Columbia Pacific CCO™

Part of the CareOregon Family

OHA Transformation and Quality Strategy (TQS)
2024

CCO: Columbia Pacific CCO

Table of Contents

Section 1: Transformation and quality projects

A. Project title: Project 1: Supporting Members Living with Severe Mental Illness and/or SUD

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

If continued, insert unique project ID from OHA:

B. Components addressed

1. Component 1: Behavioral health integration
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

New projects

Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

The work of the CareOregon Quality and Health Outcomes committee (COQHO) over the past several years culminated to the identification of priority populations that will be consistent focus areas for all regions including CPCCO. Throughout 2023, workgroups met to provide input and guidance on subpopulation definitions and to identify data needs to support the ongoing ability to set and measure targets for population health improvement. Members living with mental illness and substance use disorders were two of the priority populations identified. Within those two large buckets, the following priority subpopulations were identified: members with serious mental illness, members ages 12-17, members with co-occurring disorders, members with alcohol use disorder, and members with opioid use disorder.

While determining which subpopulations to focus on, research and CPCCO's provider network confirmed that the priority subpopulations (members living with serious mental illness, members with co-occurring disorders, and members living with alcohol use, or opioid use disorders) were most likely to have high rates of hospitalization and have higher rates of negative health outcomes. In addition, youth services for behavioral health across the continuum of care had the least robust access.

In reviewing data, we found that Tillamook County has higher rates of members under 18 with a mental health diagnosis, compared to Columbia and Clatsop Counties, as well as higher rates of members under 18 with races other than white compared to the other counties. To ensure that these members have meaningful access to care, CPCCO will begin to gather data from school-based health centers, behavioral health providers, and other system of care stakeholders using sources such as the System of Care Data Dashboard to better understand the disparities in access to care in all three regions.

Across all counties, members living with schizophrenia spectrum disorders were the least likely to have engaged with a primary care doctor in the past 12 months compared to other conditions. This population also shows higher rates of co-occurring physical health conditions. To address these gaps, CPCCO brought this population to the Clinical Advisory Panel (CAP) to advise and help identify, from a regional perspective, interventions to increase engagement. CPCCO also presented to CAP information regarding antipsychotic medications and best practices regarding the use of long-acting injectable medications (LAIs) and clozapine. Regular data regarding medication retention rates for these medications has not previously been easily accessible. As a part of the Quality and Health Outcomes committee work, a dashboard to provide regular information is in progress and is estimated to be published by Q3 2024. This will allow CPCCO to have more direct and consistent information to then distribute to the network around access and availability of these medications.

2023 Activity 1: For the priority population of members with a mental health diagnosis, improve coordination of care between community mental health providers (CMHPs) and primary care, improve access and retention in co-occurring services, and increase access to clozapine and long acting injectables (LAIs).

Monitoring Measure 1.1: Improvement with primary care and behavioral health integration

- ***Target***: One provider with integrated EHR
- ***Baseline***: No current providers with integrated EHR

Monitoring Measure 1.2: Access and retention in co-occurring services

- ***Target:*** Notifications of Treatment start 01.01.25 to have data for reporting.
- ***Baseline:*** No current data

Monitoring Measure 1.3: Increase access to LAIs or clozapine.

- ***Target:*** Dashboard created by Q3 2024 with ongoing information and data regarding medication adherence rates for the region
- ***Baseline:*** No current data on medication retention

2023 Activity 2: For the priority population of members with a substance use disorder, increase access to medications.

Monitoring Measure 2.1: Increase percentage from baseline of members with an alcohol and/or opioid use disorder diagnosis who have a pharmacy claim for related medications

- ***Target:*** Dashboard created by Q4 2024
- ***Baseline:*** No regular data

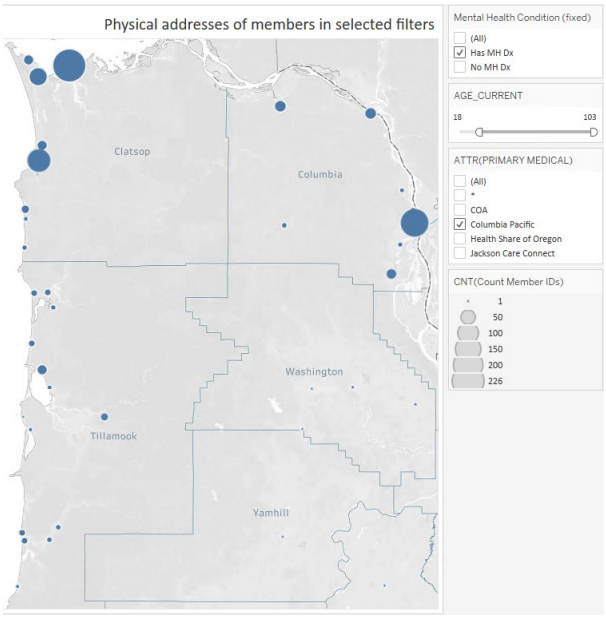
Monitoring Measure 2.2: Increase access to naloxone in the community

- ***Target:*** Updated policy and communication to provider network
- ***Baseline:*** No data or standardized way to support community with increasing access to naloxone

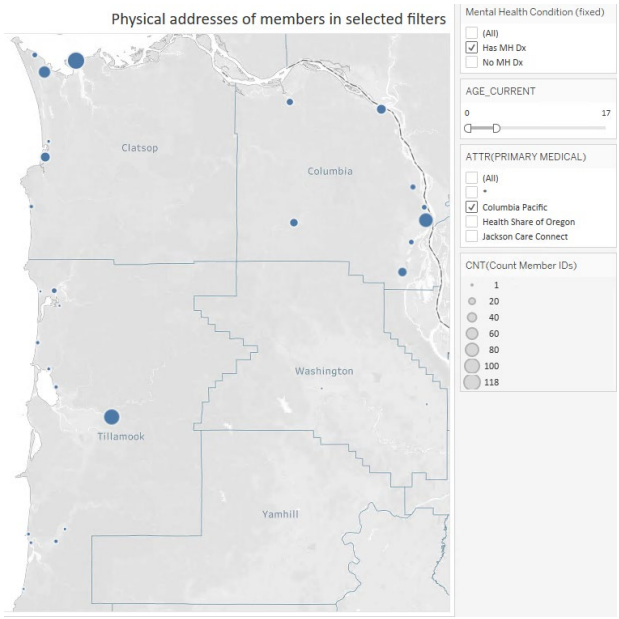
Monitoring Measure 2.3: Increase access to SUD services for youth

- ***Target:*** All major school districts provide regular data on behavioral health engagement rates
- ***Baseline:*** Two of three school-based health centers providing data on behavioral health service engagement

Members with any MH diagnosis ages 18 and over

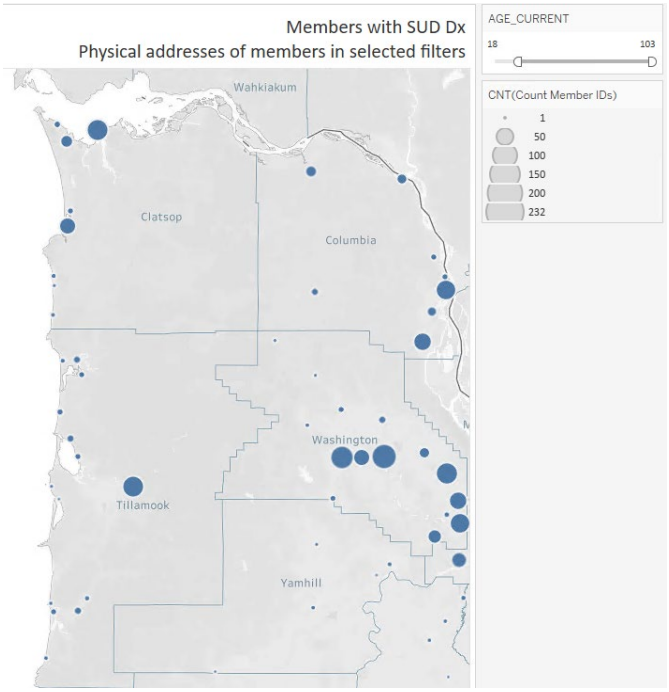


Members with any MH diagnosis ages 17 and under

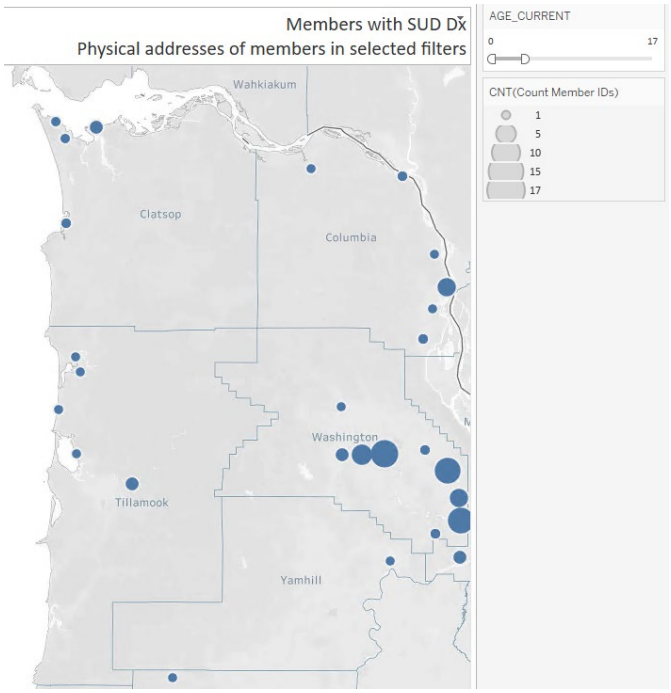


Rates and location of members with any mental health diagnosis are consistent across ages, except Tillamook having higher rates of youth with a mental health diagnosis than adults.

Members with any SUD diagnosis aged 18 and over

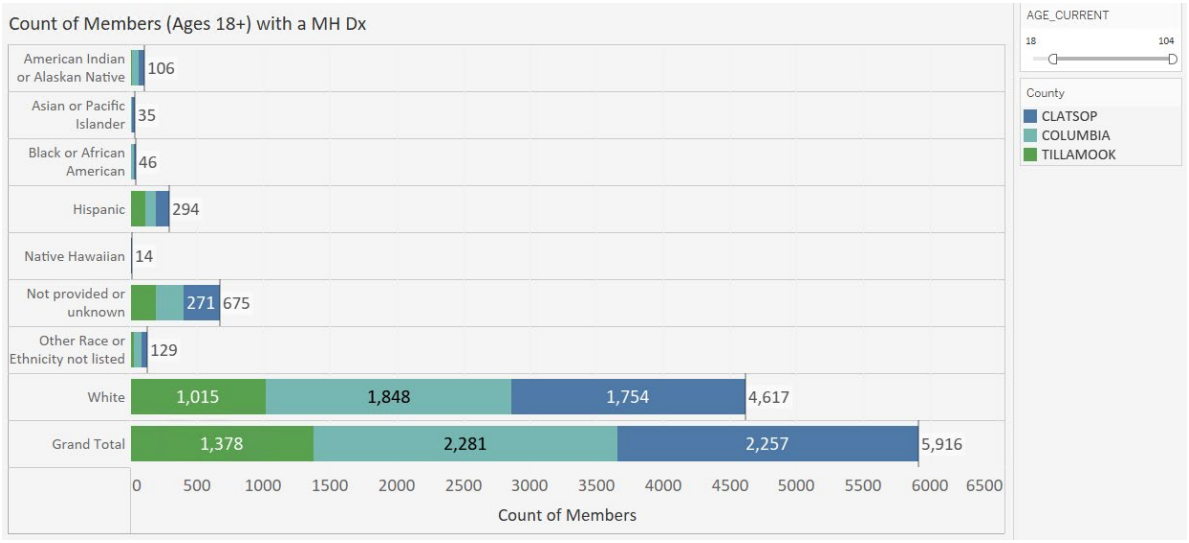


Members with any SUD diagnosis aged 17 and under



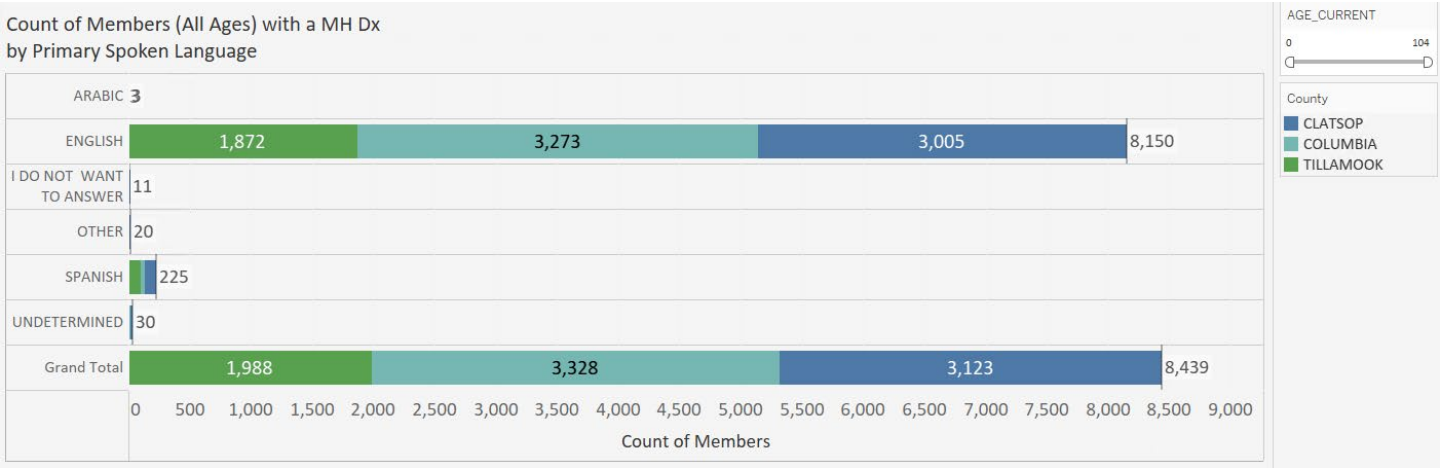
Rates of youth with a substance use disorder diagnosis are higher than adult members in Tillamook County.

Members aged 18 and over with a mental health diagnosis, by race



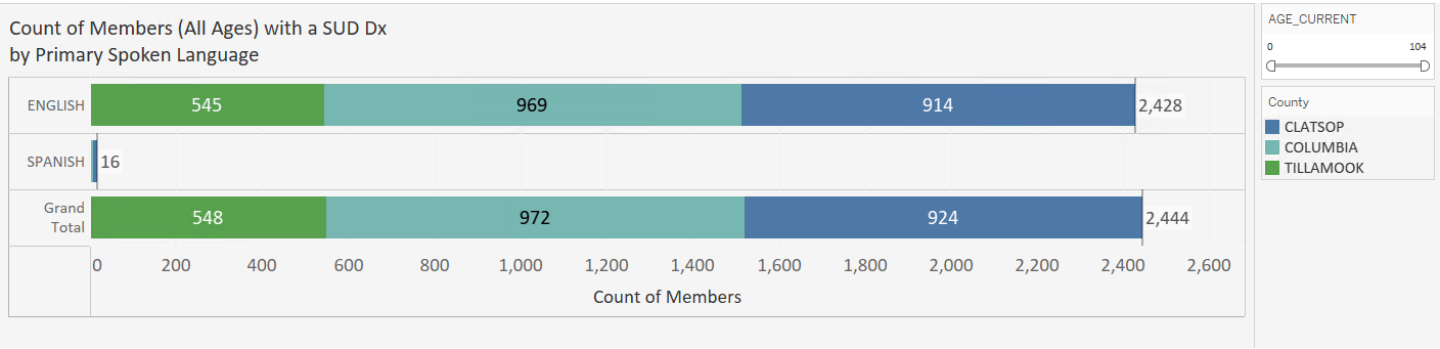
Tillamook County has a larger population of members who identify as a race other than white compared to Columbia or Clatsop counties.

Members (all ages) with a mental health diagnosis, by spoken language



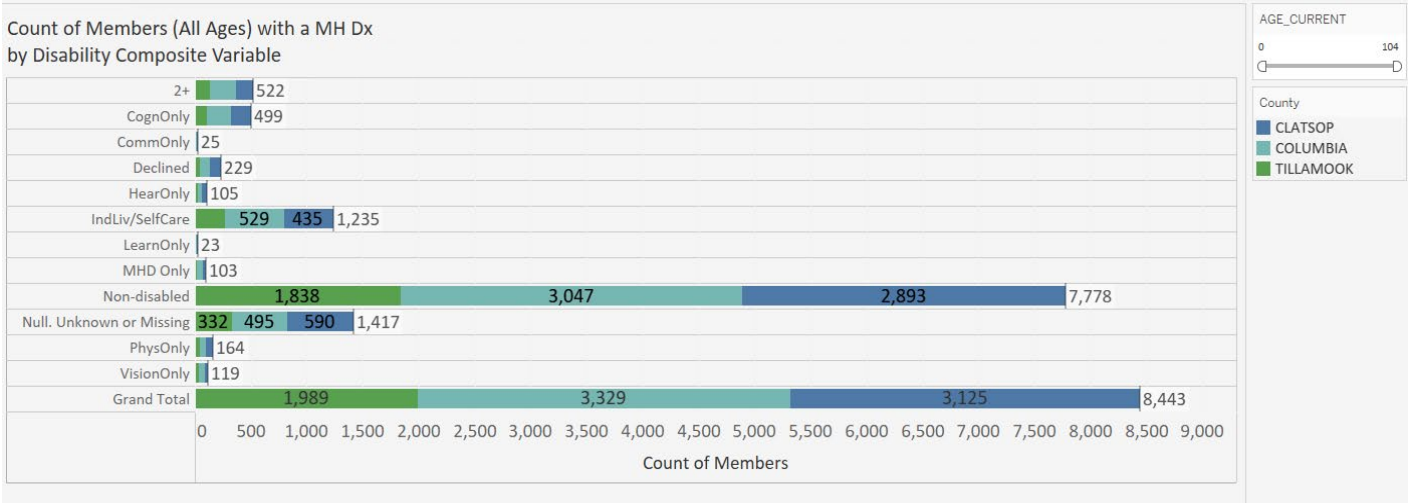
The second most common language after English is Spanish. Clatsop County and Tillamook County have larger populations of Spanish speakers compared to Columbia County.

Members (all ages) with a substance use disorder diagnosis, by spoken language



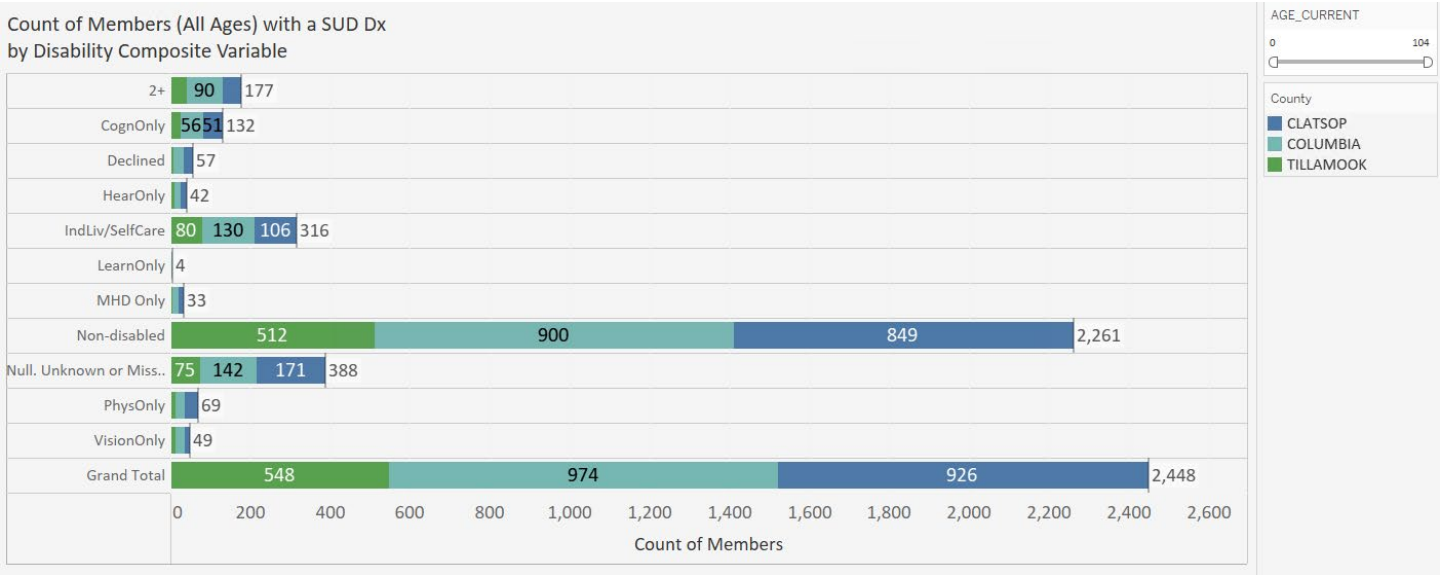
The second most common language after English is Spanish, with only 16 members falling into this category across all three counties.

