring measure 3.1	The CCO will research and identify referral platform options best suited to meet the region's provider-to-provider communication needs. The CCO will track the DCO adoption of platforms.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 platforms identified as suitable and capable options for dental provider/DCO to physical health provider referrals in the region.	One or more platforms identified as suitable and capable options for dental provider/DCO to physical health provider referrals in the region.	12/2023	Two or more platforms identified as suitable and capable options for dental provider/DCO to physical health provider referrals in the region.	12/2024
0 DCOs have adopted a referrals platform.	1 DCO has adopted a referrals platform.	12/2022	2 DCOs have adopted a referrals platform.	12/2023

A. Project 11: Case management for members with SHCN with both diabetes and behavioral health diagnoses to prevent avoidable hospitalizations, improve medication compliance and ensure regular care monitoring

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

If continued, insert unique project ID from OHA: ###

B. Components addressed

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

vii. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

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

There is significant overlap in the ICC population for members with diabetes and SMI/SPMI. Unlike other portions of the diabetic population receiving ICC services, this population has been found to have lower medication adherence, less follow-up to primary care or specialty care for their diabetes and is more likely to have avoidable hospitalizations for both diabetes complications and behavioral health care. Our CCO made significant improvements in our data tracking for monitoring under- and over-utilization by creating an algorithm that flags patients. While we have seen overall increases in behavioral health utilization due to removal of any prior authorization requirements, our data indicates members with diagnosed behavioral health conditions are 175% more likely to have an ED visit each year. 42% of our ICC population with behavioral health has one or more ED visits that could have been avoided, compared with only 20% of our ICC population without behavioral health diagnoses. In addition, when looking at the subset of those who have both diabetes and behavioral health needs, they were typically entering the ED at least once per quarter and did not have good track records for filling medications on time or attending scheduled appointments with their primary care providers or specialty care providers. Research shows treatment engagement is often sub-optimal with adherence rates of 52% for diabetic medications and 62% for antipsychotic medications in the population with SPMI and diabetes.

CDC indicates that people with diabetes are two to three times more likely to have depression than people without diabetes. However, even this population with other diagnosed behavioral health conditions had low documented depression screenings. In addition, CDC highlights that in any 18-month period, 33% to 50% of people with diabetes have diabetes distress, which has been documented to cause diabetics to slip into unhealthy habits, stop checking blood sugar, even skip doctor's appointments. With CDC data showing 1 in 5 persons with Type 2 diabetes having co-occurring depression and 1-3 persons with Type 2 diabetes having diabetes distress, we feel that more direct case management with members already diagnosed with behavioral health and type 2 diabetes could help us address the disparate and avoidable ED use. Treatment complexity for either of these conditions requires significant experience, and when members have both, building provider skill and knowledge to manage the multitude of challenges these members face will benefit from building ongoing IDT focused on this population where providers can gain knowledge from other care experts as they work together to build integrated care plans.

As part of our current work, our CCO has new triggers in our HIE system to trigger reminders to providers to ensure completion of depression screening. Our claims review process will trigger notice to care managers when diabetes or behavioral health prescriptions are not refilled regularly and when no provider encounters are billed in any quarter for these members. Our care managers can also now check to ensure integrated care plans are uploaded in HIE for members. Since we have been increasing the number of providers using HIE tools, including Collective Platform event notifications, our CCO now has 95% of physical and behavioral health and 80% of oral health providers working within the HIE system, including for sharing referrals to other providers. Provider contracts have been enhanced to support additional responsiveness for members with missed appointments to be quickly rescheduled, and for providers to more closely monitor CCO-identified triggers in their own medical records. Our CCO is also analyzing the equity of care by tracking all data by REALD and SOGI where that data is available.

We have identified 850 members of our current population who meet the criteria for ICC with diagnoses for behavioral health and Type II diabetes. We analyzed this group by REALD and SOGI data. By September 2023, ICC team anticipates opening this to rolling participation for at least one year for identified members. After

one year, providers can request to keep members in the case management cohort for an additional year or if significant improvements are made, these members can return to regular ICC monitoring. We found the majority of this population had not been referred to diabetes self-management programs or failed to participate in those programs. Groups that have been economically and socially marginalized were significantly more likely to not engage in self-management programs. While health information technology allows for more direct sharing of information with our behavioral health, primary care providers and specialists, our CCO found that few of these members had an integrated care plan in place that incorporated recommendations and goals from each provider into an easy-to-follow plan for members. Adding an equity lens by reviewing cohort care coordination data through a REALD and SOGI lens will assist our CCO in achieving targets to ensure all populations are being addressed, and allow for unique culturally specific approaches to be added where inequities persist. An initial survey found ease of access to those programs and lack of understanding of how the programs could be beneficial drove low participation in these evidence-based programs. Few had regular standing referrals to endocrinologists or internists, were less likely to have participated in offered oral health services for those with diabetes, and many we surveyed indicated they had not talked to their primary care provider about their diabetes management in the last six months. These numbers were even lower in the percentage of people of color in the cohort population identified.