Members (all ages) with a mental health diagnosis, by disability



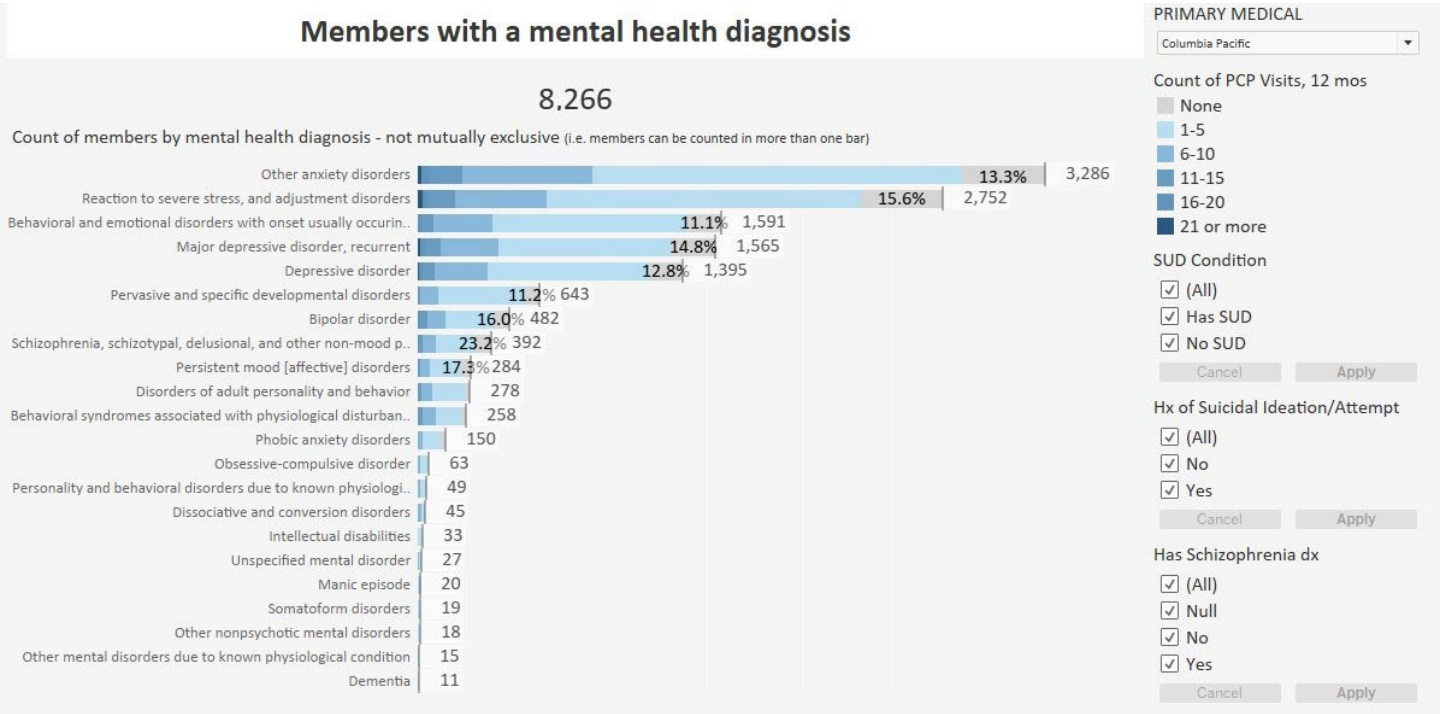
The most common category for all three counties after non-disabled and unknown is Individual Living/Self Care.

Members (all ages) with a substance use disorder diagnosis, by disability



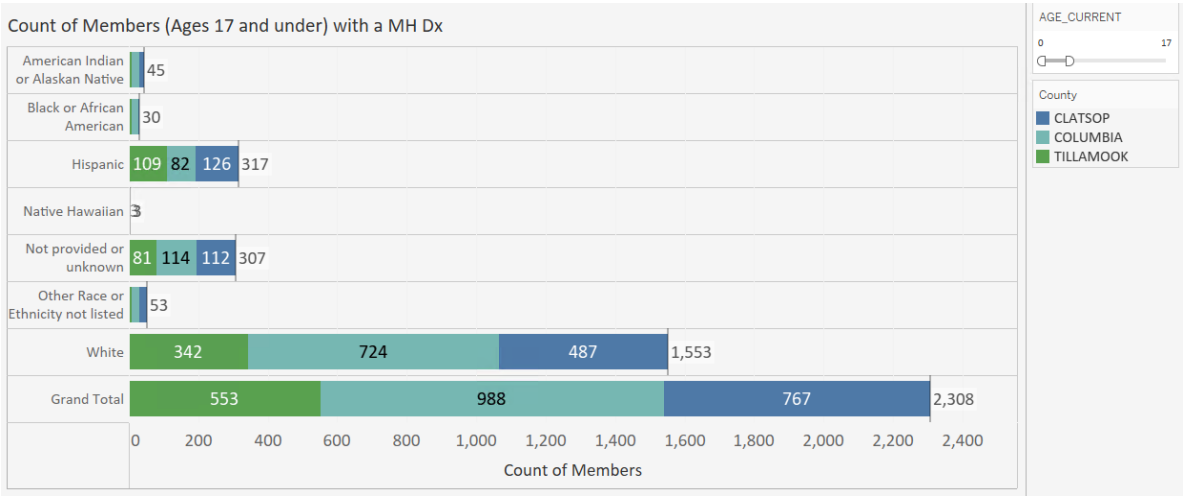
The most common category for all three counties after non-disabled and unknown is Individual Living/Self Care.

Rates of primary care visits in the past 12 months for members with a mental health diagnosis



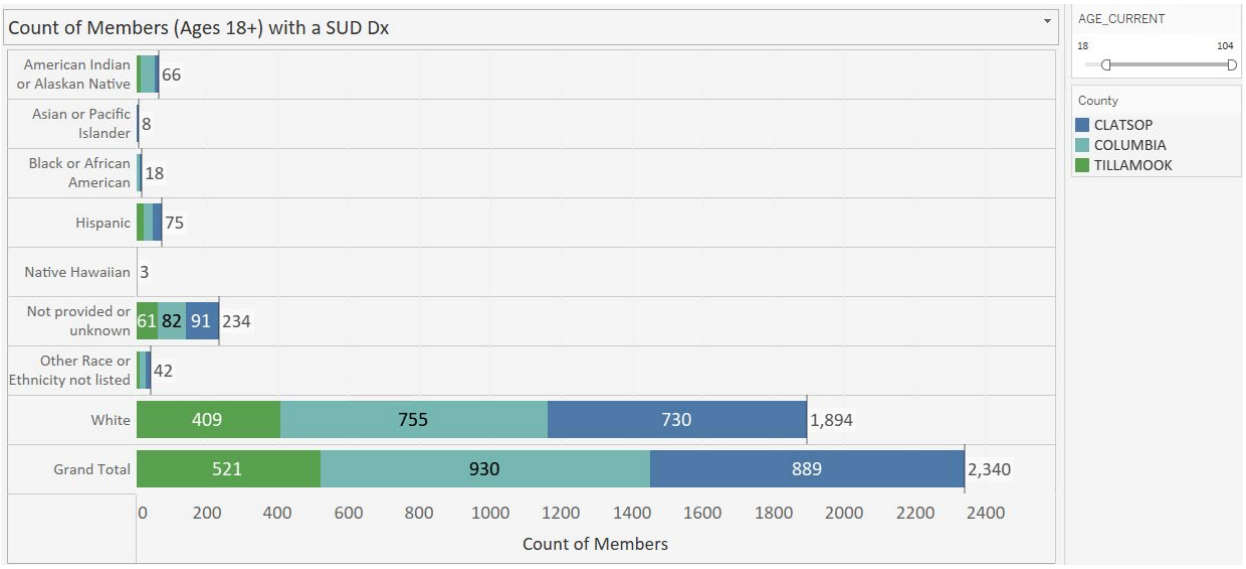
Adult members with schizophrenia spectrum disorders are far less likely to have had a primary care visit in the past 12 months than other mental health diagnoses.

Members aged 17 and under with a mental health diagnosis, by race



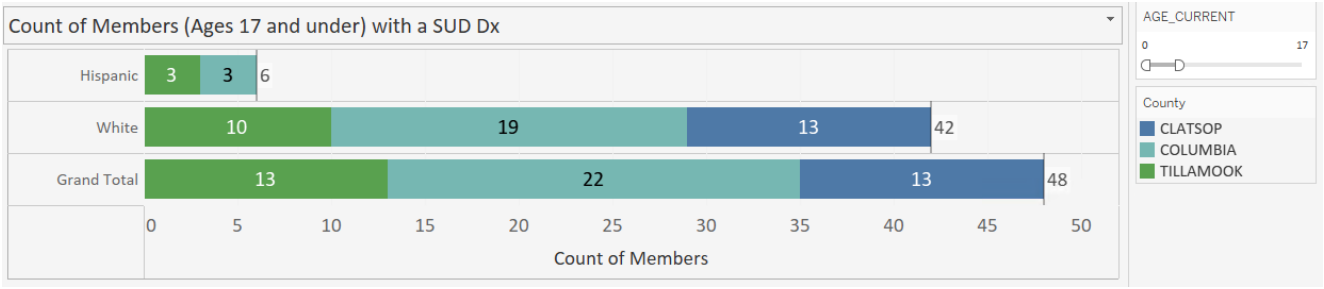
Tillamook County has a larger population of members who identify as a race other than white compared to Columbia or Clatsop counties

Members aged 18 and over with a substance use disorder diagnosis, by race



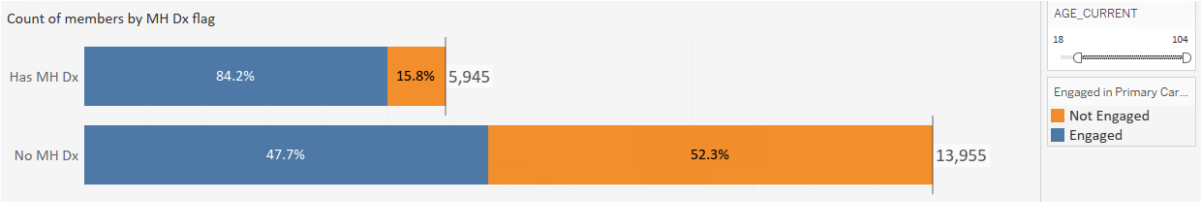
Non-white members have a higher rate of substance use disorder diagnosis across all regions.

Members aged 17 and under with a substance use disorder diagnosis, by race



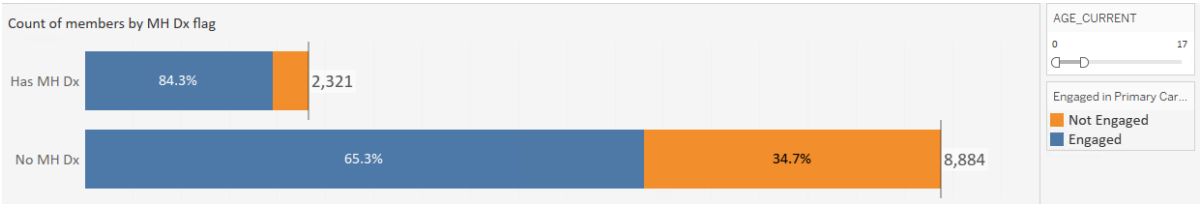
For members under age 18, there is less variability in race for rates of substance use disorder diagnoses.

Members aged 18 and over and engagement with primary care services (with a MH diagnosis vs no MH diagnosis)



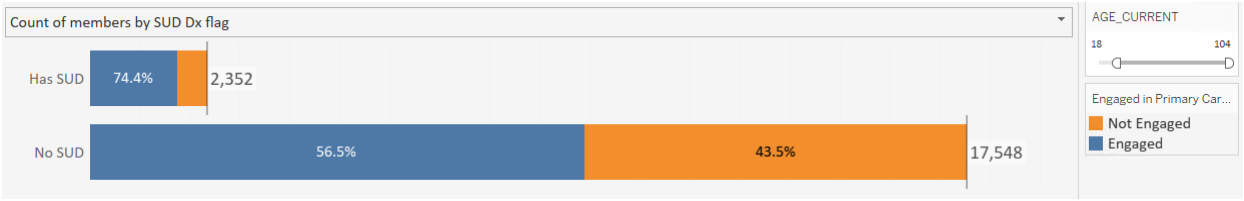
Adult members with any mental health diagnosis have better engagement rates with primary care than members who have no mental health diagnosis.

Members aged 17 and under and engagement with primary care services (with a MH diagnosis vs no MH diagnosis)



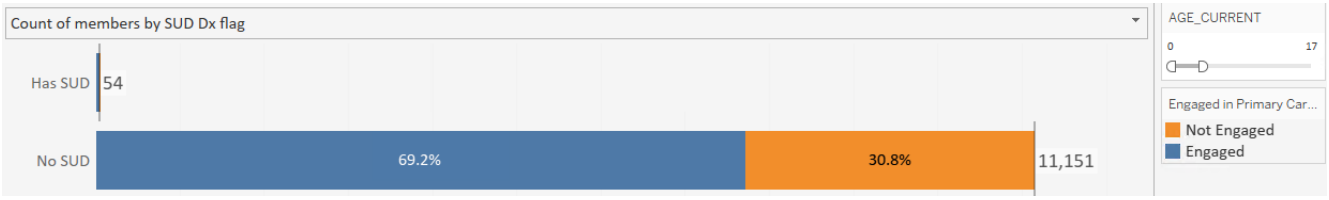
Youth members with any mental health diagnosis have better engagement rates with primary care than members who have no mental health diagnosis.

Members aged 18 and over and engagement with primary care services (with an SUD diagnosis vs no SUD diagnosis)



Adult members with any mental health diagnosis have better engagement rates with primary care than members who have no mental health diagnosis.

Members aged 17 and under and engagement with primary care services (with an SUD diagnosis vs no SUD diagnosis)



Due to very low numbers, it's more difficult to determine if youth members with any mental health diagnosis have better engagement rates with primary care than members who have no mental health diagnosis.

D. Brief narrative description

1. **Project population:**

Populations of focus for the projects include CPCCO members with mental health or substance use diagnoses with focused subpopulations being members with severe mental illness, members aged 12-17, members with co-occurring disorders, members with alcohol use disorders, and members with opioid use disorders. We will analyze data on these populations, disaggregated by sexual orientation when it's available. If any disparities or meaningful

differences are identified, we will explore the causes and develop a strategic plan as needed. In 2023, we thoroughly examined all elements of REALD GI data to identify the following gaps and corresponding activities.

2. **Intervention (address each component attached):**

Activity 1: For the priority population of members with a mental health diagnosis, our focus areas are targeted to improve coordination of care between community mental health providers (CMHPs) and primary care, improve access and retention in co-occurring services, and increase access to clozapine and long acting injectables (LAIs).

Primary Care and Behavioral Health Information Integration
For several years, CPCCO has worked with the network to explore different ways to have better integration of behavioral health with primary care services, including building out FTE for co-located therapy services in primary care settings, expanding school based behavioral health services, and bolstering bi-directional referral pathways. One area for integration that was re-explored with the network in 2023 was better integration of behavioral health providers' electronic health records (EHRs).

CPCCO utilized behavioral health listening sessions to understand support needs and developed strategic plans for providers to update their EHRs. Group and individual sessions were held with the three Community Mental Health Programs between June and August 2023 including OCHIN Epic demonstrations. Based on these listening sessions and demonstrations, CPCCO provided Columbia Community Mental Health (CCMH) with $1,628,530 in funding to transition to OCHIN Epic. Clatsop Behavioral Healthcare also acknowledged interest in continuing to explore future options of converting, though acknowledged the current timing was not ideal for their organization.

This transition for CCMH will increase their ability to provide coordination of care and increase integration between payor, primary care, and behavioral health systems. CCMH's transition to Epic now means all Columbia County providers will be on Epic platforms; this will increase collaboration, coordination, and clinical continuity leading to better health outcomes for Columbia Pacific members. This platform will also support CCMH with being able to utilize the Epic Payor Platform.

CCMH has been working closely with OCHIN to develop the foundation for their contract signed in March 2024. They have identified all core implementation team members and official kick off occurred on 5/20/2024.

BH Access and retention in co-occurring treatment
Access to needed Behavioral Healthcare services has been a growing challenge since the pandemic and is of utmost priority to ensure improved outcomes and address health disparities for all priority populations. From national data, we know that members on Medicaid are more likely to have decreased access to services, and with additional mental health and substance use diagnoses increasing likelihood of negative health outcomes. Our goal is to track current access and to support and incentivize our providers for the heroic efforts they are making to ensure members are receiving integrated, whole-person care. To this end, CPCCO has implemented two strategies: the Quality Improvement Incentive Program (QIIP) and Notifications of Treatment (NoT). By having more robust data regarding service accessibility, particularly around co-occurring services, we will be able to have a clearer picture of the gaps and be able to address these more specifically. For example, we will provide regular data regarding overall trends to providers to see the percentage of their clients receiving co-occurring services and outcomes for this population.

CPCCO's Quality Improvement Incentive Program (QIIP) is entering its 2.0 version starting in 2025. The Behavioral Health department began updating these metrics in 2023 to prioritize intentional input from regional departments and providers in the network before implementation in 2025. The goal for the QIIP is to drive meaningful and lasting changes to the behavioral health network, incentivizing clinical and operational improvements to improve health outcomes to members, and support quality care. QIIP is focused on having low administrative burden to providers

so measures that were claims based were given preference over provider reported measures. Measures for mental health and substance use disorder services were developed and will focus on engagement and initiation to treatment, retention of services, integration with Primary care services, and follow up care during and after transitions.

The second strategy is rolling out Notifications of Treatment (NoT) in our online provider portal, CareOregon Connect, to identify each episode of care starting 10.01.2024, with a full roll out on 01.01.2025. NoTs are electronic notifications that a provider submits in our online portal to notify the health plan that a member is initiating or continuing care. It is specific to the level of care the member is enrolled in, e.g., General Mental Health Outpatient or Supported Employment.

This transition will have numerous benefits for providers and members regarding service delivery and coordination of services including:

- Enhance CPCCO claims data reporting and support the whole person care for our members.
- Better coordination with hospital systems for continuity of care after receiving treatment in a higher level of care.
- Increase in accurate measurement data for providers relating to our Quality Improvement Incentive Program (QIIP) and other quality metrics.
- Better management of population health by utilization of level of care and comorbidities.
- NoTs by level of care and other metrics opens the door to reviewing existing payment methodologies to ensure they are targeted to serving members' needs.

Increase Access to Long Acting Injectables or Clozapine

With the significant rise of fentanyl use in the West Coast beginning in 2021, much effort and focus shifted towards decreasing overdose deaths and increasing access to substance use services. During 2023, with QIIP reporting in its second year, we noticed that many of the mental health specific metrics in the CPCCO region had decreased from the previous year, while providers were still maintaining or exceeding measures for SUD metrics. This along with the cross-regional focus of mental health as a priority population led us to renew efforts to support members living with mental illness. With the ongoing workforce shortage that continues to impact our region, CPCCO wanted to work on supporting measures that would both address the gaps while also having minimal impact on administrative burden. This led us to focus on increasing medications for severe mental illnesses, specifically on LAIs and clozapine. With the creation of the Quality Health and Outcomes data dashboard, data to measure medication dispensing and retention for this population provided a meaningful way to impact this goal. Research has shown that health outcomes for members living with schizophrenia spectrum disorders are more positive when on LAIs versus oral medication due to ease of retention and reduced physical health impacts from older generation antipsychotics. Our next steps will be to develop interventions to improve access to long acting injectables or Clozapine.

Activity 2: For the priority population of members with a substance use disorder, our focus areas are aimed at increasing access to and prescribing more vital medications and services.

Increase percentage from baseline members with an alcohol and/or opioid use disorder diagnosis who have a pharmacy claim for related medications

As the North Coast region continued to experience impacts of staffing shortages, particularly with licensed medical providers, supporting rebuilding the substance use continuum of care has been a high priority for the region. With the loss of many behavioral health providers and closures of SUD specific programming, CPCCO saw an increase in the number of members who were diagnosed with alcohol use disorder with low rates of medication dispensing events. In addition, the community reported a significant rise in fentanyl usage, leading to buprenorphine, even with

increased dosing, being less effective in managing withdraw and methadone being required. The data dashboard the Quality and Health Outcomes team is working on will also include information on dispensing and retention for medications used to treat opioid and alcohol use disorders. With this information, CPCCO can provide more specific data and trends to the provider network and explore how to support increased access to these lifesaving medications.

Increase access to Naloxone in the community

Across all ages, CPCCO has also been reviewing access to naloxone as a strategy to prevent overdose deaths. CPCCO has partnered with regional Public Health departments to review funding needs and other sources, such as the Clearing House, to have enough naloxone for distribution. Currently, CPCCO is supporting funding with Clatsop Public Health to bolster harm reduction events and supplies, including naloxone kits. With members at risk of or having experienced an overdose, being a cross regional priority population, the need for more standardized way to fund and distribute naloxone to the community was escalated as a priority. As a result, Medical Director leadership worked with Behavioral Health leadership to identify funding needs/annual budgets to ensure that people who are witnessing or at risk of experiencing an overdose will have access to naloxone. This is in addition to the covered benefit of naloxone prescriptions. CareOregon has just completed the process and funding for CPCCO to partner with local Community Based Organizations (CBOs) to fund naloxone for the community. We will be executing contracts through the end of Q4 2024.

Integration of BH and Primary Care services for Youth

The North Coast region has also consistently identified youth as a priority population to work on expanding services continuum for mental health and substance use disorder diagnoses. In 2022, CPCCO supported Columbia Health Services (CHS) with expanding mental health services in schools throughout Columbia County as a strategy to improve coordination between behavioral health and primary care services. As this work has continued, CPCCO began in 2023 to look at School Based Health Centers more specifically as opportunities to increase integration of behavioral health and primary care for youth. During CPCCO's SUD summit, held in October 2023, the clinical and community-based networks engaged in robust discussion regarding the need for increased prevention and coordination between systems with youth. During these discussions, staff and school counselors voiced interest in having more resources and coordination with other providers in the region to support prevention and treatment options.

Currently, CPCCO convenes monthly with CHS and Columbia Community Mental Health (CCMH) to support collaboration and access to care for youth members and their families with school-based health centers and mental health services embedded within schools. CHS also expanded into Clatsop County's Jewell School in 2023 and began running their school-based health center.

Tillamook's Neah-Kah-Nie School Based Health has been increasingly engaged with CPCCO, especially in discussing barriers they're experiencing to supporting our Youth members in meeting their needs. CPCCO is focusing on continuing to build relationships with this provider to support them in breaking any barriers.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Improve coordination of care between community mental health providers (CMHPs) and primary care, improve access and retention in co-occurring services, and increase access to clozapine and long acting injectables (LAIs).

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of behavioral health providers with integrated EHR.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No BH providers with integrated EHR	1 BH provider with integrated EHR	12/2025	2 BH providers with integrated EHR	12/2026
Monitoring measure 1.2	Increase access retention in co-occurring behavioral health services through data monitoring.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current way to determine co-occurring services or retention rates	Notifications of treatment (NoT) submitted by providers	01/2025	Baseline data determined and improvement targets set	06/2025
Monitoring measure 1.3	Increase access to LAIs or clozapine through data monitoring.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current data dashboard for regular monitoring	Dashboard created	12/2024	Baseline data determined and improvement targets set	06/2025

Activity 2 description: Increasing access to and prescribing more vital medications and services.

☐ Short term or ☒ Long term

Monitoring measure 2.1	The percentage of members with an alcohol and/or opioid use disorder diagnosis who have a pharmacy claim for related medications.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current data dashboard for regular monitoring	Dashboard created	12/2024	Baseline data determined and improvement targets set	06/2025
Monitoring measure 2.2	Increase access to naloxone in the CP region through data monitoring.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No regular data or standardized way to distribute community-based naloxone	Development of a policy and communication to provider and community network	12/2024	Develop and execute contracts to distribute community-based naloxone, and track distribution.	06/2025
Monitoring measure 2.3	Increased access to SUD services for youth through data monitoring.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

Engagement data in behavioral health services from two counties	Engagement rate data from three counties	12/2025	Baseline data determined and support needs identified	12/2026

A. Project title: Project 2: Meaningful Language Access

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

If continued, insert unique project ID from OHA: 416

B. Components addressed

1. Component 1: CLAS standards
2. Component 2 (if applicable): Health equity: Cultural responsiveness
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

CPCCO has used a variety of data sources to better understand the needs of our members with interpretation needs.

Table 1: Counts of Spoken Language for Members Who Indicated They Need Language Interpretation Services on their OHP Application – Sorted by County of Assigned Primary Care Clinic

	Assigned PCP (group)				
Language Description	Clatsop County Clinics	Clinics outside CPCCO region	Columbia County Clinics	Tillamook County Clinics	Grand Total
Spanish	383	27	61	103	574
English	30	1	12	5	48
Arabic	1		7		8
Simplified Chinese			3	2	5
Panjabi	2				2
Traditional Chinese				1	1
Thai			1		1
Spanish Assumed				1	1
English Assumed			1		1
Burmese	1				1
Bosnian			1		1

Distinct count of Mbr id (copy) broken down by Assigned PCP (group) vs. Language Description. The data is filtered on Cco, Enroll Status, Assigned PCP and interpreterneeded. The Cco filter keeps Columbia Pacific. The Enroll Status filter keeps Active. The Assigned PCP filter keeps 22 of 386 members. The interpreterneeded filter keeps 1. The view is filtered on Language Description, which excludes Null.

Table 2: Intersection between language and race/ethnicity.

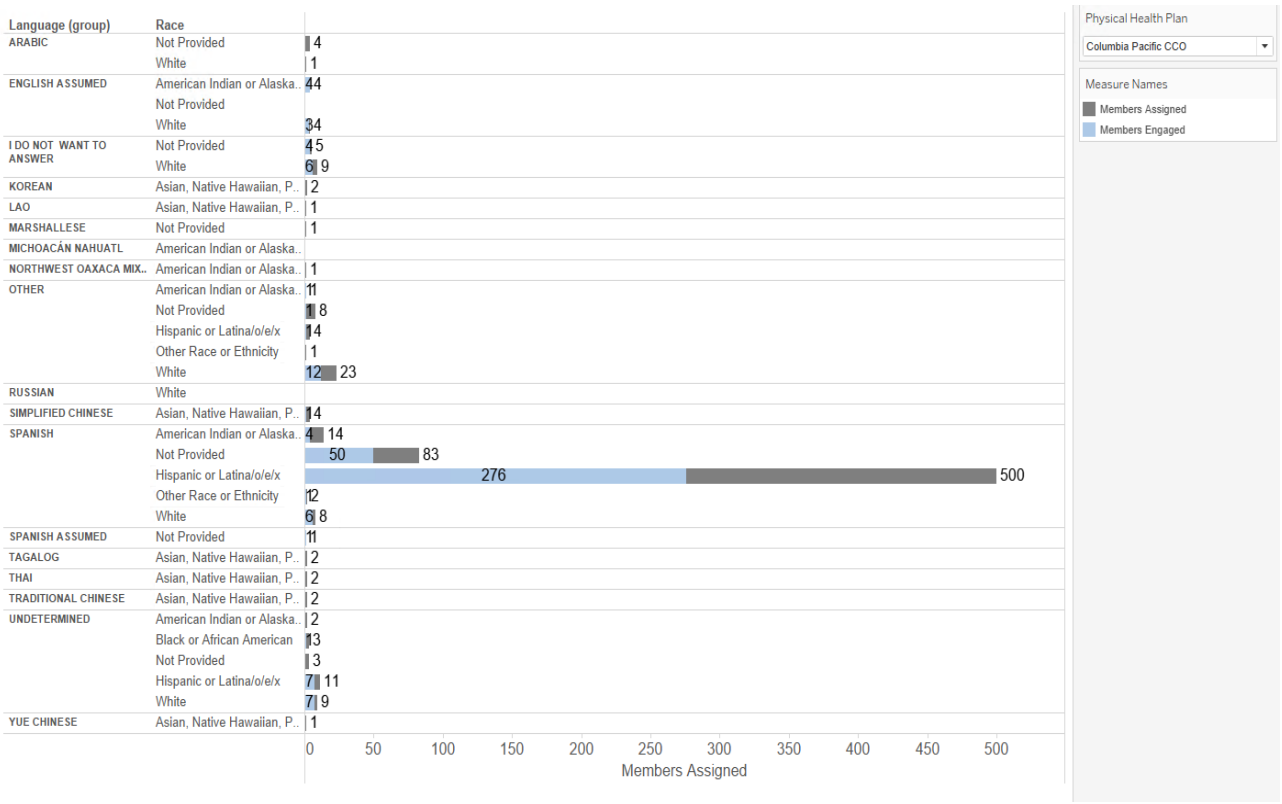
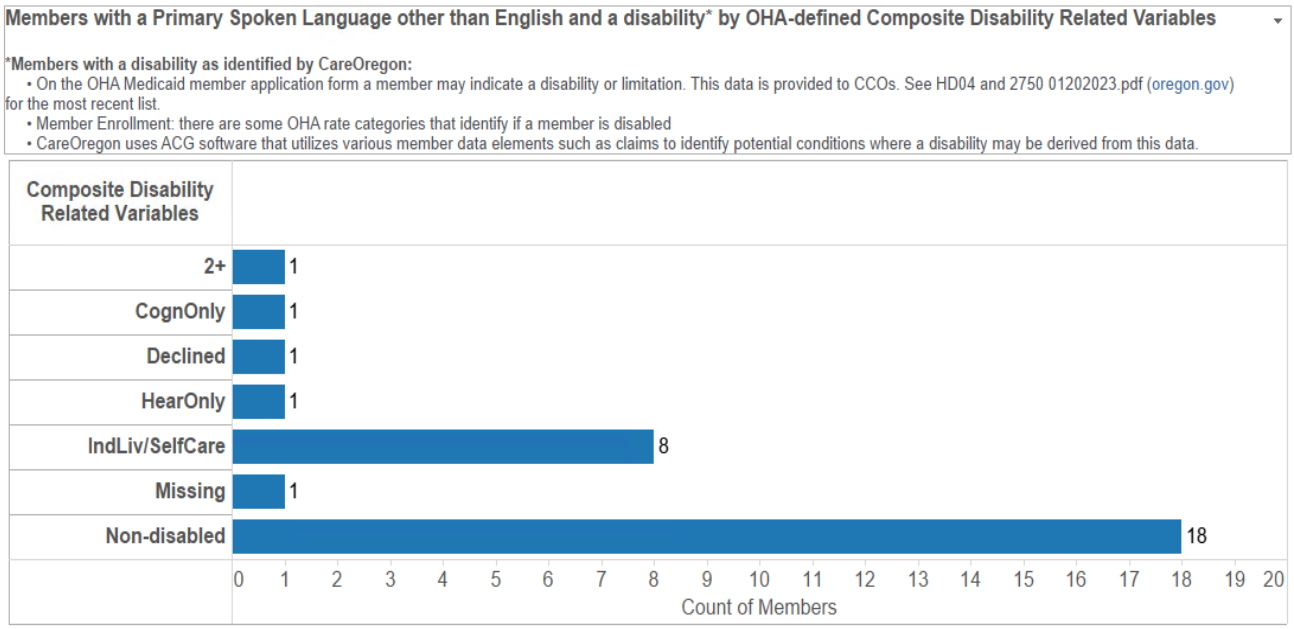
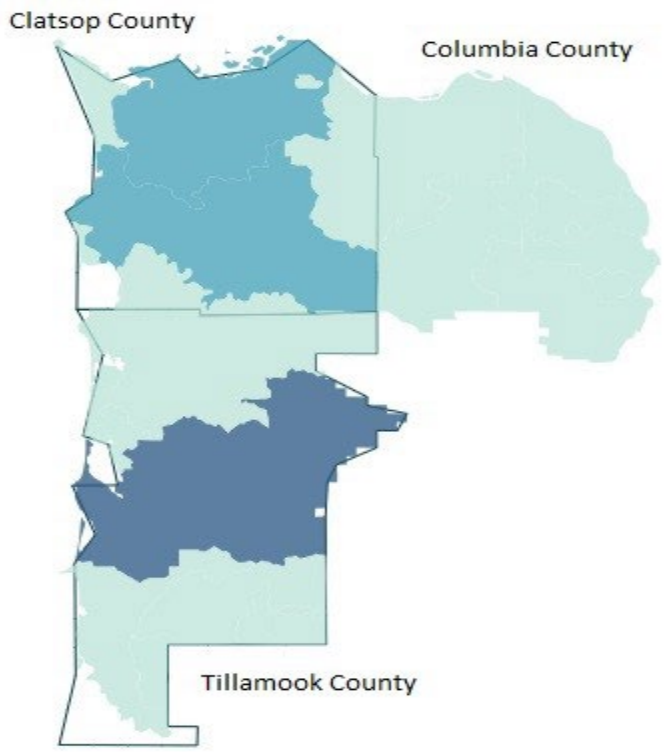


Table 3: Non-English speakers with a disability.



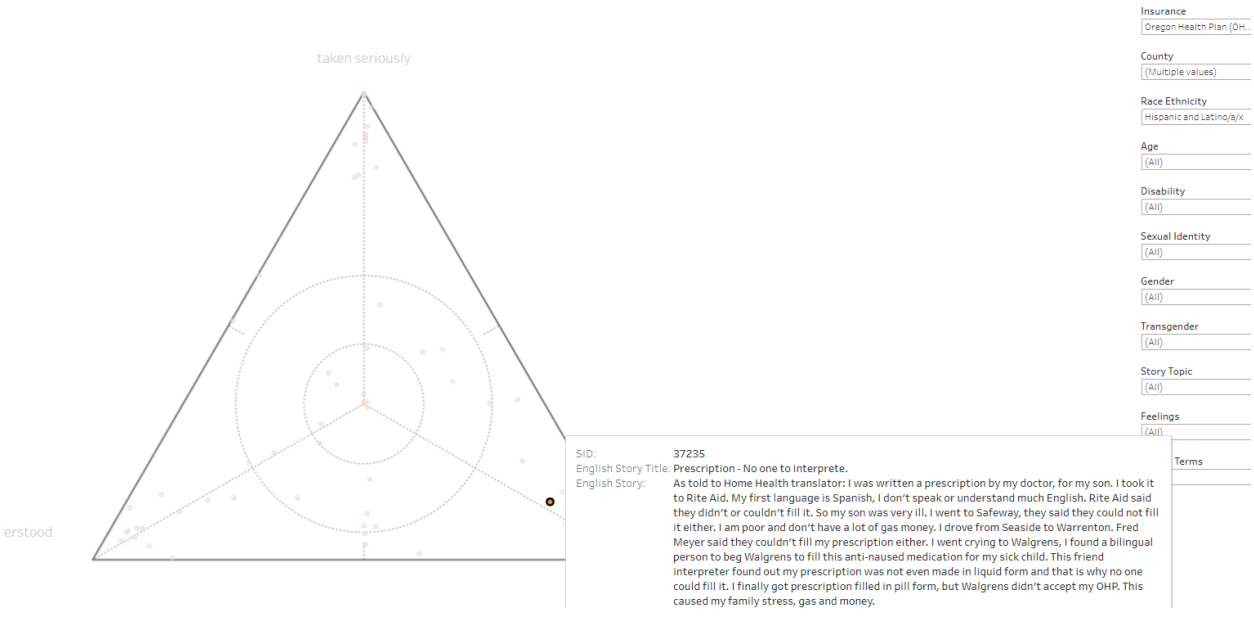
Despite the small numbers, this is a vulnerable population, and we consider it a major accomplishment when we are successful in reaching them as they encounter double the barriers.

Spanish speakers represent our highest language concentration, and these members mostly reside in three different zip codes that are served by 5 different clinic systems within the two counties:

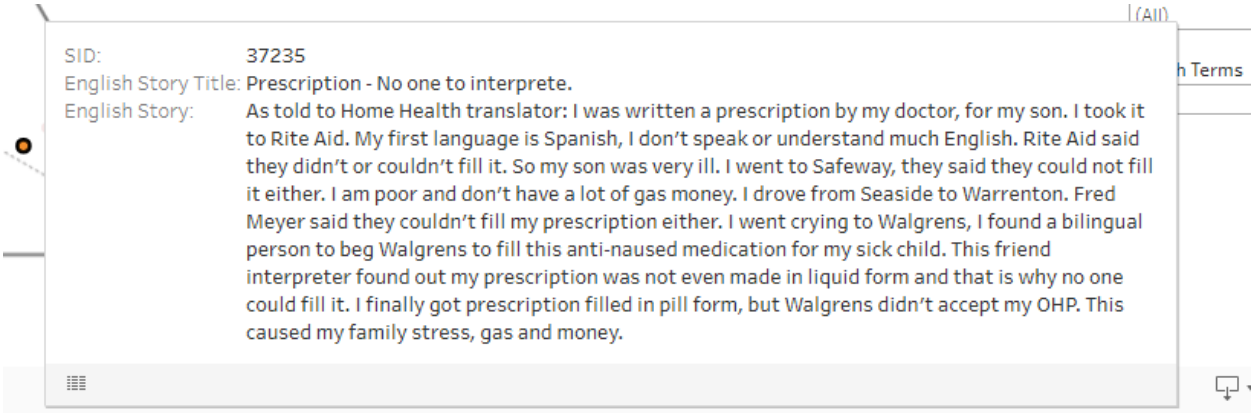


As part of our Regional Health Improvement Plan, we collected more than 1300 narrative surveys as part of our participatory action research approach. This process involved direct conversations with community members and CPCCO members about their health needs and experiences. Participants shared a story that they felt best described their experiences and then themed and scored their story themselves. In addition, participants were given the opportunity to self-identify along a broader spectrum of identities aligned with REALD & GI while also allowing more nuance than standard survey forms:

The data from these stories has been uploaded to Tableau so that we can readily access it:



This data allowed us to gather a much more nuanced understanding of our members' experiences. While we didn't see any significant differences in the experiences of our Spanish Speaking members when looking at that population's intersectionality across REALD & GI categories, we did get a deeper understanding of the myriad of barriers they experience when trying to access services. A good example related to trying to access medications is provided here:



In addition to analyzing the barriers and needs from the members' perspectives, we have also been looking at our network's barriers and needs. Over the past few years, the CPCCO team has been assessing the current state of interpretation within the network and found many barriers that impede the adoption of best practices to providing interpretation. From 2020-2022 our quality improvement team has been involved in anonymous consumer assessments, retrospective chart reviews, a narrative assessment via our Primary Care Value Based Payment program, and an additional retrospective review of 2019 claims. Beginning in 2022 CPCCO has been offering technical assistance with guidance for servicing patients and reporting data, but the team decided in 2023 to pivot towards focusing on a comprehensive needs and gap analysis with our clinic systems.