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

Our investment in improving our population health analytics and claims utilization algorithms in 2022 provides a platform for us to take a new approach to follow-up for a population that has been demonstrated to have significant barriers to follow-through with care management, which has resulted in high ED utilization as noted in Section C. Addition of ability to analyze data by REALD and SOGI means that we can identify persistent inequities in care and outcomes success and determine where unique culturally adaptive approaches may be necessary. Our CCO investment in our HIT infrastructure to better support providers in ability to share care planning and referrals across the HIE platform will enable this project to be successful. Our goal for 2023 is to create a unique case management program to address and serve this population. In addition to the ICC case manager, each member will be assigned a community health worker to assist them in meeting targets for ensuring medication refills, following up with scheduled appointments, linking members with preventive programs and ensuring integration of behavioral health care by providers who understand the complexity of diabetes care and the co-occurring behavioral health diagnoses. Care managers have a new list of direct follow-up tasks with primary care providers on members identified to be part of a year-long case management cohort, from screenings to tracking medication refills and follow-up on referrals to specialists and self-management programs. As part of the program, the CCO will provide educational outreach to providers on the importance of identifying individuals with diabetes with depression or anxiety and potential diabetes distress.

In addition, as noted in the British Journal of General Practice in 2018, “Diabetes is 2–3 times more common among people with SMI than the general population and antipsychotic medication is both obesogenic and diabetogenic. The disabling nature of SMI makes it more difficult to adhere to medication regimens, to keep review appointments, to lose weight and take regular exercise — all of which would improve health outcomes. Organizational barriers related to parallel services that do not integrate physical and medical care results in the most vulnerable patients falling between the cracks.” We also know that higher percentages of certain populations are more likely to develop diabetes and less likely to receive follow-through care that prevents complications. As noted in our previous section, the data that shows this combination of health care diagnoses has been shown to have poor results and adherence. This leads us to

believe a new more targeted approach is necessary. CCOs have targets to improve care for members across systems and creating goals to have this target population have integrated care plans that address the unique diabetic and behavioral health needs of this population are critical to impacting outcomes. Our region has limited endocrinologists; however, it could be critical to ensure primary care homes have access to consultation from these providers and from diabetes educators for developing comprehensive care plans. IDT meetings will incorporate an endocrinologist to incorporate expertise into integrated care plan development.

E. **Brief narrative description**:

The CCO ICC team will coordinate care for the identified cohort of 850 members by building internal workflows for monitoring identified metrics and assigning a community health worker to work closely with cohort members to support follow-up. The care manager will convene monthly IDT meetings to work with all providers to ensure an integrated care plan is built for each member in the cohort. ICC will create easy access to oral health care, specialists and behavioral health care for members, and CHWs will directly follow-up with members when any appointment is missed. The ICC team will monitor short-term and long-term metrics to ensure they are meeting targets to improve care outcomes for populations with diabetes and behavioral health diagnoses. We also anticipate a need to train community health workers in diabetes self-management programs to build additional access to the self-management in our region and for our diverse populations (primarily Vietnamese and Spanish-speaking). These community health workers will also be the ones working directly with our ICC team care managers to build relationships with cohort members and conduct the follow-up identified for project success. We will begin to track all data variables by including data breakdown by REALD and SOGI to monitor equity targets for improvements are met and strategies to impact persistent inequities can be implemented.

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

Activity 1 description: Train CHWs/peer educators in diabetes self-management programs and with additional information on both SMI/SPMI and diabetes treatments and medications, stress management, trauma-informed care approaches, motivational interviewing techniques and crisis management over weekly sessions/modules.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Participation in training			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Provide CHWs/peer educators with Stanford CDSMP DSM training	Provide primary care and behavioral health providers with increased access to self-management programs for patients Increase participation of non-English speakers by 30% in self-management programs, especially in	2/2023 3/2023	40% of cohort participates in self-management program; track participation on training by REALD and SOGI population data to determine increased participation across population subgroups	12/2024

	Vietnamese and Spanish-speaking subgroups of cohort.			
Provide weekly training and education to CHWs/peer educators working with ICC team to support cohort members	90% of CHWs/peer educators complete all weekly modules	6/2023	N/A	N/A