When assessing our primary care network, we have found that:

i. The largest clinic systems use remote interpretation services (Cyracom, AHN). These are national services that would be difficult to get certified with the state of Oregon due to their multi-state footprint. The clinic systems using these national vendors account for about 41.48% of our total assigned population but when we look specifically at the assignment of our Spanish speaking members, we see that clinics using these national vendors account for just under 68% of that population.
    a. Top 5 clinic systems for Spanish speaking member assignment:

	Columbia Pacific
Tillamook Clinic (national vendor)	25.49%
Clatsop Clinic System (national vendor)	19.63%
Clatsop Clinic (Oregon certified interpreters)	15.38%
Tillamook Clinic System (national vendor)	13.22%
Clatsop Clinic System (national vendor)	9.34%

Note: Vendor indicated to have Oregon certified interpreters does not mean all their interpreters are certified/qualified

ii. Most clinics do not have OHA certified or qualified services within their clinics. They use bilingual staff internally, but are reticent to get those staff proficiency tested, despite the CCO paying for it, due to the high degree of staff turnover. The rural health care workforce shortage has become so acute that, while still

committed to paying for certification and proficiency testing, we now provide additional funds to support staff recruitment, relocation costs, and professional trainings/certifications of any kind.

iii. Most clinics do not bill us for interpretation services or do not use our interpretation vendor contracts despite our ongoing promotion of these services and technical assistance around their utilization. This is due to CPCCO often being the payor for only 20% of the population the clinic is serving and the system preferring workflows that are built to meet the needs of the entire population they serve.

iv. Reporting interpretation services for clinic visits is difficult due to limited EHR data capture and reporting mechanisms which necessitates meticulous chart reviews. Approximately 60% of CPCCO members are assigned to clinics that utilize EPIC, which has continued to be a barrier to data capture due to its limited reporting features, requiring detailed chart reviews to access interpretation service information.

v. Finally, while we have identified that most clinics do have a workflow or an established policy for offering interpretation, some may be informal and not consistently used. This seems like the biggest opportunity for improvement moving forward due to the agency for change residing at the clinic workflow level rather than requiring EHR changes or interpretation vendor changes.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

CPCCO completed all our Activities and Benchmarks:

Activity 1: Build an infrastructure for data review and technical assistance plan by: 1) Identifying clinic reporting needs to accurately report for 2023 CCO incentive metric and 2) Refining the monitoring process for PCPM data collection review and action planning

Monitoring Measure 1.1 Clinic reporting needs assessment
Target: Five clinic systems' needs assessed by 6/2023
Benchmark: Nine clinic systems need assessed by 9/2023

Monitoring Measure 1.2 PCPM data collection review and action planning refinement
Target: Data review incorporating action planning by 9/2023
This activity was completed and generated the learnings outlined in the previous section. The key barrier to data collection is EHR configuration, and the main barriers to using certified/qualified interpreters are national vendors and staff retention struggles within our rural communities.

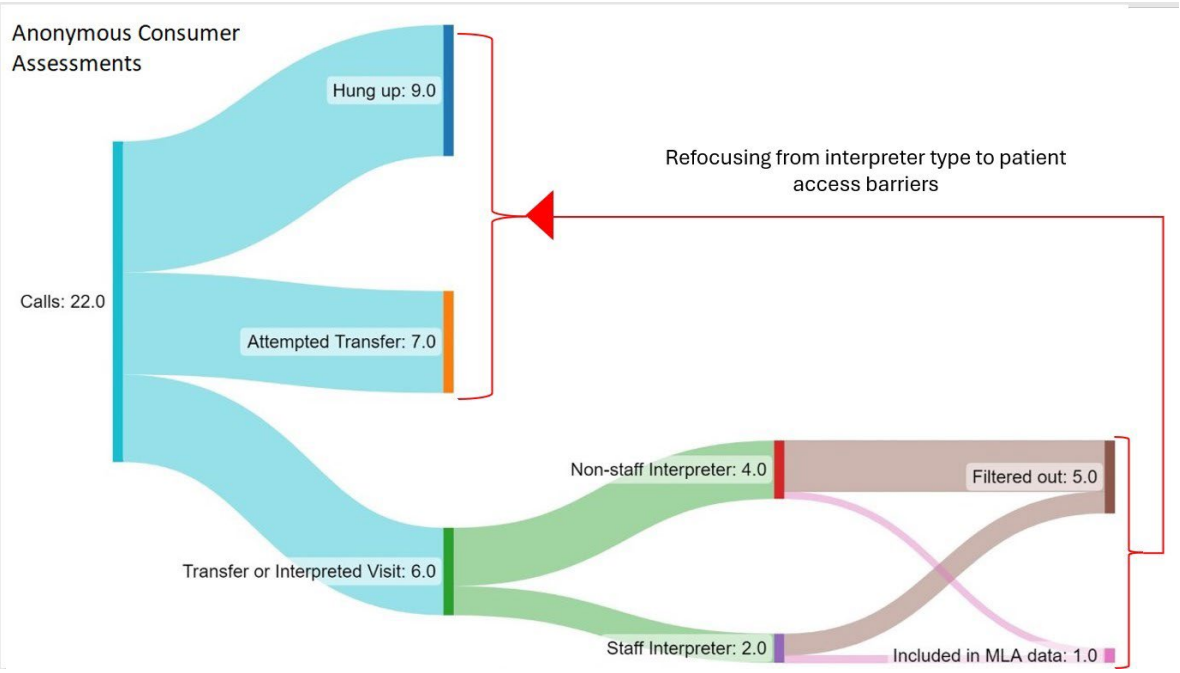
Activity 2: identify interpretation service needs through clinic workflow assessment

Monitoring Measure 2.1: Interpreter services workflow assessment
Target: Assessment conducted in five clinics by 9/2023
Benchmark: Needs identified in five clinics through assessment results 12/2023

This activity was also completed and CPCCO had many learnings and insights. We identified that if we define the need/problem in accordance with the OHA Meaningful Language Access metric, which is defined as having access to certified/qualified interpreters then we learned the many systemic barriers that have prevented our clinic systems from utilizing that interpreter workforce, such as the use of national interpretation vendors, and the barrier that have prevented good data capture of that work, such as EHR configuration. That said, we have also learned that rescoping our definition of the need/problem statement might set us up to more meaningfully address inequities experienced by this population as well as situate our intervention closer to where our clinics are better poised to make change. These insights are described below.

3. **Lessons learned over the last year:**

In addition to the above, we reassessed the results of our anonymous consumer assessments that were completed at the beginning of 2020. During the consumer assessments, we had Spanish speaking interpreters call various clinics throughout our network and attempt to schedule an appointment. Those assessments revealed that two thirds of those calls did not result in a scheduled appointment and instead resulted in being hung up on or an attempted transfer that led to nowhere. Upon reflection, CPCCO decided to refocus our work collaborating with clinics on centering the needs and experiences of our Spanish speaking members:

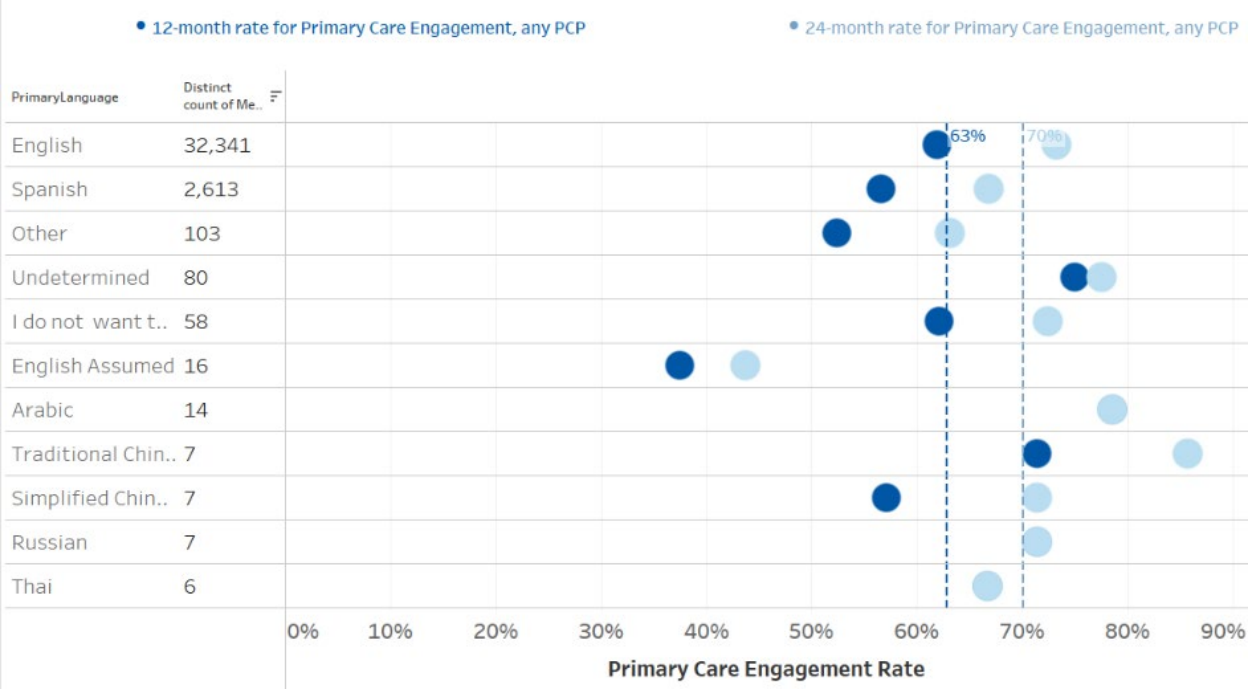


Note: Twenty-two calls were completed as part of our anonymous consumer assessments of which nine resulted in being hung-up on, seven an attempted transfer, and only six in a successfully scheduled visit. The portion of the visual identifying interpreter type and inclusion in the MLA dataset is conjecture.

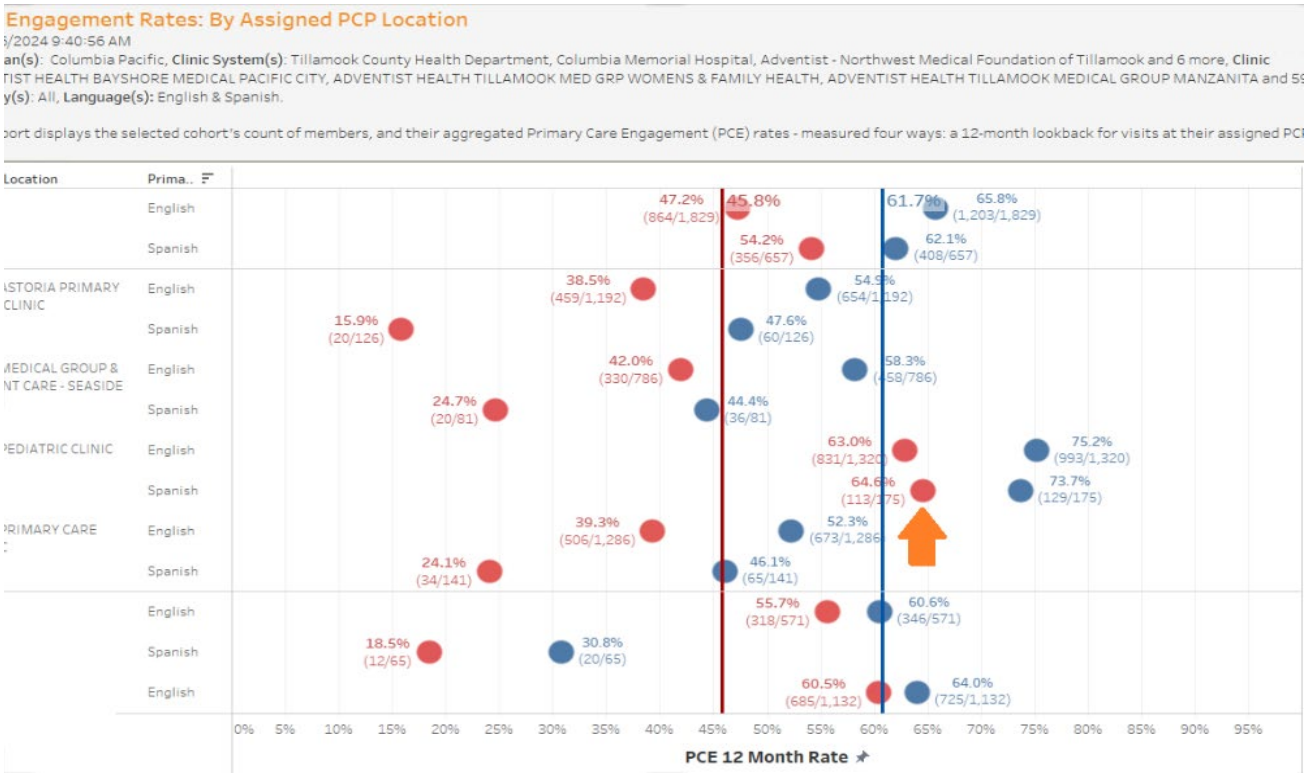
D. Brief narrative description

1. Project population:

The CPCCO Spanish speaking population. This language group was chosen because it has the highest language concentration. If workflows are redesigned to meet this population's needs then the clinics will be better poised to support other language speakers too. As indicated above, 574 members have identified themselves as Spanish speakers via their OHP applications. However, by pulling in additional data sets we have identified as many as 2,613 Spanish speaking members. When we look at our engagement rates of this population in primary care services, we see that their rates lag behind those of our English-speaking population:



When we combine this data with the findings from our anonymous consumer assessment, we can infer that the lower engagement stems from a lack of access due to clinics not providing immediate interpretation access. These trends seemed to persist when we looked across REALD & GI categories. CPCCO analyzed all elements of REALD & GI data to identify gaps and access health disparities regarding language access. As sexual orientation data becomes more available, we will analyze it for any meaningful differences and develop a strategic plan based on the causes. That said, we did see one outlier with regards to one of our pediatric clinics whose engagement rates for their Spanish speaking youth exceeded not only the rest of our network's rates but even that clinic's engagement rates for their English-speaking population:



Identifying bright spots as well as areas of focus will help us build momentum off areas where people are already deploying best practices.

2. **Intervention (address each component attached):**

In March of 2024 we reconfigured our Language Access workgroup to incorporate our learnings. We focused on two key changes: 1) reorienting ourselves to focus on access to healthcare verses access to a specific kind of interpretation, and 2) reconfiguring our workgroup members to center the experiences of Spanish speakers concurrently with the intended quality improvement initiatives. We decided to build upon our anonymous consumer assessments by evolving that approach into a structured observation and Plan, Do, Study, Act (PDSA) cycle. As part of this cycle, we plan to use Universal Design Principles to evaluate whether any proposed improvements will also improve accessibility for patients with disabilities, such as those who are mute, hard of hearing, or visually impaired. This approach ensures that our processes cater to the needs of all members while enhancing outcomes based on insights gained. To start the process, we will identify one to three partners, focusing on our primary care clinics and possibly a community mental health provider, and invite them to participate in observing an appointment call.

We have two native Spanish speakers on our Language Access Workgroup. One is our Provider Relations Specialist with expertise working directly in clinic settings and directly supporting our network. The other person is a certified Community Health Worker who works directly with our members and Community Advisory Councils. She is also a trained interpreter certified by Oregon. We also have two Innovation Specialists participating in our workgroup. These staff work directly with our network on quality improvement initiatives. They meet regularly with network partners to provide technical assistance, facilitate quality improvement conversations, and provide thought partnership. Our plan is to conduct appointment scheduling calls in a structured format. Our Spanish speaking staff will pose as OHP members attempting to schedule an appointment while speaking only in Spanish. We will invite the appropriate clinic leader to listen in on these calls along with one of our Innovation Specialists. They will have an observation tool to help them identify key components to watch for throughout the call. After the call we will schedule a debrief where the three people can debrief the call and our Spanish speaking staff can add additional context to the observation tool by adding in observations from their experience. After the debrief the clinic leader can identify an area for improvement.

Common barriers we identified in our original anonymous consumer assessment were broken phone trees, front desk staff not knowing how to obtain an interpreter, or over reliance on a Spanish speaking staff that might not be available in that moment to provide interpretation. Once the clinic leader has identified what they want to focus on, our Innovation Specialists will provide support, technical assistance, and structured time to focus on the improvement. We can then repeat the call process to see what improvements have been made and repeat as necessary to continue improvement. Once improvements have been made to the initial appointment scheduling call the team can move onto the next step in the workflow, such as reviewing the visit to see if an interpreter was preemptively scheduled for the appointment, and so on.

This project supports members with disabilities according to the CLAS standards as a way to improve the quality of services provided to all individuals, which ultimately helps reduce health disparities and achieve equity with the scoped objective to focus on offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access under the U.S. Department of Health and Human Services Office for Civil Rights. At minimum, the federal law includes the ADA Act, Title VI of the Civil Rights Act, Section 1557 of the Affordable Care Act and the CFR 45, Part 92 for members with limited LEP and the state law requires the statues 413.550 and 413.552.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Identify network partners to conduct assessments with.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of network partners identified			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No network partners have been identified yet. This measure aims to identify 1-3 network partners by the end of 2024.	Identify at least 1 network partner	07/2024	Identify 1-3 network partners	12/2024
Monitoring measure 1.2	Conduct assessment calls			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
We have currently not conducted any assessment calls	Conduct assessment calls	12/2024	Conduct assessment calls	12/2024

Activity 2 description: Develop quality improvement initiative based on findings from assessment calls

☐ Short term or ☐ Long term

Monitoring measure 2.1	Number of appropriate PDSA cycles related to identified focus areas from the assessment calls.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No PDSA cycles conducted	At least 1 PDSA cycle completed	09/2024.	Completed 1-3 PDSA cycles	12/2024

A. Project title: Project 3: Oral Health Services in Primary Care

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

If continued, insert unique project ID from OHA: 421

B. Components addressed

1. Component 1: Oral health integration
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued project

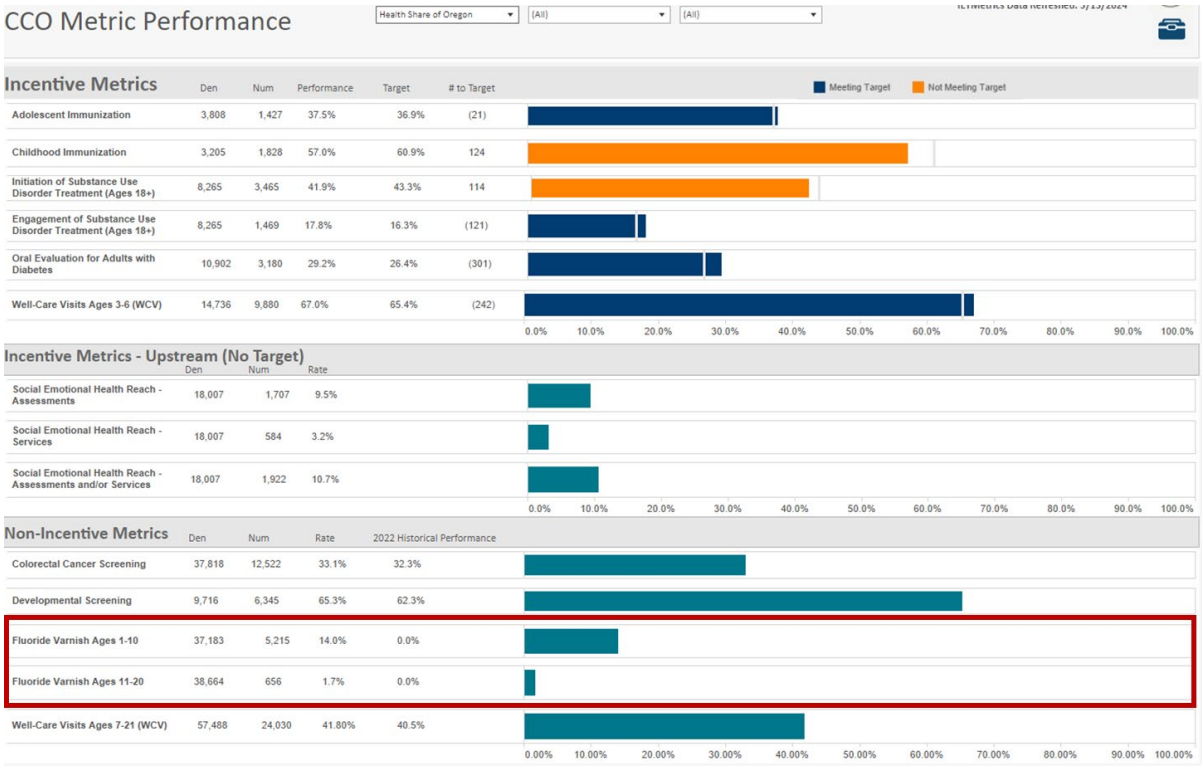
1. Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):

Columbia Pacific understands that the most impactful pediatric oral health integration efforts include screening, fluoride varnish application and referral during well child visits. With our focus on delivery of oral health services outside of traditional dental settings, there is a concurrent need for effective member-level data sharing between referring primary care providers and dental providers to create a closed loop referral system. The new efficient and transparent data sharing pathways we are creating between health care providers to support members' total health prove to be innovative and pioneering. We met major project milestones of our oral health integration project, such as the addition of dental data and actionable member lists to PCP metrics dashboards. One of the biggest learnings from the review of our 2023 TQS was the underestimation of resources needed to develop Health Information Technology (HIT) with row level security between six dental care organizations, CPCCO and our primary care network of referring providers. Our previous years' work developed the infrastructure for dental navigation tools and referral submissions from PCPs, CBOs and maternity providers. As the number of engaged PCPs sending referrals to dental continues to increase, we became solution focused to work through emerging barriers with HIT. Data quality issues emerged with our large enterprise-wide bidirectional referral project, requiring executive action across departments to reassess and realign product functionality. In the 2024 brief narrative section, we enhanced project activities from our lessons learned to ensure that we will have a quality final product.

Progress to date on last year's goals include:

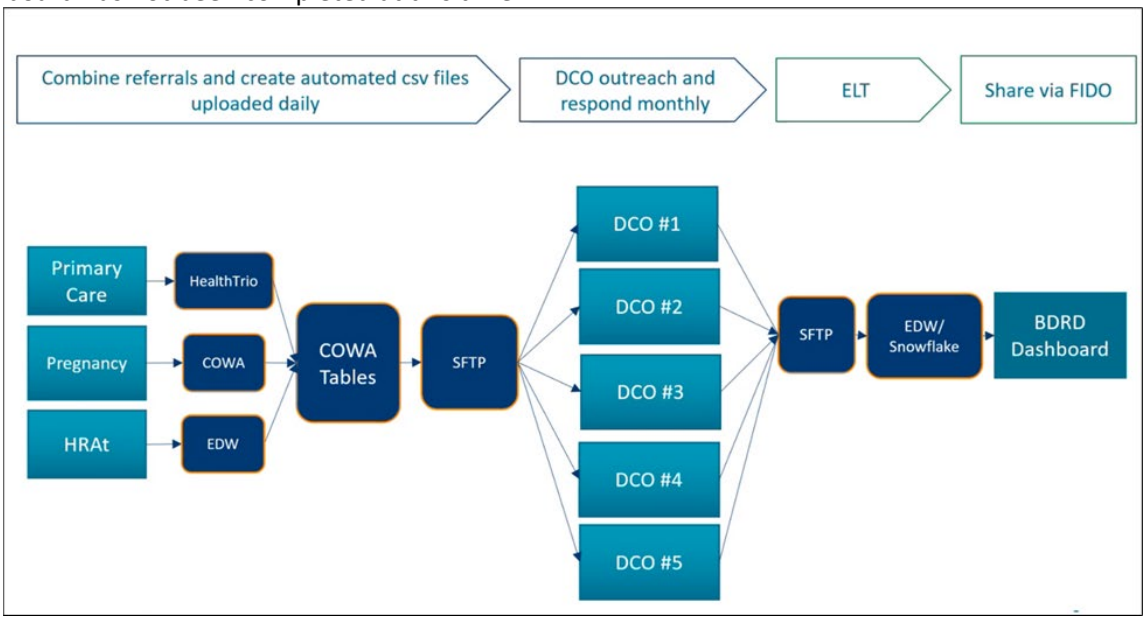
Activity 1) Enhancing HIT: Add dental engagement data to PCP dashboards. Data to include dental visit information, preventive dental services metric data by PCP and dental plan/clinic assignment

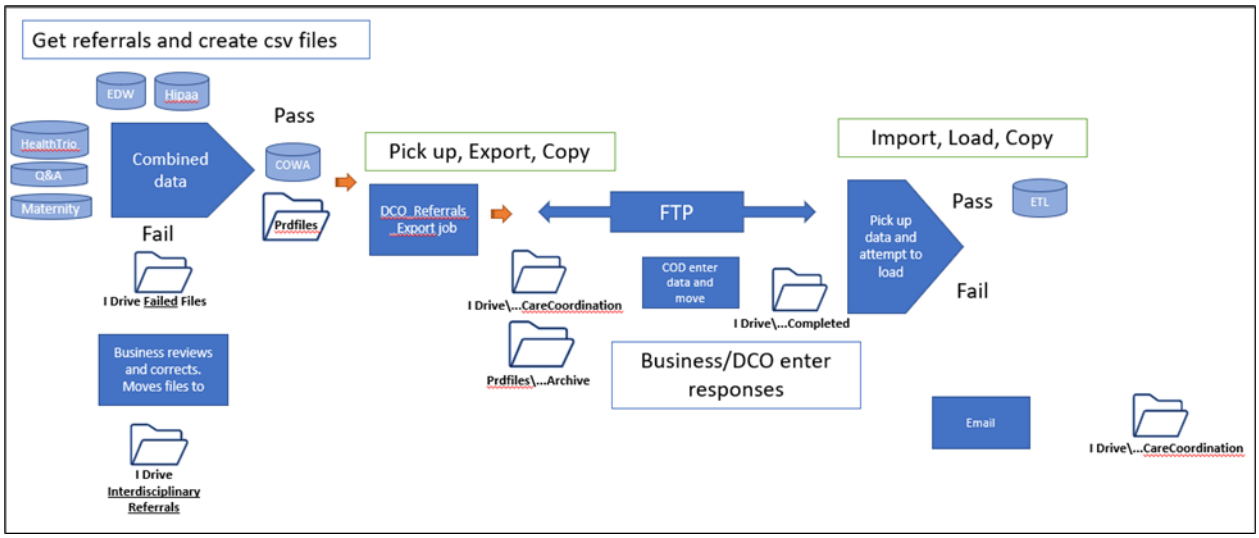
- Monitoring Measure 1.1 The addition of actionable dental data on PCP dashboards was met by the target timeline
- Monitoring Measure 1.2 Four (4) provider sites trained on the use of the actionable dashboard were met by target timeline

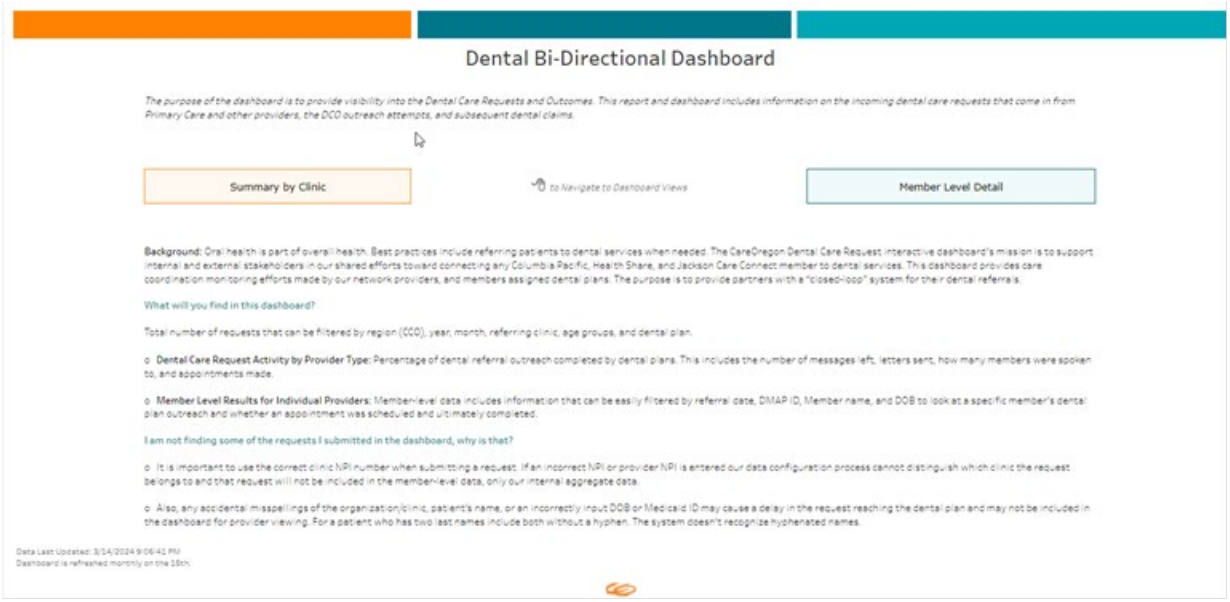


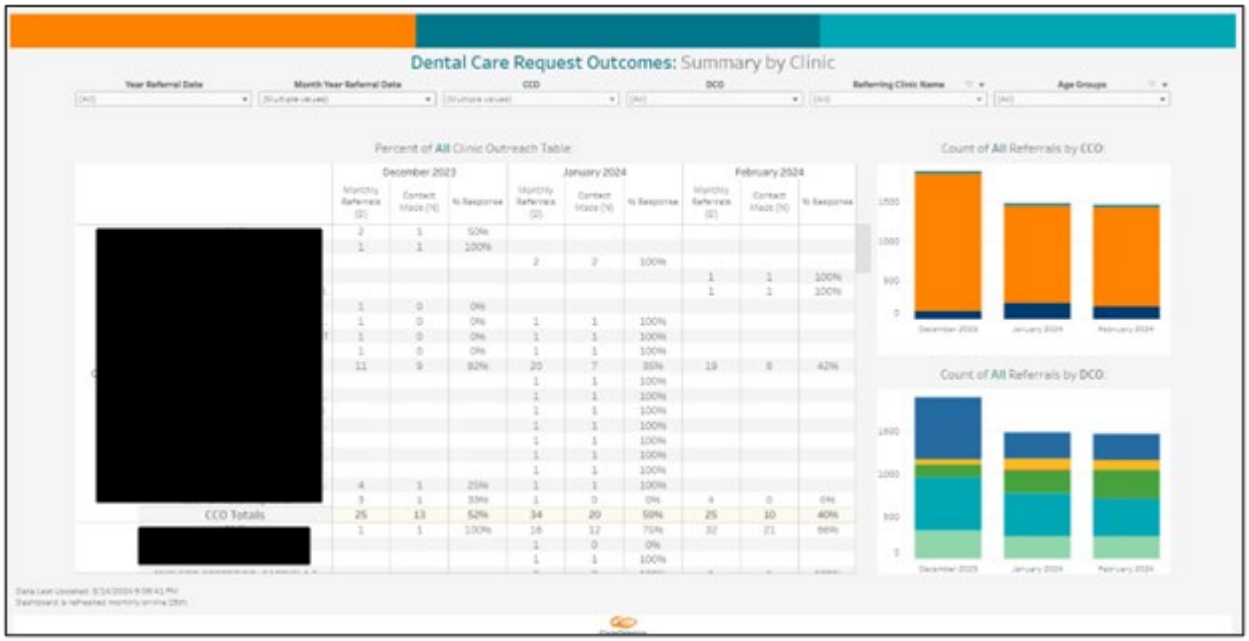
Activity 2) Enhancing HIT: Work with the analytics team to determine the number and percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit, and to develop a data dashboard visualization

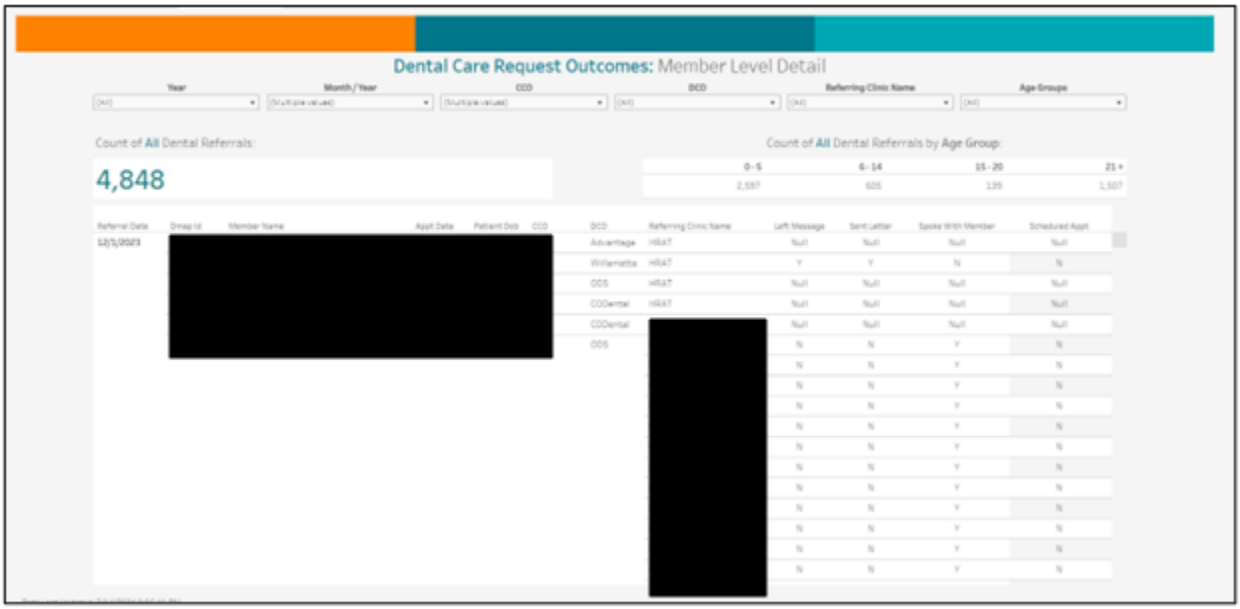
- Monitoring Measure 2.1 Completion of a dashboard to visualize dental care requests is in progress but not completed by the target date. A draft dashboard has been completed and is undergoing improvements. Included below are process flow visuals for dashboard build out and examples of the draft dashboard landing page, Summary by Clinic and Member Level Detail pages enhanced before launch
- Monitoring Measure 2.2 Analyze and monitor the number and percentage of dental care requests for children that result in a completed dental visit within 30, 60, and 90 days of the request has not been met as the dashboard has not been completed at this time




Get referrals and create csv files
EDW
Hipaa
HealthTrio
Q&A
Maternity
Combined data
Pass
COWA
Prdfiles
Fail
I Drive Failed Files
Business reviews and corrects. Moves files to
I Drive Interdisciplinary Referrals
Pick up, Export, Copy
DCO_Referrals_Export job
FTP
I Drive\...CareCoordination
Prdfiles\...Archive
COD enter data and move
I Drive\...Completed
Business/DCO enter responses
Import, Load, Copy
Pick up data and attempt to load
Pass
ETL
Fail
Email
I Drive\...CareCoordination

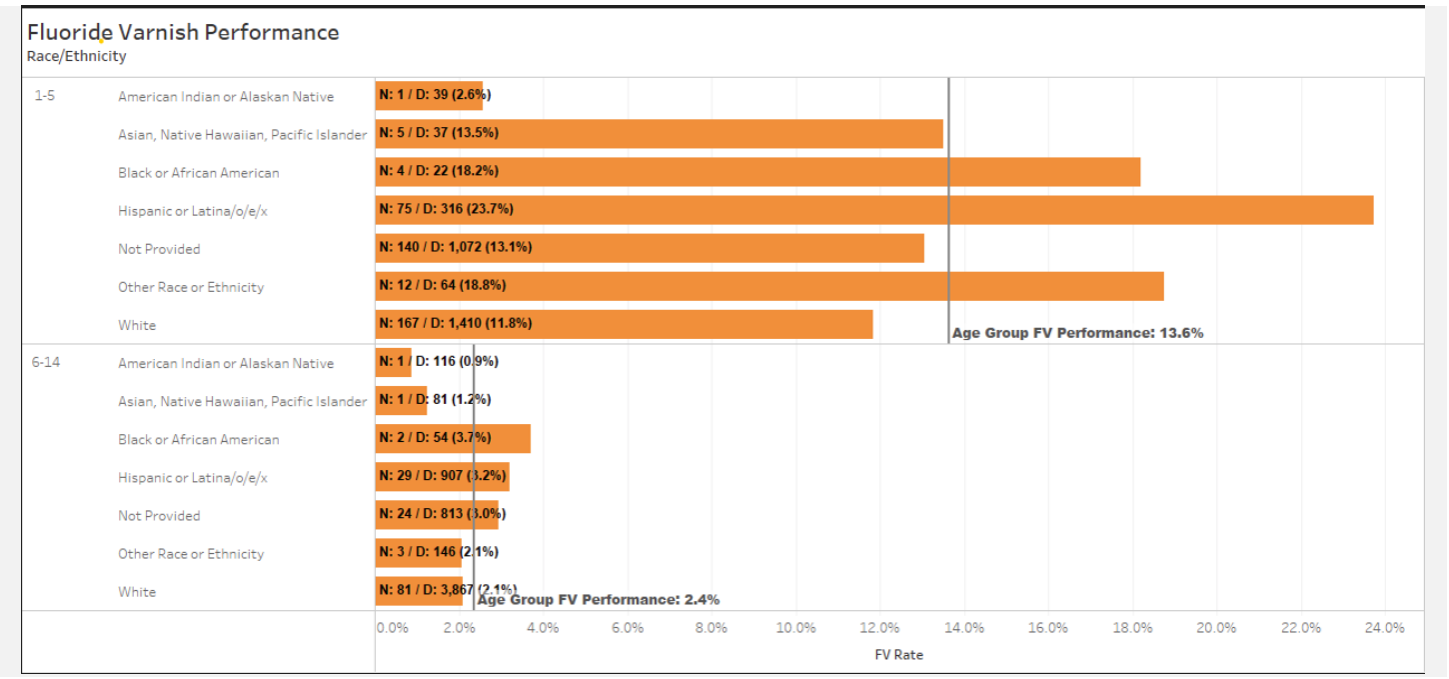

Dental Bi-Directional Dashboard
The purpose of the dashboard is to provide visibility into the Dental Care Requests and Outcomes. This report and dashboard includes information on the incoming dental care requests that come in from Primary Care and other providers, the DCO outreach attempts, and subsequent dental claims.
Summary by Clinic
to Navigate to Dashboard Views
Member Level Detail
Background: Oral health is part of overall health. Best practices include referring patients to dental services when needed. The CareOregon Dental Care Request interactive dashboard's mission is to support internal and external stakeholders in our shared efforts toward connecting any Columbia Pacific, Health Share, and Jackson Care Connect member to dental services. This dashboard provides care coordination monitoring efforts made by our network providers, and members assigned dental plans. The purpose is to provide partners with a "closed-loop" system for their dental referrals.
What will you find in this dashboard?
Total number of requests that can be filtered by region (CCO), year, month, referring clinic, age groups, and dental plan.
o Dental Care Request Activity by Provider Type: Percentage of dental referral outreach completed by dental plans. This includes the number of messages left, letters sent, how many members were spoken to, and appointments made.
o Member Level Results for Individual Providers: Member-level data includes information that can be easily filtered by referral date, DMAP ID, Member name, and DOB to look at a specific member's dental plan outreach and whether an appointment was scheduled and ultimately completed.
I am not finding some of the requests I submitted in the dashboard, why is that?
o It is important to use the correct clinic NPI number when submitting a request. If an incorrect NPI or provider NPI is entered our data configuration process cannot distinguish which clinic the request belongs to and that request will not be included in the member-level data, only our internal aggregate data.
o Also, any accidental misspellings of the organization/clinic, patient's name, or an incorrectly input DOB or Medicaid ID may cause a delay in the request reaching the dental plan and may not be included in the dashboard for provider viewing. For a patient who has two last names include both without a hyphen. The system doesn't recognize hyphenated names.
Data Last Updated: 3/14/2024 9:06:41 PM
Dashboard is refreshed monthly on the 15th.