Activity 2 description: Track data elements that ensure members in the cohort for case management of diabetes and SMI/SPMI are receiving the follow-up and tracking identified for the project.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Improvements in core care management goals of SMI/SPMI and diabetes Type II case management cohort are tracked to review team performance in creating access and follow-up as envisioned.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Less than 10% of target group does not have integrated care plans	80% of members in target group have integrated care plans; track REALD and SOGI data to ensure equitable care plan development	12/2023	Integrated care plans for target population are in HIE and shared with all providers -- 90%; verify equitable care plan development across all cohort members by breaking down data by REALD and SOGI	6/2024
System flags provide ICC are manager and CHW ability to track referrals, provide appointment reminders and follow-up to any missed appointments for cohort	Care managers and assigned community health worker meet quarterly goals to monitor and provide follow-up for 80% of referrals and appointments for cohort members. Follow-up and rescheduling happens within 2 weeks of missed appointments. Data analysis reviewed document and track equity by providing data review by REALD/SOGI	4/2023 6/2023	90% of cohort members have scheduled twice yearly specialist visits, monthly behavioral health care visits as indicated and quarterly primary care visits. Ensure equity by breaking down data by REALD and SOGI. 60% of cohort receives referral to and 40% participates	12/2024 12/2024

			in self-management program.	
Use of Hospital Event notifications triggers provides opportunity for direct follow-up on any ED utilization or hospitalization for cohort members	For 75% of cohort, CHW assigned to member either meets member in ED or completes member follow-up within 24 hours. This includes ensuring providers have access to discharge plans or information quickly. For 75% of cohort, CHW ensures follow-up appointments scheduled post ED visit with primary care, specialist and/or behavioral health as soon as possible. Track data by REALD and SOGI to ensure equity in meeting target goals in all populations and identify additional outreach strategies where targets are falling short in subpopulation groups	8/2023 8/2023 12/2023	90% of cohort receives direct CHW support services that include direct follow-up to ensure discharge plans are provided to providers and follow-up appointments are providers. 90% of cohort receives follow-up appointments for primary care and/or behavioral health within two weeks of ED visits. Track data by REALD and SOGI to ensure equity in meeting target goals in all populations.	12/2024 12/2024 12/2024
Cohort members receive scheduled visits with diabetes educators within six months of participation in cohort	For 75% of cohort, CHW assists in sharing information about diabetes education services available to member and assists in scheduling appointments within 4 months of members admission to cohort Track data by REALD and SOGI to ensure equity in meeting target goals in all populations and identify additional outreach strategies where targets are falling short in subpopulation groups	12/2023 12/2023	100% of cohort receives diabetes education services within 4 months of admission to cohort. Track data by REALD and SOGI to ensure equity in meeting target goals in all populations.	12/2024 12/2024
Cohort members receive depression screening within 4 months of selection to cohort	60% of primary care providers for identified cohort create flags to ensure members receive depression screening	6/2023	80% of primary care providers have system flags and can report to CCO on	12/2023

			status of depression screening quarterly Track depression screening completion by REALD and SOGI data to ensure equity in completion data	12/2023
Primary care providers receive updates on tools for diagnosing diabetes distress, including recognized screening tools, self-management programs to refer clients to	40% of primary care offices serving members receive training to improve diagnosis, treatment and referral to self-management training for diabetics	8/2023	65% of primary care providers in network have adopted identified tools to screen for diabetes distress Increase referrals to self-management programs for diabetes by 60%; analyze data by REALD and SOGI to determine equity in referral outreach	12/2023 12/2023

Activity 3 description: Monitor member health and outcome metrics to document improvement for cohort populations.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Track longer-term health and outcome metrics for cohort population for two years.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Reduce avoidable/unnecessary ED visits	Reduce ED visits in targeted population by 70% Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	12/2023 12/2023	Reduce ED visits overall for all diabetics and all SMI population by 50%; Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	12/2024
Targeted population has improved Hemoglobin A1C control	80% of targeted population has improvement in A1C values	12/2023	CCO sees all Diabetics and SMI members have improved A1C values. [Target X	12/2024

	Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	12/2023	improvement %]; Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	
Targeted population has improved medication adherence [Track medication refills and document regular filling. CHWs conduct informal surveys with all members quarterly]	Cohort improves regular medication compliance from Q1 to Q4, (as additional members enter improvement tracked over 4 quarters) Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	12/2023 12/2023	Document correlation of medication filling with ED visits in annual period for cohort members; target improvement goals annually –x% of members in cohort have 90% compliance with medication refills over 1 year period; Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	12/2024