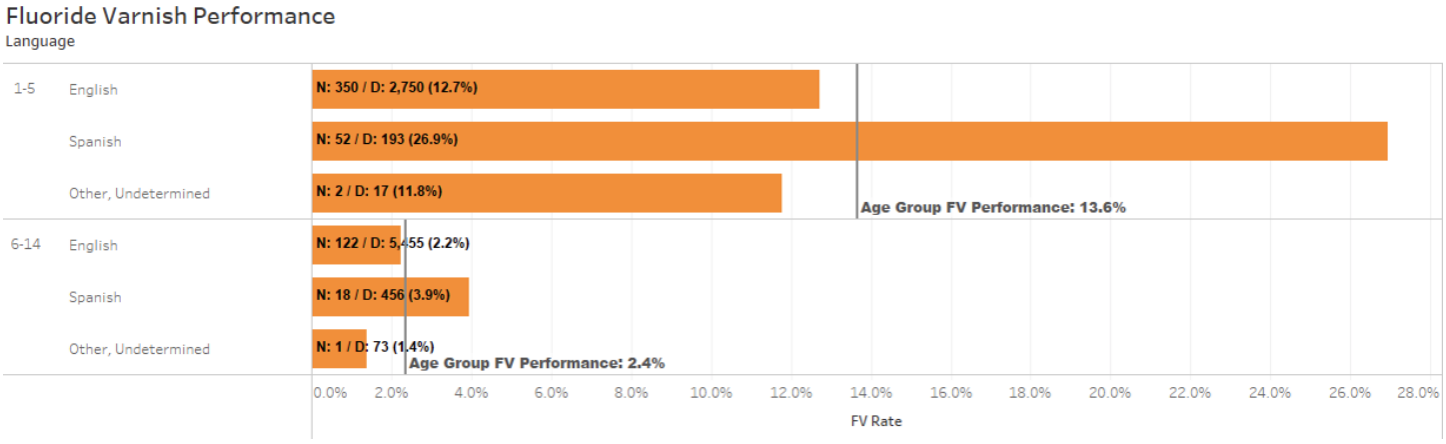


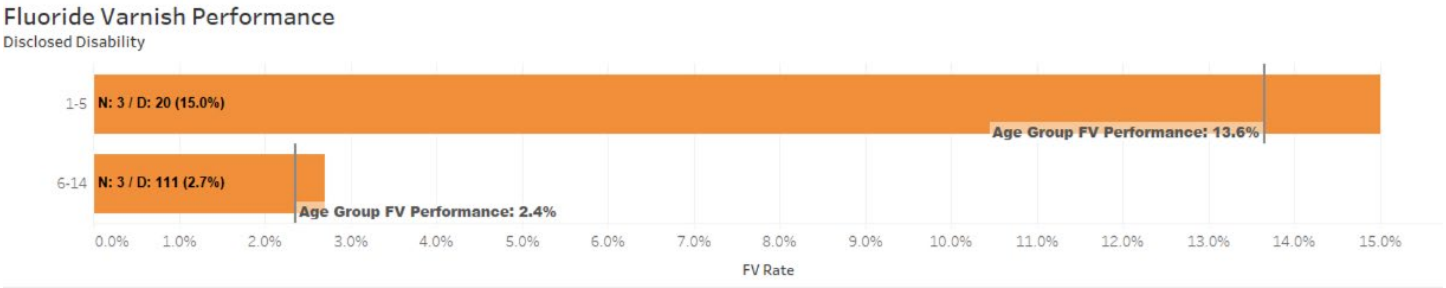


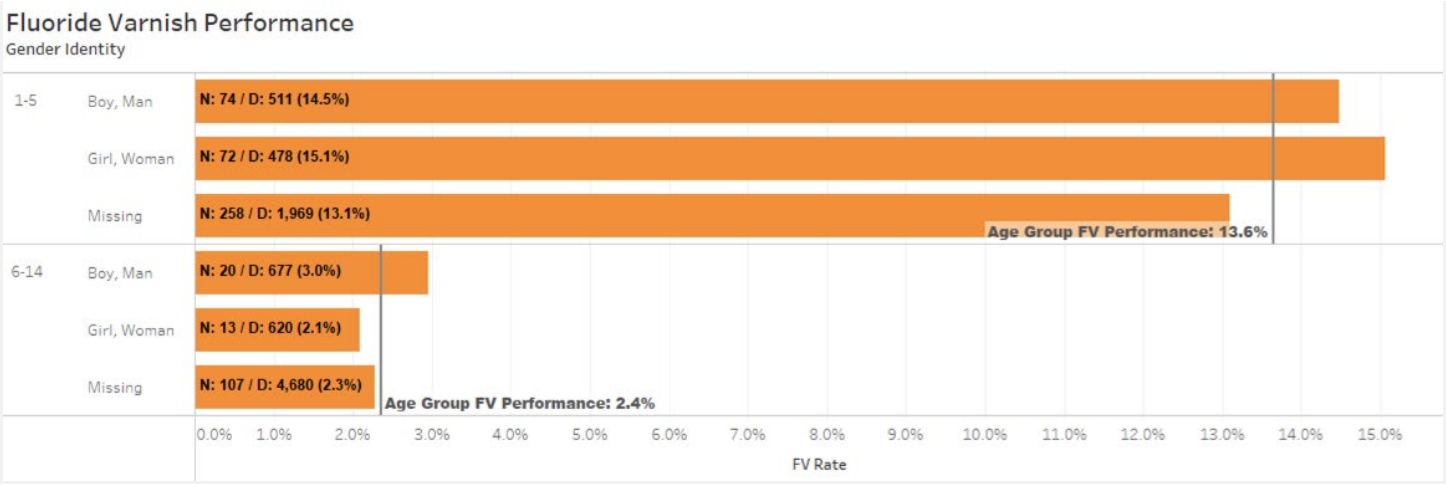
Activity 3) Oral health outside of dental settings: Analysis of dental services in physical health claims for quality improvement

- Monitoring measure 3.1 Determine baseline performance at the PCP-level of sites applying fluoride varnish in primary care and determine an improvement target for fluoride varnish applications in 2024 has been met by the target timeline. Fluoride varnish application in primary care data has been disaggregated by READL and GI for analysis. This data represents members receiving varnish in primary care and does not include dental provider contributions
- Monitoring measure 3.2 Dental claims in physical health data analysis developed and reported is on track to be met by target timeline of 6/2024
- Monitoring measure 3.3 Deliver provider findings and resources for quality improvement to four (4) provider sites is on track to be met by target timeline of 12/2024


Fluoride Varnish Performance
Race/Ethnicity
1-5
American Indian or Alaskan Native
N: 1 / D: 39 (2.6%)
Asian, Native Hawaiian, Pacific Islander
N: 5 / D: 37 (13.5%)
Black or African American
N: 4 / D: 22 (18.2%)
Hispanic or Latina/o/e/x
N: 75 / D: 316 (23.7%)
Not Provided
N: 140 / D: 1,072 (13.1%)
Other Race or Ethnicity
N: 12 / D: 64 (18.8%)
White
N: 167 / D: 1,410 (11.8%)
Age Group FV Performance: 13.6%
6-14
American Indian or Alaskan Native
N: 1 / D: 116 (0.9%)
Asian, Native Hawaiian, Pacific Islander
N: 1 / D: 81 (1.2%)
Black or African American
N: 2 / D: 54 (3.7%)
Hispanic or Latina/o/e/x
N: 29 / D: 907 (3.2%)
Not Provided
N: 24 / D: 813 (3.0%)
Other Race or Ethnicity
N: 3 / D: 146 (2.1%)
White
N: 81 / D: 3,867 (2.1%)
Age Group FV Performance: 2.4%
0.0% 2.0% 4.0% 6.0% 8.0% 10.0% 12.0% 14.0% 16.0% 18.0% 20.0% 22.0% 24.0%
FV Rate


Fluoride Varnish Performance
Language
1-5
English
N: 350 / D: 2,750 (12.7%)
Spanish
N: 52 / D: 193 (26.9%)
Other, Undetermined
N: 2 / D: 17 (11.8%)
Age Group FV Performance: 13.6%
6-14
English
N: 122 / D: 5,455 (2.2%)
Spanish
N: 18 / D: 456 (3.9%)
Other, Undetermined
N: 1 / D: 73 (1.4%)
Age Group FV Performance: 2.4%
0.0% 2.0% 4.0% 6.0% 8.0% 10.0% 12.0% 14.0% 16.0% 18.0% 20.0% 22.0% 24.0% 26.0% 28.0%
FV Rate


Fluoride Varnish Performance
Disclosed Disability
1-5
N: 3 / D: 20 (15.0%)
Age Group FV Performance: 13.6%
6-14
N: 3 / D: 111 (2.7%)
Age Group FV Performance: 2.4%
0.0% 1.0% 2.0% 3.0% 4.0% 5.0% 6.0% 7.0% 8.0% 9.0% 10.0% 11.0% 12.0% 13.0% 14.0% 15.0%
FV Rate



Activity 4) Addressing health disparities: Analysis of dental care requests resulting in a completed dental visit stratified by member race and language. The target date for this activity was originally 6/2025. This work is contingent on the progress with the dashboard buildout and is slated for completion by 8/2025

2. Describe whether last year's targets and benchmarks were met (if not, why):

In 2023, we successfully added dental data, in the form of a fluoride varnish measure, to our metrics dashboard that is available externally to our Primary Care partners. In addition to metrics performance data, the dashboard allows providers to export an actionable member list for engagement. All providers with dashboard access received information on the data update and additional technical assistance was provided when requested by partners. We also determined the baseline of fluoride varnish applications in physical health claims for quality improvement which keeps us on track for the data analysis and opportunities for quality improvement. This oral health integration project encountered some barriers with the finalization of the HIT dashboard to visualize dental care requests, which we planned to complete by 12/2023. The complexities of this enterprise-wide, large-scale project that includes health information data exchange with row level security between six dental care organizations, CPCCO and our primary care network of referring providers has proven to be challenging. The win is that multiple milestones have been met, including the product platform and methodology. Milestones include the implementation of referral outreach data exchange from dental plans and the draft dashboard build out in FIDO, our data and analytics platform. During the validation process, data quality issues and inconsistencies were uncovered. To ensure accuracy and quality of information sharing, teams stepped back to re-evaluate the product. We are not able to meet our goals to analyze and monitor the dental care requests nor build additional data visualizations until the dashboard is final.

3. Lessons learned over the last year:

While this large scale, HIT dashboard project operates under an approved enterprise-wide charter and weekly project management huddles, the greatest learning was the need for a steering committee comprised of multi-department leadership. The complexities of numerous dependencies spread amongst various departments and teams proved to be a challenge and required additional oversight to ensure alignment and communication for the final product. With the establishment of the steering committee, we have already seen great strides in movement towards the desired end goal and product.

D. Brief narrative description

1. **Project population:** Children ages 1-5 years in Primary Care settings
2. **Intervention (address each component attached):**

Understanding that primary care teams have multiple demanding priorities for provision of care during a short visit time, we believe that provider buy-in is essential for the successful implementation of oral health integration practices. To best align with the Bright Futures and United States Preventive Services Task Force (USPSTF) primary

care recommendations for fluoride varnish application at the time of primary tooth eruption, the project population age has been updated to ages 1-5.

An important lever to note is the incentive offered through our Primary Care Payment Model (PCPM) for fluoride varnish application and dental referrals for this age group. Additionally, we strive to make oral health integration an easy lift and as seamless as possible for network partners. Our integration and dental navigation tools, with targeted training, help advance the knowledge and awareness of primary care teams on the importance of oral health for children ages 1-5 years. We also aim to improve dental navigation and dental visit adherence with the ultimate goal of increasing dental utilization and lowering the incidence of dental caries.

Now that we have current and historical claims and dental care request data from multiple partners, we are positioned to implement thorough and meaningful data analysis practices for quality improvement with an equity lens. The PCP Children's Preventive Dental Services dashboard is our own health information technology tool designed to further strengthen integration efforts. This dashboard transmits basic dental health data points to PCPs and includes information on their members' dental needs they did not previously have easy access to. Provider training on the use of the dashboard, with oral health education and dental navigation tools, is available and provided to take actionable steps on the data and support member outcomes. Continued PCP training, utilization, and spread of the dental care request process builds communication pathways for care coordination with dental plans. This health plan support addresses a gap identified in navigation to dental services where the burden often falls on the PCP and patient to understand and navigate the complexities of the benefit structure.

Continuation of HIT enhancement to improve our dental care referral platform and bidirectional communication is key to support member care. Data analytics and dashboard buildout on the percentage of children who had a dental care request submitted by the physical health provider and who completed a dental visit may provide insight on gaps within the navigation system, health disparities and/or access concerns. This will allow for data-driven conversations and improvement activities with PCP and dental plan partners on timely access to care. Analysis of covered oral health services in primary care, such as screening or assessment and fluoride varnish claims data to understand variability in data and determine strong and underperforming clinics will allow for shared learning and additional technical assistance.

This is the first year we have disaggregated oral health in primary care data available for analysis. All elements of REALD & GI data were analyzed to identify gaps. This data allows for a discussion on populations accessing oral health services by PCPs. Denominators are small as this data does not reflect the entire assigned population, only members who received fluoride varnish in PC settings. 2023 fluoride varnish claims data in primary care by race/ethnicity for children ages 1-5 show that the percentage of American Indian/Alaska Native, Asian/Native Hawaiian/Pacific Islander and white children is below the performance of the total age group. In this evaluation, we are aware that the white population has the most numerators and largest denominator of any population. Further strengthening this work, we plan to add REALD and SOGI data to both our oral health services in primary care and dental care request dashboards to allow continuous evaluation for interventions and discussion with network partners. Analysis of oral health data disaggregated by sexual orientation will be done when available. If any disparities or meaningful differences are identified, we will explore the causes and develop a strategic plan to address those differences.

To ensure that oral health services in primary care and dental navigation initiatives are kept at the forefront with our PCP network providers, we facilitate workshops and workgroup presentations throughout the year. Additionally, our MedsEd continuing education series for health care professionals is hosting a webinar in June 2024 on the importance of integrating oral health care referrals into practice workflows. The webinar's focus includes champion providers presenting their work integrating oral assessments and fluoride varnish application with dental referrals into standard practice and addresses the importance of oral health in social determinants and overall health impacts.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Enhancing HIT: Work with the analytics team to determine the number and percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit, and to develop a data dashboard visualization.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Completion of a dashboard to visualize dental care requests			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Dashboard not available	Dashboard created	5/2025	Dashboard created	5/2025
Monitoring measure 1.2	Analyze and monitor the number and percentage of dental care requests for children that result in a completed dental visit within 30, 60, and 90 days of the request.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline not available	Determine 2024 baseline and future improvement target set.	08/2025	Baseline determined and future improvement target set.	08/2025
Monitoring measure 1.3	Number of findings delivered to primary care partners for quality improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No findings available	1-5 findings delivered to primary care partners	12/2025	1-5 findings delivered to primary care partners	12/2025

Activity 2 description: Oral health outside of dental settings: Analysis of dental services in physical health claims for quality improvement

☐ Short term or ☒ Long term

Monitoring measure 2.1	Number of fluoride varnish claims in physical health for ages 1-5 analyzed for quality improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data not analyzed yet	Data fully analyzed with accompanying findings and progress report	06/2024	Data fully analyzed with accompanying findings and progress report	06/2024
Monitoring measure 2.2	Number of findings delivered to primary care partners for quality improvement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

No findings available	1-5 findings and resources delivered to four (4) provider sites	12/2024	1-5 findings and resources delivered to four (4) provider sites	12/2024
Monitoring measure 2.3	Enhance current oral health services in primary care dashboard to include REALD and SOGI data			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Stratification data (REALD and GI) is available, not currently on the oral health services dashboard	Enhanced dashboard includes REALD and SOGI data	12/2025	Enhanced dashboard includes REALD and SOGI data	12/2025

Activity 3 description: Addressing health disparities: Analysis of dental care requests resulting in a completed dental visit stratified by member race and language.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Dental care request data stratified by race, ethnicity, language, disability, sexual orientation and gender identity is added to data visualizations			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Stratification data (REALD and GI) is available, not currently combined with dental care request data	Stratification data (REALD and SOGI) combined with dental care request data	08/2025	Stratification data (REALD and SOGI) combined with dental care request data	08/2025
Monitoring measure 3.2	Number of dental care requests by race, ethnicity, language, disability, sexual orientation, and gender identity analyzed to identify health disparities			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current analysis of dental care request data by REALD and SOGI	Data fully analyzed by REALD and SOGI	12/2025	Data fully analyzed by REALD and SOGI	12/2025

A. Project title: Project 4: PCPCH Supports

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

If continued, insert unique project ID from OHA: 78

B. Components addressed

1. Component 1: PCPCH: Tier advancement
2. Component 2 (if applicable): PCPCH: Member enrollment
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):

In 2023, the Primary Care Innovation Specialist outreached to the Tier 3 clinics in CPCCO, which were Nehalem Bay and Columbia Health Services to offer technical assistance and support. They also offered the opportunity to engage in a multi-session learning series on Practice Coaching for Primary Care Transformation, which explored best practices and foundational elements in high preforming primary care teams. Columbia Health Services responded to outreach, engaging in the Practice Coaching for Primary Care training (they sent 3 members of their care team) and discussing the best path forward in their attestation process. Their primary support staff who works with PCPCH standards was going on medical leave in 2023, so our Primary Care Innovation Specialist was able to support them in the process of assuring all documents and processes were ready, and they were able to complete a site visit before their leave started. Nehalem Bay did not respond to outreach attempts and in 2023, their PCPCH status lapsed. They are no longer PCPCH recognized. Nehalem Bay accounts for 3% of CPCCO's total membership. All other clinics were Tier 4 or Tier 5. In addition to supporting outreach to the Tier 3 clinics, the Primary Care Innovation Specialist supported Columbia Memorial's Astoria primary care clinic in obtaining 5 Star status, an increase from their previous Tier 4 status. This work was completed through 1:1 technical assistance, meeting with clinics individually online, through phone calls, and in-person meetings to help them better understand the PCPCH standards, how their work aligns with current standards, and helping them to enhance workflows to better meet standards.

With 95% of CPCCO's population ranked Tier 3 or above, the below analyses detail the distribution of our population with more information in terms of race and disability. It is clear in both graphics that most of each population and their subcategories are in Tier 4. There are multiple significant successes reflected in the graphics below. Including the top two Tier 5 categories by race are Afro-Caribbean at 25% and Middle Eastern/North African at 26.87%. These percentages reflect the equitable access and inclusivity that CPCCO continues to strive for. Another significant success for us lies in the distribution of our population with two or more disabilities, with 67.43% ranked in Tier 4 and 17.18% in Tier 5, and the distribution of our population that is hearing only, with 56.29% ranked in Tier 4 and 21.38% ranked in Tier 5. Overall, the majority of CPCCO's population with disabilities is categorized under Tier 4. This is also true when you look at our members based on their language and gender identity. No other meaningful differences by language and gender identity were identified in our analysis.

PCPCH by Race - Aggregated CPCCO

Race(Group)	PCPCH Tier: Not PCPCH R..	Tier 3	Tier 4	Tier 5
Afro-Caribbean	19.44%	5.56%	50.00%	25.00%
American Indian or Alaskan Native	11.53%	4.43%	65.71%	18.33%
Asian	12.63%	4.66%	61.38%	21.33%
Black or African American	11.18%	3.52%	65.08%	20.21%
Hispanic	9.43%	2.07%	68.68%	19.81%
Middle Eastern/North African	10.45%	2.99%	59.70%	26.87%
Native Hawaiian or Pacific Islander	9.47%	2.63%	66.58%	21.32%
Not Provided	13.61%	3.24%	64.34%	18.81%
Other Race or Ethnicity	12.77%	3.91%	65.29%	18.02%
South American	17.86%	4.76%	61.90%	15.48%
White / European	12.33%	3.66%	63.20%	20.82%

PCPCH by Disability - CPCCO

Disability	PCPCH Tier: Not PCPCH R..	Tier 3	Tier 4	Tier 5
2+	11.82%	3.57%	67.43%	17.18%
CognOnly	12.18%	3.45%	65.48%	18.88%
CommOnly	13.43%	4.48%	59.70%	22.39%
Declined'	9.09%	4.90%	67.13%	18.88%
HearOnly	17.30%	5.03%	56.29%	21.38%
IndLiv/SelfCare	12.11%	3.38%	63.99%	20.52%
LearnOnly	2.78%	11.11%	75.00%	11.11%
MHD Only	12.20%	3.66%	64.63%	19.51%
Missing'	11.29%	2.51%	63.57%	22.63%
Non-disabled	11.95%	3.52%	64.26%	20.27%
Not Provided	20.00%	2.33%	59.81%	17.86%
PhysOnly	9.07%	4.12%	68.87%	17.94%
Unknown'	13.43%	2.24%	61.57%	22.76%
VisionOnly	13.61%	2.22%	64.24%	19.94%

We will analyze PCPCH data disaggregated by sexual orientation when it's available. If any disparities or meaningful differences are identified, we will explore the causes and develop a strategic plan as needed.

2. Describe whether last year's targets and benchmarks were met (if not, why):

In 2023, Monitoring measure 1.1 was Outreach to Tier 3 clinics. The target/benchmark for this measure was to outreach to five Tier 3 clinics by 8/2023. This target was met. Monitoring measure 2.1 was to analyze interpretation and language needs. The target for this measure was to complete outreach to non-PCPCH clinics to ensure language interpretation policies and procedures are in place for assigned members by 9/2023. The target was not met due to the reduction in members seen at one clinic and the other two clinics closing. Additionally, we reframed the Meaningful Language Access work in CPCCO because of the remaining issues related to access at our PCPCH clinics.

3. Lessons learned over the last year:

We learned through a substantial evaluation of our focused interventions that due to clinic capacity and status our focus should remain on outreach and technical assistance to increase member enrollment and tier advancement.

D. Brief narrative description

1. **Project population:** Primary Care Clinics in the Columbia Pacific CCO Service Area.
2. **Intervention (address each component attached):**

CPCCO analyzed all elements of REALD & GI data to identify the following gaps and activities.

Activity 1: Nehalem Bay is the largest Primary Care Clinic in the CPCCO service area that is not PCPCH recognized. Nehalem Bay's PCPCH status expired in April 2023, and they have not yet reapplied. Nehalem Bay has 984 members, which accounts for 3% of CPCCO's total population. By supporting Nehalem Bay in re-attesting to PCPCH standards and regaining their certification, CPCCO would have 98% of its membership assigned to a PCPCH clinic (currently 95% of the population is assigned).

Activity 2: The Innovation Team assists clinics with advancing their PCPCH tiers through providing outreach and support around PCPCH standards. This work is performed through individual practice coaching and technical assistance meetings and larger learning collaborative sessions. One-on-one meetings are designed to provide tailored support specific to the clinic's needs. It is where innovation specialists and the clinic can review current tier status, evaluate areas of opportunity, and discuss project implementation for tier advancement. Sometimes one-on-one work involves reviewing PCPCH standards to help clinics identify work that is already happening within their

system that they may be unaware is a practice standard. The new standards taking effect in 2025 will impact our efforts in that clinics have shown hesitancy to attest in 2024, knowing that they will need to attest again in 2025. This may result in lower engagement in 2024 for clinics that need to attest. We will also have a higher number of clinics needing to attest in 2025, given that all clinics will need to attest again. This will stretch clinics and innovation staff as both teams already struggle with competing priorities, and an increased workload on PCPCH attestation will pull focus from other projects.

Activity 3: Learning Collaboratives are a place for the CPCCO network to learn from one another. In these spaces clinics learn about innovative practices happening within their region, can ask questions, and gain insight and ideas on how to improve their practices by those who are doing the work. The Community Health Worker Collaborative that is provided in sponsorship with CareOregon is specifically designed to help clinics advance in a specific practice area. The innovation team attends the sessions to learn alongside the clinics and then follows up to provide one-on-one support in helping clinics to implement goals established in the sessions. This work aligns with PCPCH Standards 5.C-Complex Care Coordination and Core Attribute 6: Person and Family Centered Care (specifically around 6.B Education and Self-Management Support). Part of the collaborative is for clinics to discuss and learn from each other the role and scope of CHWs. As a result, the implementation and application of PCPCH standards may evolve. The innovation team can discuss these topics with clinics during their follow-up meetings.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Supporting CPCCO clinics in increasing PCPCH Member Enrollment through outreach and technical assistance.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of CPCCO clinics that completed their application to be a PCPCH.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Nehalem Bay Clinic (formerly Reinhart Clinic) PCPCH recognition expired 4/12/2023.	Provide at least two outreach attempts and general support to Nehalem Bay to re-apply for PCPCH.	6/2024	Nehalem Bay reapplies for PCPCH.	12/2024

Activity 2 description: Supporting CPCCO clinics in advancing PCPCH Tiers through outreach and technical assistance.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Number of CPCCO clinics that completed attestation for 2025.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
6 Clinic systems will need to attest in 2025 (Columbia Memorial Hospital, Columbia Health Services, Legacy St. Helens, Adventist, OHSU Scappoose, and Tillamook	Provide at least two outreach attempts and general support to clinics, informing them of new 2025 PCPCH standards.	12/2024	All 6 clinics have submitted their attestation.	12/2025

County Community Health Centers).				

Activity 3 description: Supporting Tier Advancement through the CWH Collaborative.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Number of CPCCO clinics that completed the OPCA CHW Collaborative.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2 clinics (Nehalem Bay and Tillamook County Community Health Center) are engaged in the CHW Learning Collaborative.	Nehalem Bay and Tillamook complete the CHW learning collaborative.	6/2024	Nehalem Bay and Tillamook complete the CHW learning collaborative.	6/2024

A. Project title: Project 5: RCT Psych Transitions Tracking

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

If continued, insert unique project ID from OHA: 419

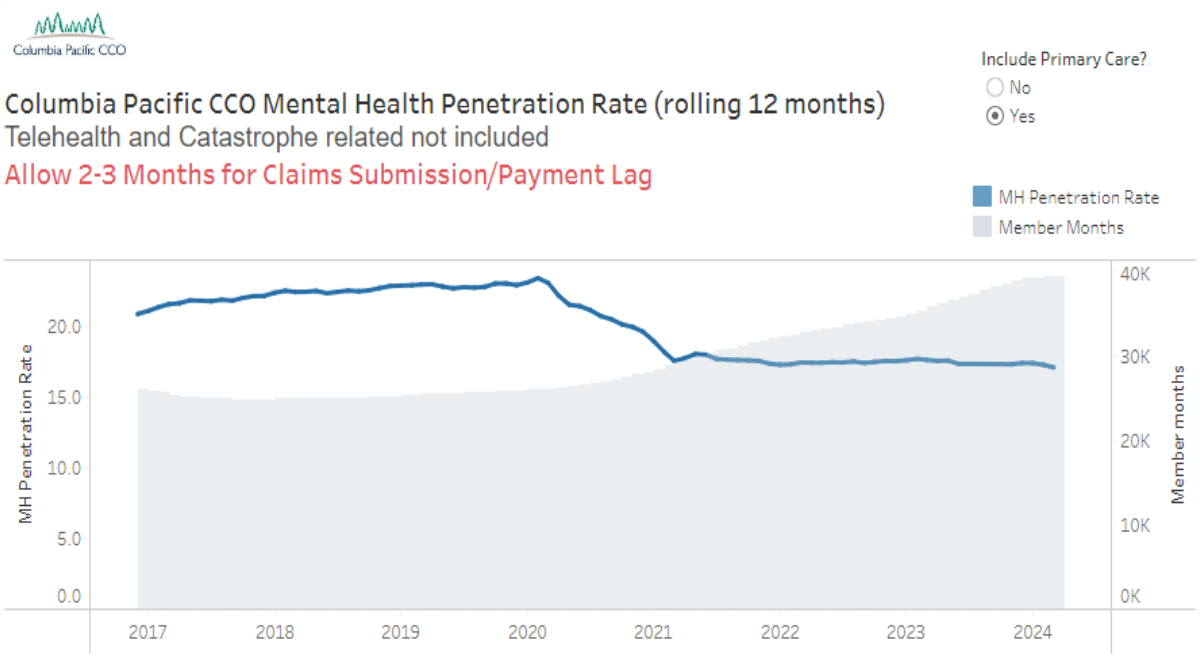
B. Components addressed

1. Component 1: SHCN: Non-duals Medicaid
2. Component 2 (if applicable): Serious and persistent mental illness
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):
Columbia Pacific CCO does not have any psychiatric hospital beds within our service region. Out-of-area hospitalizations increase the risk that members will not receive adequate support as they return to their communities. This has been exacerbated by the stabilizing but still present behavioral health workforce shortage that has impacted our in-area behavioral health providers particularly hard. Self-reported data from each county's Community Mental Health Provider (CMHP) indicates that while things are slowly improving, there still can be a waiting period (for some members) for appointments with individual therapists following discharge from acute care. Tracking of the overall MH penetration rates for 2023 shows that behavioral health utilization by our members remains low at 17%, but importantly has stabilized since the sharp drop in 2020-2021.



Yearly Mental Health Penetration Rate (GOBHI contract ended May 2019)

Timely access to follow-up care after a psychiatric hospitalization, represented through the seven day follow up metric, for our most acute and vulnerable members living with severe and persistent mental illness (SPMI) and special health care needs (SHCN), remains a priority. We aimed to have our data team reconcile three data sources to create an accurate and reliable psychiatric transitions report for those members requiring a seven-day follow-up and coordination on discharge. An additional goal was to have organization specific dashboards that could be shared

directly with providers to identify targeted areas for improvement. The Regional Care Team (RCT), our dedicated care coordination team, has decided to focus efforts and interventions dependent on age and lengths of stay.

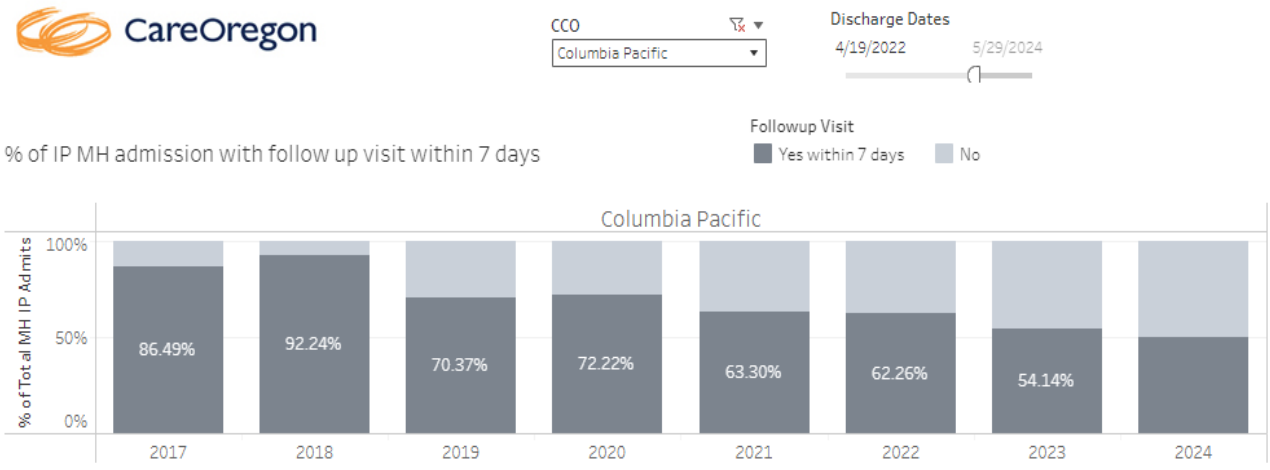
Youth inpatient BH follow-up Interventions:

- RCT utilized PointClickCare cohorts for youth BH Inpatient notifications
- Reviewed multiple data sources to identify current care coordinator involvement and provider involvement to determine if youth already is already being supported in the community
- Assigned an Intensive Care Coordinator when not already followed by BH or if unsure that youth has support
- Utilized ICT meeting for cross-system consult/support/referral considerations
- Continual outreach and care coordination for as long as needed/appropriate to ensure 7-day follow up appointment made

Adults with 3-5 day BH inpatient stay Interventions:

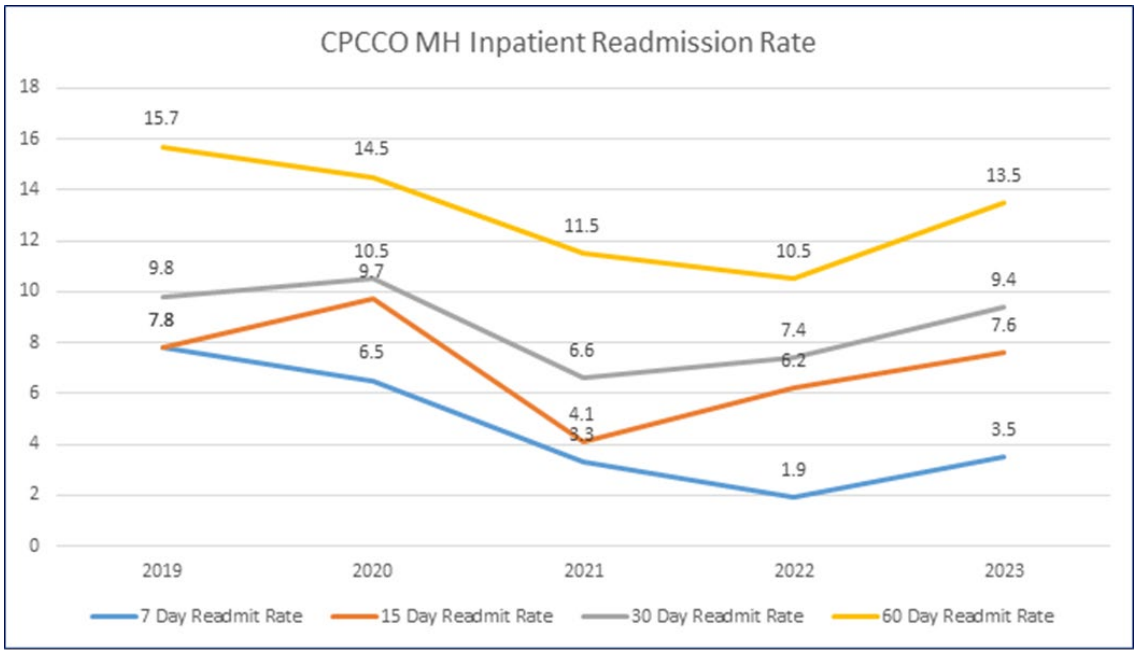
- Dependent on capacity: RCT utilized PointClickCare cohorts for adult BH Inpatient notifications with stays longer than 3 days
- Reviewed multiple data sources to identify current care coordinator involvement and provider involvement to determine if youth already is being supported in the community
- Assigned an Intensive Care Coordinator when not already followed by BH or if unsure that the member has support
- Utilized ICT meeting for cross-system consult/support/referral considerations
- Continual outreach and care coordination for as long as needed/appropriate to ensure 7-day follow up appointment made

Accompanying the drop in overall mental health utilization from pre-pandemic levels is the difficulty members had in completing 7-day follow-up visits post-mental health admission. Between 2019 and 2023, the percentage of members with a 7-day follow post-mental health admission decreased by more than 15 percentage points, including a 6-percentage point reduction in the past year.

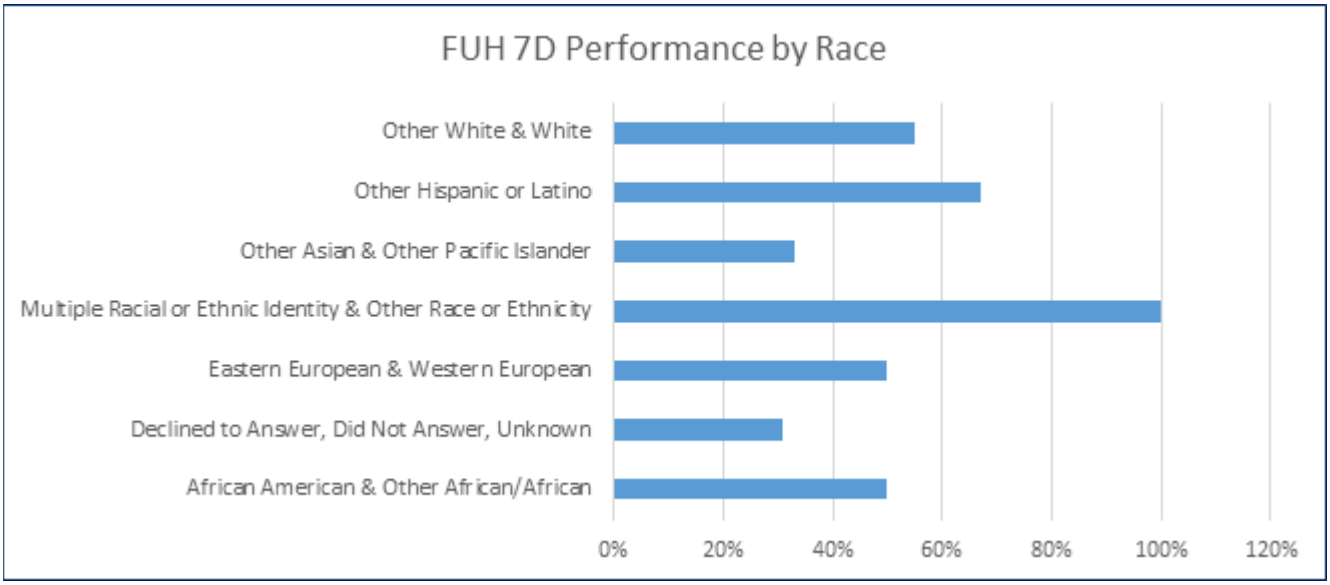


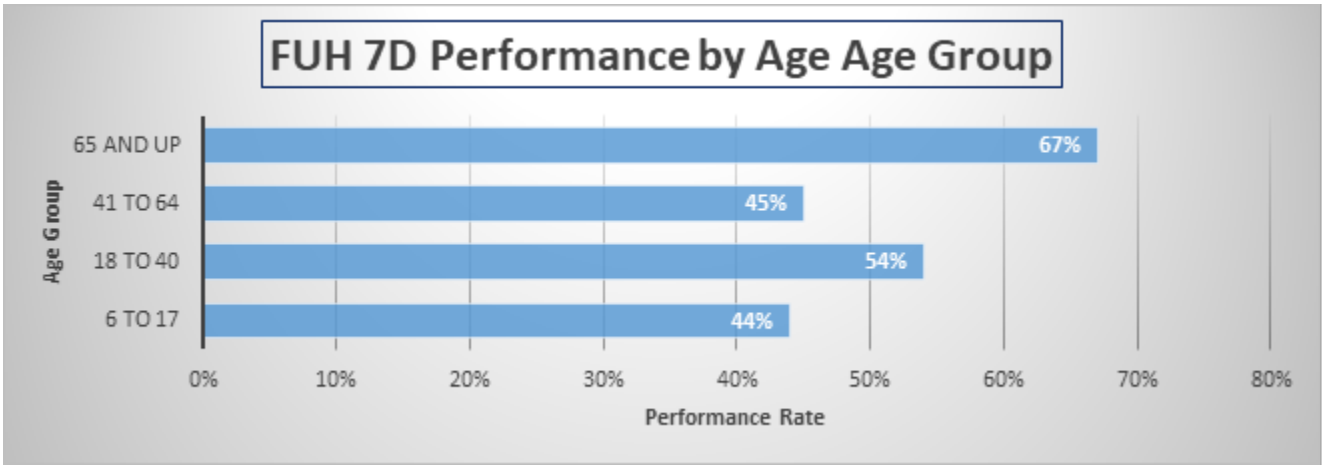
In 2023, 171 CPCCO members were identified as having an inpatient mental health admission according to the 7-day follow up specifications. These two access barriers during the pandemic, we believe, built up unmet member demand. For example, in 2019 we had approximately 75 admissions but by 2023 we had approximately 175 – an 80% increase.

This could be a contributing factor to why we observe increasing rates of mental health inpatient readmissions from 2022-2023, as the following charts will illustrate. The strain of post-pandemic built-up member demand is being felt by healthcare providers nationwide.



Stratification using REALD of mental health admissions with follow-up visit within seven days was completed. Members who identify as Asian or Pacific Islander had a lower rate of follow up than average. 57.1% of female members had a follow up visit within 7 days compared to 42% of males which does represent a meaningful difference by gender. No differences were found by language or disability status. This analysis will be repeated in the future to include sexual orientation data. Results will inform the RCT's approach to working with members on coordinating follow up care and reducing barriers to care.