A. Project 12: Medicaid Efficiency and Performance Program (MEPP) - Diabetes

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

If continued, insert unique project ID from OHA: ##

B. Components addressed

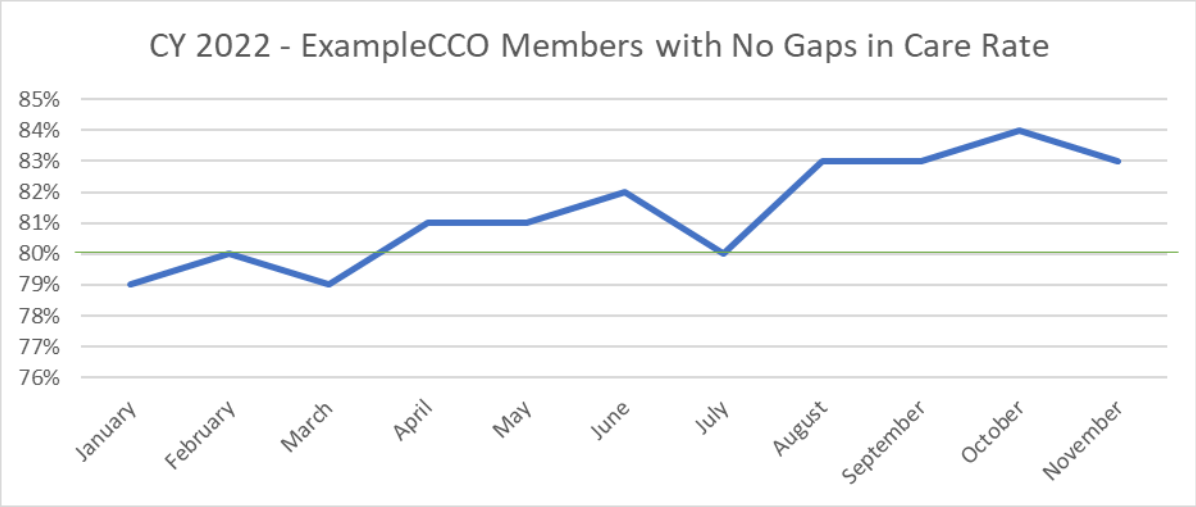
i. Component 1: Utilization review
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this is a social determinants of health & equity project, which domain(s) does it address?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

ExampleCCO operates a robust utilization management program that includes tracking and trend analysis of utilization on a PMPM basis in all major service categories to identify potential under and over utilization of services. Additionally, to ensure quality of care and appropriate utilization, ExampleCCO's utilization management program actively tracks gaps in care in management of chronic diseases on a member-specific

basis. Utilization analysis is stratified by various member-level characteristics to identify utilization patterns that may be unique for specific cohorts. This includes but is not limited to race, ethnicity, language and disability data (REALD) as well as sexual orientation and gender identity (SOGI), when available. Trend and gaps in care analysis are reviewed by an internal clinical advisory team. The team makes recommendations on policies to impact utilization based on the aforementioned analysis. Examples of policies include changes to prior authorization policy, provider engagement and incentive strategies to close gaps in care and/or to reduce utilization of low-value care, and member engagement strategies. The proposed strategies are informed by REALD and SOGI data when possible as member and provider engagement may differ based on population-specific context.

Through these utilization management efforts, our organization targets having 80% of members with chronic disease having no gaps in care. The graphic below illustrates a rolling 12-month average of performance on this metric for CY 2022. ExampleCCO was able to exceed the target in aggregate for CY 2022 with performance at 85% compared to the target of 80% (based on the 12-month rolling average for December 2022).



In addition to the utilization management related analysis noted above, ExampleCCO leverages MEPP analytics provided by the state to further advance our utilization management efforts. Specifically, our CCO used MEPP to identify opportunity and inform strategies related to utilization of services to treat and manage diabetes. In the MEPP analytics for CY 2018–2021, diabetes is found to have an adverse actionable event (AAE) rate of 36%, which means that 36% of the costs of services were for services that could have potentially been avoided with better upstream care and active management. This compares to the prior period (CY 2017–2019) of 34%. Additionally, by augmenting the MEPP analytics with REALD and SOGI data, ExampleCCO additionally found that non-English speakers made up a disproportionate share of the identified AAEs, with an AAE rate of nearly 50%. Specifically, non-white Hispanics with limited English proficiency saw significantly higher inpatient hospitalization rates and emergency room utilization for high blood sugar.

D. **Project context**: Include justification for the chosen or continued project with CCO- and region-specific data, and progress to date for continued projects

The diabetes episode represents the second highest total expenditure condition and the second highest AAE rate of all episodes in the MEPP dashboard. Based on this, ExampleCCO selected the diabetes episode as one of the three areas of focus for the MEPP program. This is a new intervention for the CCO this year and is replacing a hypertension episode intervention (see Section 2 regarding discontinued interventions). Additionally, the gaps in care analysis supported additional efforts for improvement management of the

condition. Lastly, monitoring of HbA1c for other quality programs indicated additional opportunity to improve outcomes.

ExampleCCO's clinical advisory team reviewed the analysis of the MEPP data, gaps in care analysis, and HbA1c data and noted that all three statistics showed greater opportunity in Community A compared to all other communities, with the greatest opportunity for the non-white Hispanic population with limited English proficiency. The AAE rate for the diabetes in Community A (based on an analysis by zip code) is 45% compared to the CCO aggregate 36%, with a 55% AAE rate for the aforementioned population. The majority of AAE costs are for ED utilization and inpatient admissions related to uncontrolled blood sugar. 35% of members with diabetes in Community A (40% for the population identified with REALD data) had gaps in care compared to the CCO-wide rate of 15-20%. 40% of members with diabetes in Community A (50% for non-white Hispanics with limited English proficiency) had HbA1c rates indicating poor control compared to a CCO-wide rate of 20%. Further, the MEPP analysis highlighted that three practices in Community A bore the majority of AAE costs (65% of AAE costs in Community A, 30% of which can be attributed to the aforementioned population).

Based on the analysis, the clinical advisory team recommended implementation of a targeted provider outreach program to ensure the three providers identified understand which patients with diabetes have gaps in care; the practices are equipped with resources to connect patients with community and state resources to address food insecurity/healthy eating options; these resources are available in Spanish and that translation services are readily available when engaging the non-white Hispanic population with limited English proficiency; and the practices are receiving information regarding ED visits and admissions/discharges for patients with diabetes (and other conditions) to ensure follow-up care that can prevent readmissions is received.

E. Project or program brief narrative description

ExampleCCO will implement a multipronged provider outreach and support strategy to ensure the target practices are well positioned to address gaps in care, community referral, and clinical follow-ups. In addressing these three areas, our CCO intends to impact both over- and under-utilization of services while improving quality of care for members with diabetes in Community A, which has been shown to have a disproportionate impact on the CCO's aggregate statistics. The primary intervention strategies for this project are described below.

- ExampleCCO will develop practice-specific gaps in care reporting for members with diabetes. This information will be shared with the three target practices through a mutually agreed to process, on a monthly basis. The report will specifically identify non-white Hispanics with limited English proficiency to ensure the practice is leveraging appropriate language services when engaging patients regarding the care of their diabetes.
- Quarterly reporting of the HbA1c will be provided to the three practices in Community A that are the focus of this project. The HbA1c results will also be stratified by race, ethnicity and language so the practice can better understand whether additional language supports are having an impact or potentially remain a barrier to achieving better diabetes management.
- ExampleCCO will facilitate formalizing care coordination agreements between the three target practices and Community A's local hospital to ensure the providers are communicating when attributed patients are seen in the ED or admitted to the hospital.
- ExampleCCO will identify resources in Community A that can support addressing food insecurity and access to healthy food for patients referred by the target practices. The contact/process information will be shared with the three practices to support referral.

F. Activities and monitoring for performance improvement

Activity 1 description: Gaps in Care Date Reporting and Improved Closure Rate

To support the target practices in addressing gaps in care for the target population, ExampleCCO will provide patient-level reporting that identifies specific gaps in care and includes identification of the target population discussed above. The practice can use the information for targeted patient outreach and to potentially inform changes to clinical practice flow to reduce the prevalence of gaps in care. The following steps outline the process for implementing this component of the project/intervention:

- Conduct outreach to target providers (3 providers in Community A)
- Develop and implement practice gaps in care reporting process, including goals and population stratification to capture populations of interest
- Begin data reporting
- Ongoing follow-up/support to help practice reach gap closure goal (no more than 20% of patients with gaps in care related to treatment of diabetes)

☒ Short term or ☒ Long term

Monitoring measure 1.1	(short-term) Provider-specific reporting of gaps in care related to diabetes implemented			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
No current reporting	Reporting to all three practices in place	05/2023	Same as target	Same as target

Monitoring measure 1.2	Gaps in care rate (% of continuously eligible members with diabetes that have gaps in care that did not get closed during the reporting period)			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Provider A – 35% aggregate, 55% non-white Hispanic (NWH) w/limited English proficiency Provider B – 38% aggregate, 60% NWH w/limited English proficiency Provider C – 33% aggregate, 52% NWH w/limited English proficiency	27.5% aggregate and 40% for target population 29% aggregate and 42% for target population 26.5% aggregate and 38% for target population	12/2023	<20% aggregate and <30% for target population	12/2024

Activity 2 description: HbA1c Data Reporting and Improved Management

To support the target practices in improving diabetes management of patients, ExampleCCO will provide the practices with quarterly HbA1c reporting with population stratification to include non-white Hispanics with

limited English proficiency. The practice can use the information to guide member engagement strategies. The HbA1c performance monitoring statistics will reflect the impact of all aspects of the project as they all contribute to better management of diabetes and improved control. The following steps outline the process for implementing this component of the project/intervention:

- Conduct outreach to target providers (3 providers in Community A)
- Develop and implement HbA1c reporting with population stratification, including goals
- Begin data reporting
- Ongoing follow-up/support to help practice reach goal

☒ Short term or ☒ Long term

Monitoring measure 2.1	HbA1c reporting on patient panel including demographic stratification			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
None – not currently reported to practices	Reporting to all three practices in place	05/2023	Same as target	Same as target

Monitoring measure 2.2	HbA1c poor control performance statistic reported to target practices (percent of diabetic patients with HbA1c level above 9.0%)			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
Provider A – 40% aggregate, 45% NWH w/limited English proficiency Provider B – 42% aggregate, 49% NWH w/limited English proficiency Provider C – 38% aggregate, 41% NWH w/limited English proficiency	35% aggregate and 38% for target population 37% aggregate and 39% for target population 33% aggregate and 35% for target population	12/2023	30% aggregate and 35% for target population 32% aggregate and 36% for target population 28% aggregate and 30% for target population	12/2024

Activity 3 description: Care Coordination Agreements

A key activity in managing utilization and improving quality/outcomes is ensuring appropriate primary care follow-up for certain types of ED visits and after most inpatient admissions. To support the target practices in improving follow-up activities, the CCO will support the practices in developing care coordination agreements and protocols related to ED and inpatient admissions at Community A's local hospital. ExampleCCO will do the following in support of this intervention:

- Conduct outreach to target providers (3 providers in Community A and Community A's local hospital)
- Facilitate a meeting between each of the practices and the hospital where care coordination and notification processes are established using industry standard guidelines with practice specific process modifications

- Support the practices in formalizing the agreement
- Period check-in to verify follow-up is occurring for the target population consistent with the agreements put in place.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Care Coordination and Agreements Between Providers			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
None – agreements not yet in place	Care coordination agreements in place between hospital and all three providers	6/2023	Same as target	Same as target

Activity 4 description: Community Referral for Food Insecurity and Access to Healthy Food
Barriers to appropriate nutrition can result in challenges in management of diabetes. To support practices in both identifying nutrition-related barriers to diabetes management, ExampleCCO will identify available community resources and help the target practices with internal clinical and administrative process flows to identify and refer to community resources for diabetic patients in needs of support. The following steps will be implemented:

- Identify community resources related to nutrition and food insecurity in Community A
    - Includes identification of a process for referral and a point of contact to facilitate referrals from practices
- Conduct outreach to target providers (3 providers in Community A)
- Work with practices to develop and document practice protocols for asking diabetic patients about their access to appropriate nutrition, including having appropriate language resources to assist individuals with low English proficiency.
- Work with practices to develop and document practice protocols for referring positive screens for nutritional needs to community resources
- Follow-up to ensure protocol is being leveraged

☒ Short term or ☐ Long term

Monitoring measure 4.1	Community Referral Processes Implemented by Practice			
Baseline or current state	**Target / future state**	**Target met by (MM/YYYY)**	**Benchmark / future state**	**Benchmark met by (MM/YYYY)**
None – no documented process in place	Documented process for community referrals in place at all three target practices	6/2023	Same as target	Same as target

A. Project 13: Regular metabolic screening for patients with serious mental illness on psychotropic medications

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: Behavioral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this is a social determinant 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) for the component(s) selected with CCO- or region-specific data.

Advancing behavioral health equity is a critical component of holistic behavioral health care and a key OHA strategic goal. Healthy People 2030 defines health equity as "the attainment of the highest level of health for all people." Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities. CCO members with a diagnosis of serious mental illness or serious and persistent mental illness (SPMI) have a disproportionate risk of death from dramatically increased preventable cardiometabolic risk factors. This presents a paradigm for a high-risk, disadvantaged cardiovascular health disparity population.

According to Nielsen RE, Banner J and Jensen SE (2021), members with serious mental illness are dying earlier because of the following: higher rates of medical comorbidity, higher rates of obesity and associated cardiometabolic syndrome, poor health care and health disparities, Iatrogenic exposure, lifestyle, and health behaviors. The leading cause of death for individuals with SPMI is cardiovascular disease followed by cancer and then pulmonary disease. Eighty-five percent of the premature deaths were due to largely preventable conditions such as high blood pressure, high cholesterol, diabetes, and heart disease (see "Cardiovascular disease in patients with severe mental illness" https://pubmed.ncbi.nlm.nih.gov/33128044/).

ExampleCCO's available diagnosis and REALD data, which include SPMI as a disability, indicate X% of the CCO's members have a serious mental illness. Of those, X% are currently prescribed psychotropic medications.

Because of these data, behavioral health integration for ExampleCCO focuses on three areas: embedded behavioral health providers, EHR interoperability for care coordination and monitoring, developing population health initiatives such a disease registry, and use of a validated screening tool.

1. Clinic integration: 45% of primary care providers have embedded BH providers; 45% of BH clinics have embedded primary care providers
2. EHR interoperability for care coordination and monitoring: integrated EHRs implemented in 45% of BH clinics and 60% of primary care providers.

3. Population health quality initiatives: 0% of clinics currently use an DSM V Serious Mental Illness disease registry; 0% of clinics currently screen for metabolic syndrome using a validated screening tool; 10% of clinics employ culturally diverse care team members representative of patients.

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

Persons with major mental disorders lose 25 to 30 years of potential life in comparison with the general population, primarily due to premature cardiovascular mortality. (https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08_0.pdf). One of the causes for this is adverse metabolic side effects associated with psychotropic medications.

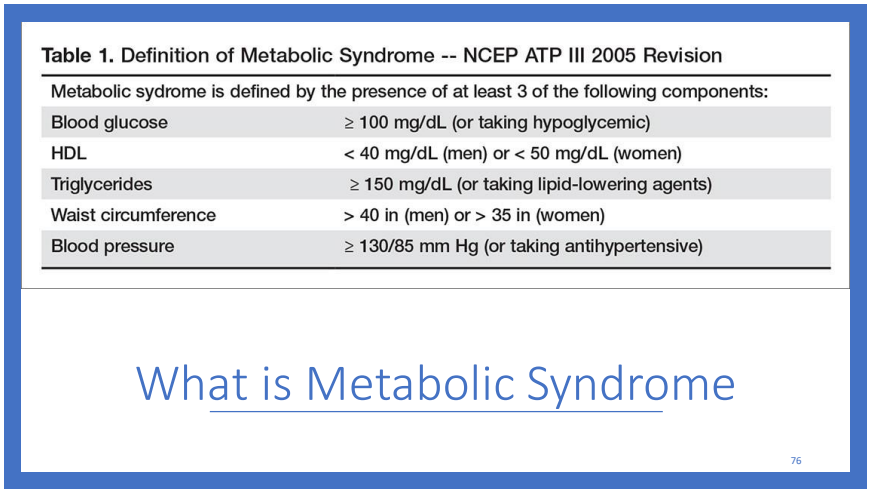
Although the prevalence of obesity and other risk factors such as hyperglycemia are increasing in the general population, patients with major mental illnesses have an increased prevalence of overweight and obesity, hyperglycemia, dyslipidemia, hypertension and smoking, and substantially greater mortality, compared with the general population. Persons with major mental disorders lose 25 to 30 years of potential life in comparison with the general population, primarily due to premature cardiovascular mortality. The causes of increased cardiometabolic risk in this population can include non-disease-related factors such as poverty and reduced access to medical care, as well as adverse metabolic side effects associated with psychotropic medications, such as antipsychotic drugs. Individual antipsychotic medications are associated with well-defined risks of weight gain and related risks for adverse changes in glucose and lipid metabolism.

ExampleCCO is seeing similar patterns to those presented in the above report. Based on diagnosis codes and disaggregated REALD data for disability, members with mental illnesses such as schizophrenia and bipolar disorder have an increased prevalence of metabolic syndrome and its components (25% greater than general CCO membership), risk factors for cardiovascular disease (45% greater than general CCO membership), and type 2 diabetes (25% greater than general CCO membership). Focusing on metabolic screening and follow-up for this population has great potential for improving health outcomes.

In future years, ExampleCCO plans to refine the project's activities by using REALD and SOGI data to look at how this populations' intersectionalities (race, ethnicity, sexual orientation, gender identity) impact their risk factors and protective factors for metabolic syndrome.

E. **Brief narrative description**:

Based on the medical risk profile of persons with major mental illnesses (a disability captured by REALD data), and the evidence that certain medications can contributed to increased risk, this project will focus on screening and regular monitoring of metabolic parameters such as weight (body mass index), waist circumference, plasma glucose and lipids, and blood pressure are recommended to manage risk in this population. Treatment decisions should incorporate information about medical risk factors in general and cardiometabolic risk. This project will include creating a disease registry, adopting metabolic screening for patients on this disease registry, and implementing closed-loop referrals for follow-up on metabolic indicators if indicated by screening results.



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

Activity 1 description: Create a disease registry to identify percentage of patients who meet DSM V diagnosis for schizophrenia and schizoaffective disorder that are on psychotropic medications.

☒ Short term or ☐ Long term

Monitoring measure 1.1	# Patients with appropriate DSM V diagnosis			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0%	50%	6/30/23	90%	12/31/23
Monitoring measure 1.2	# Patients on psychotropic medications with appropriate DSM V diagnosis			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0%	50% Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	6/30/23	90% Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	12/31/23

Activity 2 description: Implement consensus-based metabolic screening schedule using a validated tool, and complete appropriate closed-loop referrals or interventions as indicated by screening.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Metabolic screening completed			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0%	35%	12/31/23	60%	12/31/24

	Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations		Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	
Monitoring measure 2.2	Closed-loop referrals or indicated interventions are completed			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0%	60% Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	12/31/23	80% Analyze data by REALD and SOGI to ensure equity in meeting target goals in all populations	12/31/24

Section 2: Discontinued Project(s) Closeout

A. **Project short title:** Using grievance and appeal data to remove NEMT barriers for members
B. **Project unique ID (as provided by OHA):** 541
C. **Criteria for project discontinuation:** Project has failed to meet its expected outcomes and cannot be updated to meet the outcomes.
D. **Reason(s) for project discontinuation in support of the selected criteria above:** After more than two years, this project has not been able to meet its targets or benchmarks. While specific barriers to NEMT services were identified, the required system level changes to address those barriers were not feasible due to lack of leadership buy-in across multiple sectors. Additionally, due to a change in who the CCO contracts with for NEMT services and how grievances and appeal are collected for NEMT services, the current plan to assess grievances and appeals is no longer feasible.

A. **Project short title:** Targeted ED utilization reduction for members with mental illness through the Assertive Community Treatment (ACT) program
B. **Project unique ID (as provided by OHA):** 401
C. **Criteria for project discontinuation:** CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
D. **Reason(s) for project discontinuation in support of the selected criteria above:** While this project initially showed success, during this COVID-19 pandemic the CCO has seen reduced ED utilization rates for members will mental illness with a simultaneous increase in behavioral health utilization through in-person and telehealth. The ACT program will continue, but this project will be reduced to shift resources and expand the CCO's health-related needs screening and closed loop referral project. This shift is in response to member needs during the pandemic with XX% of members in the health-related needs project showing an increase of at least XX% in health-related needs.

A. **Project short title:** Increasing maternity care access
B. **Project unique ID (as provided by OHA):** 19
C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes
D. Reason(s) for project discontinuation in support of the selected criteria above: While this project will continue as a long-term program, after four years it has met its intended goals and benchmarks. CCO will continue to incorporate use of population health data, segmented by region (county), age groupings, race,

ethnicity, and service delivery, and language (and disability where data available) to identify and address new maternal care gaps. The long-term program is supported by and sustainable based on the dashboard, metrics, maternal care team, and referral system that were developed through this TQS project.

A. **Project short title:** Linguistically appropriate and accessible materials
B. **Project unique ID (as provided by OHA):** 173
C. **Criteria for project discontinuation:** Project fails to meet TQS guidance in 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:** Written assessment from OHA identified that while the project described clearly supported the CCO requirement to provide translated materials or materials in other formats, there was no clear identification of a gap to be addressed based on any data, nor a clear plan for how this project will address a gap to improve quality or push health system transformation.

A. **Project short title:** Medicaid Efficiency and Performance Program (MEPP) – Hypertension
B. **Project unique ID (as provided by OHA):** 123
C. **Criteria for project discontinuation:** Fully matured project that has met its intended outcomes
D. **Reason(s) for project discontinuation in support of the selected criteria above:**
ExampleCCO's 2022 MEPP projects include an intervention related to Hypertension. The intervention was to provide targeted patient education regarding home monitoring of blood pressure. Education materials were developed and sent to the target population (all individuals identified to have pre/hypertension). We attest that the intervention was completed to fidelity. The intervention was designed to be a one-time release of educational materials.

The performance measure related to the intervention was a process measure – educational materials sent to and received by 95% of members with pre/hypertension by 10/2022. While the intervention was implemented to fidelity, the actual rate of materials being received by members was 94%. The rate fell short of the target due to members having invalid mailing addresses. 6% of educational materials were returned to the CCO due to invalid addresses. As this project is being discontinued, it is being replaced by the diabetes related project described above.