2. Describe whether last year's targets and benchmarks were met (if not, why):

In 2023, Monitoring measure 1.1: Single, internal data source for 7-day follow-up rate had a target of producing 7-day follow up rates consistently from internal data by 6/2023 and a benchmark of setting improvement targets based on that data source by 8/2023. The first aspect of this target was met; however, the benchmark was not because we had not chosen an improvement target for this measure. While capacity restraints initially prevented the selection of improvement targets, we have since updated our goals in the Activities and Monitoring for Performance Improvement section, specifically under activity 3. Monitoring measure 2.1: 7-day follow-up metric stratification has a target of having the ability to stratify the 7-day follow-up data by REALD by 8/2023 and a benchmark of conducting the stratification analysis by 9/2023. This has been met. An initial analysis is above. Monitoring measure 3.1: Reduce 30-day Mental Health re-admission rate to 6.5%. This was not met. A full analysis of why there was a drastic 2% increase over the last year has not been completed so we have not been able to identify the causes.

3. Lessons learned over the last year:

Through the pandemic years we saw a reduction in readmission rates overall however, the rate in all categories rose from 2022 to 2023. Transition interventions used throughout the care coordination process include understanding the cause of the readmission, providing member-specific education about red flags, which are explained as warning signs or symptoms that indicate the member's condition is worsening and could result in ED visits or hospital readmission. The RCT's overall capacity to actively track all inpatient admits decreased thus requiring the team to focus efforts on specific populations or lengths of stay. See further explanation, below. This shift may or may not have impacted the rates. Access to mental health services in the region has also decreased and although great effort is being put into this, we have yet to see access increase.

D. Brief narrative description

1. **Project population:** Members with an inpatient admission with a mental health diagnosis.
2. **Intervention (address each component attached):**

Transitional care is a core function within our care coordination services. Hospital discharge is a complex process representing a time of significant vulnerability for members. Due to this, transitions support is currently provided to all CPCCO members experiencing psychiatric hospitalization. This work reflects best practice in member care, improves health outcomes, and has been demonstrated to support meaningful reductions in readmission rates.

Members who are admitted to inpatient acute care are screened by one of our intensive care coordination (ICC) team members. ICCs help connect members to the most appropriate care coordination team and ensure that

members receive a follow-up appointment with a new or established behavioral healthcare provider. Care Coordinators on the ICC and Regional Care Teams (RCTs) are uniquely positioned and trained to access health plan supports for both clinical and social needs concerns. They can assist members in accessing care through coordination of services with the provider and they also can access CCO resources such as the HRSN benefit, NEMT and housing supports in order to address social needs barriers to seeking and receiving follow up care. Care Coordinators work with the members to access care in a way that is member-centered and respects client autonomy by helping choose locations and providers that meet the client's self-identified needs. Connecting members to community-based services aims to help them receive care in more integrated and whole-person care focused settings and prevent additional, future mental health related hospitalizations. Two populations of focus receive specialized workflows.

For members who are youths, the RCT utilizes PointClickCare cohorts for youth BH inpatient notifications. They review multiple data sources to identify current care coordinator involvement and provider involvement to determine if the youth is already being supported in the community. If the member is not already followed by a behavioral health provider or if the level of support is unclear, they will be assigned an Intensive Care Coordinator. Additionally, Interdisciplinary Care Team meetings are utilized for cross-system consultation, support and referral considerations. The assigned care coordinator will continue to engage with the member and conduct outreach for as long as needed/appropriate to ensure the follow up appointment(s) are made.

For adult members with 3–5-day BH inpatient stays, engagement is dependent on capacity of the RCT. The RCT utilizes PointClickCare cohorts for adult BH Inpatient notifications with stays longer than 3 days. They review multiple data sources to identify whether the member has current involvement with a care coordinator already is being supported in the community. An Intensive Care Coordinator is assigned when the member is not already followed by a behavioral health provider or if the level of support is unclear. Additionally, Interdisciplinary Care Team meetings are utilized for cross-system consultation, support and referral considerations. The assigned care coordinator will continue to engage with the member and conduct outreach for as long as needed/appropriate to ensure the follow up appointment(s) are made.

In addition to ongoing care coordination interventions, CPCCO will conduct an analysis to determine the root causes of the 2% increase in 30-day readmission rates that was seen between 2022 and 2023. The results of this analysis will be used to identify potential changes and/or new interventions to help address this outcome.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Explore 30-day Readmission data to identify root causes for the increase in readmissions.

☒ Short term or ☐ Long term

Monitoring measure 1.1	30-day Readmission Rate			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Analysis of the 30-day readmission rate from 2022 to 2023 has not been completed	Initial analysis of the 2% jump in readmission rate	09/2024	Develop interventions to impact 30-day readmission rate	12/2024

Activity 2 description: Ensure seven day follow up can be stratified by REALD and SOGI to review for equity and access implications. Completion of initial analysis to identify any current trends in impacts based on REALD.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Completion of 7-day follow-up metric stratification			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data has been stratified	Validate 7 day follow up data and re-perform the analysis using the new REALD & GI repository data source for more granular results.	08/2024	Complete analysis, including sexual orientation data in the stratification analysis upon availability from OHA.	10/2024

Activity 3 description: Utilize Regional Care Team and Intensive Care Coordination Processes to improve health outcomes for members experiencing hospitalization for mental health conditions

☒ Short term or ☒ Long term

Monitoring measure 3.1	7 day follow up (this is our short-term health outcome/process measure)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 Baseline Rate: 54.1%	57.1%	12/31/2024	2023 Medicaid National Average	12/31/2025
Monitoring measure 3.2	30-day mental health re-admission rate			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
9.4%	9.0%	12/2024	7.0%	12/31/2026

A. Project title: Project 6: Vulnerability Framework and Rapid Access Care Planning

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

If continued, insert unique project ID from OHA: 502

B. Components addressed

1. Component 1: SHCN: Full benefit dual eligible
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):

In 2023, CPCCO launched a Regional Care Team (RCT) focused on the dual eligible population. After intense recruitment, training, and onboarding, member empanelment gained momentum in July-August 2023. Care Coordinators leveraged Rapid Access Care Plan data, in addition to Health Risk Assessment Tool results, claims data, and event notifications in their risk stratification work. In November, CPCCO transitioned care coordination software platforms from GSI to Epic Compass Rose. Adopting Epic required us to rebuild workflows and reports, which also gave us a chance to refine how the dual RCT works with members, set new documentation expectations, and begin to identify new quality and process improvement opportunities.

CPCCO and CareOregon's implementation of Epic Compass Rose has been a success. All care coordination staff work from Compass Rose as their foundational workflow and documentation system. Enhancements are ongoing, as expected from any new transformation. One relevant limitation we are currently working through is data availability. Given the incredibly tight timeline that we had to bring Epic online, the rebuilding of many key reports is expected to continue through 2024. Simultaneously, the background data system architecture is going through a complete redesign and modernization. We will analyze data disaggregated by sexual orientation when it's available as well. If any disparities or meaningful differences are identified, we will explore the causes and develop a strategic plan as needed.

Age

In 2023, the top adult age groups in CPCCO are 55-64 and 65-74, collectively representing 64% of the population. Comparing the 2022 and 2023 populations, we observe a meaningful shift in proportionality in the 75-89 age group (decreasing from 23% in 2022 to 12% in 2023) and in the 55-64 age group (increasing from 18% in 2022 to 25% in 2023). As Medicaid redeterminations continue in 2024, there is the possibility of observing another shift in age group proportions next year.

Age	Percentage of Population - 2023	Percentage of Population - 2022
90 and older	1%	2%
75 to 89	12%	23%
65 to 74	39%	36%
55 to 64	25%	18%
45 to 54	10%	9%
35 to 44	7%	7%

25 to 34	6%	5%
19 to 25	1%	1%

REALD & GI Data

In 2023, 244 members met the criteria for most vulnerable D-SNP members. The most vulnerable cohort was disaggregated by REALD and Gender Identity. 50% of the members in this cohort have at least one disability, which aligns with expectations given the criteria for inclusion. Over 95% of cohort members are English speaking but there are a small number of Spanish speakers which highlights the need for the RCT to utilize bilingual staff and be well-trained in the use of interpreters. Finally, more than 85% of gender identity data was missing which makes it difficult to draw meaningful conclusions from this data.

Disability Status	Percentage of Cohort
2+ Disabilities	8.20%
Cognitive Disability	3.28%
Hearing Disability	0.82%
Independent Living/Self Care Disability	25.00%
Mental Health Disability	0.82%
Non-Disabled	49.59%
Physical Disability	3.28%
Vision Disability	0.82%
Missing or Unknown	8.2%
Primary Spoken Language	**Percent of Cohort**
English	95.90%
Spanish	1.64%
Missing Data	2.46%
Gender Identity	**Percent of Cohort**
Boy, Man	5.33%
Girl, Woman	9.02%
Missing Data	85.66%

Race/Ethnicity

Data completeness improved from 75% to 96% from 2022 to 2023 which represent substantial gains. CPCCO notes multiple shifts in the percentage of the population that identifies as Asian and White/Caucasian. See table, below. When available, the RCT considers race/ethnicity when discussing options with a member, including their preferences for a Primary Care Provider (PCP).

Race/Ethnicity	Percentage of Cohort - 2023	Percentage of Cohort - 2022
American Indian/Alaska Native	3%	Not Collected
Asian	2%	15%
Black/African American	2%	4%
Latino/a/x/e	4%	5%
Multi/other	1%	Not Collected
White/Caucasian	84%	51%
Not provided	4%	25%

2. Describe whether last year's targets and benchmarks were met (if not, why):

Monitoring measure 1.1 Percent of identified members who have a Rapid Access Care Plan (RACP) developed in 2023:

- Target/Future State: 50% of identified members have an RACP created
  - Status: Met by target date of 07/2023
- Benchmark/future state: 100% of identified members have an RACP created
  - Status: Met by Benchmark date of 07/2023

Both objectives were met in 2023. RACPs were created and stored as discrete profiles for each MOC (Model of Care) Most Vulnerable member. This made loading RACP profiles into Compass Rose more direct when we transitioned away from GSI. This important information was a priority for us to get it into the hands of our Care Coordinators.

Completed RACPs are used to inform the development of 100% of care plans for MOC Most Vulnerable cohorts. Below is a screenshot of how an RACP is displayed to a Care Coordinator in Epic Compass Rose. Note in the left-hand column how our MOC risk types are cascaded to front line staff and emphasized. Last year, we highlighted how risk types are central to our identification and risk stratification approach.

Rapid Access Care Plan

Flowsheet Row	Documentation from [redacted] in Care Coordinated Organization Enrollment with Co Racp
Access Risk Care Plan	
Goal 2	Member has access to access to appropriate health care services to support their needs
Clinical Risk Care Plan	
Problem	Member risk related to access of health care services - cognitive and/or physical barriers
Intervention	Referral for In Home services and/or primary or specialty care
Social Risk Care Plan	
Problem 2	Member risk related to access to care in preferred language
Goal 2	Member has access to services and materials in preferred language and/or access to interpreter services
Intervention 2	Assess for member having adequate access to culturally appropriate care

For 2024, CPCCO is adopting a new measure that builds on the success of the RACP approach in 2023, which focused on ramping-up operations, staffing, and systems.

Percentage of MOC Most Vulnerable cohorts that received coordination.

a. As detailed in our MOC, the cohort of MOC Most Vulnerable members is regularly refreshed. In addition to updating the care plan with RACP information, we are adding the care coordination intervention as a target activity. This intervention will be documented in the member's care plan.

Monitoring measure 1.2, Percent of members' Rapid Access Care Plans have been actively updated:

- Target/Future State: 25% of identified members with an RACP have been actively updated by their assigned care coordinator
  - Status: Not met by target date of 07/2023

- Benchmark/future state: 50% of identified members with an RACP have been actively updated by their assigned care coordinator
    - Status: Met by Benchmark date of 12/2023

The July 2023 target of 25% of members having an RACP updated by their assigned care coordinator was not met. Due to the need to staff the new RCT, we did not have enough care coordinator FTEs to update the necessary number of members' RACPs during Q1-Q2 2023. However, the December 2023 benchmark of 50% was met and exceeded. By the close of 2023, 100% of MOC Most Vulnerable-identified members had their RACPs updated. Notably, this level was achieved despite our transition of care coordination software platforms to Epic Compass Rose starting in November.

CPCCO attempted to identify any differences between members who had an updated RACP by the end of 2023 and those members who did not have an updated RACP by the end of 2023 through the lens of REALD data. However, the sample sizes were too low for any findings to be generalizable to either group. If any disparities or meaningful differences are identified, we will explore the causes and develop an intervention plan as needed.

For 2024, CPCCO is adopting a new measure that builds on the success of the RACP approach in 2023, which focused on ramping-up operations, staffing, and systems.

Panel sizes of RCT care coordinators who are working with MOC Most Vulnerable-identified members.

b. In 2023, the newly formed RCT had a baseline panel size of 50 actively engaged members. For 2024, we are connecting panel size targets to our population management strategy. By July 2024, we will establish a target for the number of members empaneled needed to achieve plan goals, and by December 2024 we will begin implementation of the panel size expansion project.

Monitoring measure 2.1, Percent of members with social risk who receive an accompanied service (Unite Us referral, connection to Papa Pals, or food services through Mom's Meals or member OTC card):
Due to the complexity of the various sources for 2.1, this breakdown was not feasible at this time. The Business Intelligence team is actively working on creating a source table for these various programs, with the hope of accurately reporting this in the future. Because of this limitation, CPCCO is unable to evaluate this measure using REALD data.

For Activity 2 in 2024, Monitoring Measure 2.1 will focus on increasing the number of accepted referrals to Advanced Illness Care (AIC) programs. The baseline is 3-5 members are evaluated for referral by the AIC referral workgroup every month. By July 2024, we will establish the baseline number of accepted AIC referrals and formalize and refine referral criteria. By December 2024, we will increase the number of accepted AIC referrals by 25%.

Monitoring measure 2.2, Member engagement with PCP or other specialty services:

- Target/Future State: 50% of members identified will have a PCP or Specialty Care visit
    - Status: Met by target date of 07/2023
- Benchmark/future state: 80% of members identified will have a PCP or Specialty Care visit
    - Status: Met by Benchmark date of 12/2023

The Target of 50% of members identified will have a PCP or Specialty Care visit by 07/2023 was met, as was the Benchmark of 80% of members with access or social risk receive a targeted service/intervention from their RACP. The final total reach in 2023 was 89.8% of members reached.

CPCCO attempted to identify any differences between those members who were seen by a PCP and those who were not seen by a PCP in 2023 through the lens of REALD data. However, the sample sizes were too low for any findings to be generalizable to either group.

The intent of the 2023 Monitoring Measures 2.1 and 2.2 was to place an emphasis on the importance of coordination with wraparound services and provider care. For Activity 2 in 2024, we will adopt a measure that captures both social risk referrals and provider engagement. That measure is the percentage of members with a completed, qualifying face-to-face (f2f) encounter in the past 12 months, or else have declined engagement or are unable to be reached. The f2f encounter is a cornerstone intervention of our MOC, and more completely captures the breadth of possible care coordination interventions. In 2023, approximately 50% of all CareOregon Advantage (COA) members had a f2f encounter in the previous 12 months. Our goal is to increase that percentage to 75% by July 2024 and to 100% by December 2024.

Monitoring measure 3.1, Medication adherence for improved disease management:
CPCCO's 2023 target for this measure was to achieve a 2% improvement over the previous year's adherence measure for prescribed renin angiotensin system antagonists (RASA), statins, and diabetes medications. Overall, we ended the year short of the target, achieving a 1% average improvement across all three measures.

The final performance was as follows:

- 2023 RASA adherence rate Target = 88%. End of year performance = 87%.
- 2023 Statin adherence rate Target = 89%. End of year performance = 87%.
- 2023 Diabetes adherence rate Target = 89%. End of year performance = 88%.

CPCCO attempted to identify any differences between these three measures through the lens of REALD data. However, the sample sizes were too low for any findings to be generalizable.

For 2024, we will continue to focus on improving medication adherence for these same three medications. By December 2024, we are targeting a 2% improvement over 2023 performance, and by December 2025 we are targeting a 2% improvement over 2024 performance.

Monitoring measure 3.2, Avoidable ED Visits:
Due to issues with data availability from transition of documentation systems, we are not able to determine a baseline to which 2023 performance could be compared. However, thanks to our work in 2023, we established a 2023 baseline for comparing 2024 performance and intend to continue this improvement project into 2025. In 2023, 22.2% ED visits were caused by avoidable, ambulatory-sensitive conditions.

That is our starting benchmark for 2024. By December 2024, we will target a 5% reduction in avoidable ED visits vs. expected. By December 2025, we will target a future state of a 7% reduction in avoidable ED visits vs. expected.

CPCCO attempted to identify any differences between those members who had an avoidable ED visit and those who did not have an avoidable ED visit in 2023 through the lens of REALD data. However, the sample sizes were too low for any findings to be generalizable to either group.

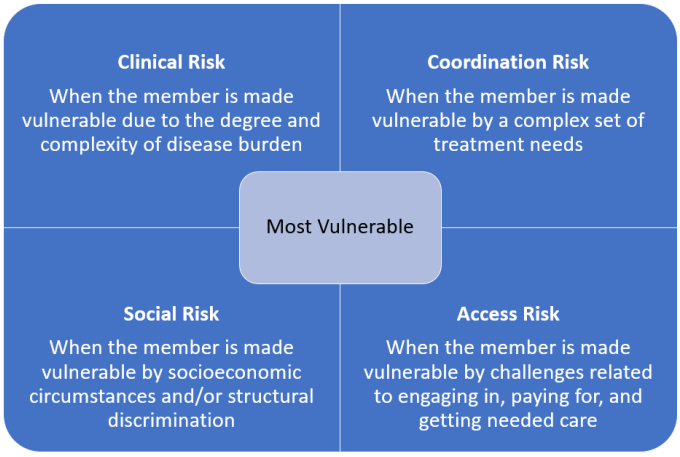
3. Lessons learned over the last year:
While we have multiple teams prioritizing and engaging in this work, the greatest learning was the overall need for more dedicated IS resources and the need for a dashboard. The complexities of the numerous data sources proved to be a challenge and required additional oversight to ensure alignment and communication for the final product. MOC

D. Brief narrative description

1. **Project population:**
CareOregon Advantage (COA), CPCCO/CareOregon's Medicare Advantage Plan, defines vulnerability as a state of increased need, often imposed on members by circumstances outside their direct control. It places them at increased risk of ineffective medical treatment and/or poor health outcomes. This state of member vulnerability

requires additional health plan resources and focused support as we work to achieve COA's mission of making health care work for everyone. COA and CPCCO directly collaborated on project design, data sharing, and measurement implementation through our comprehensive governance structure known as CareOregon Quality Health Outcomes Committee (COQHO) to support this mission. This governance structure includes representation from both teams, ensuring integrated and cohesive project management.

Last year's TQS report highlighted our member risk stratification methodology. Briefly, we define the sickest and most vulnerable members as those with clinical risk accompanied by at least one additional risk (social risk, coordination risk, or access risk).



Applying this risk stratification method to the full COA population, Rapid Access Care Plans were developed. Members were divided into four overall risk categories: High Risk, Rising Risk, At-Risk, and Healthy.

Risk Category	Description of an Example Population
High Risk (5%)	• Complex patients • Multiple comorbidities • Palliative care; Frail elderly
Rising Risk (20%)	• Chronic disease • Heart failure, COPD, ERSD, diabetes with end-organ disease • Active oncology treatment • Frequent ED utilization for non-emergent needs
At-Risk (40%)	• Moderate care needs • Acute episodic care • Tobacco use; obesity; sedentary lifestyle
Healthy (35%)	• Healthy, no risk • Maintenance activities • Routine testing

To begin the program, a cohort of 3,500 COA members (21%) was targeted, which were referred to as the MOC Most Vulnerable population. Being the first year of program approval, 2023 was spent building the infrastructure needed to implement the core elements of the care coordination model that would support these members.

According to the appropriate intervention, each member is assigned to an Intensive Care Coordinator (ICC) who maintains a caseload tailored to their needs. Depending on the need, the member may be assigned to ICCs specializing in physical health, behavioral health, or social health. This ICC is the single point of contact for the member.

As discussed in Monitoring measure 1.2, above, hiring and onboarding the COA-specific Regional Care Team (RCT) was a barrier to outreaching the target number of members to update their Rapid Access Care Plans as planned. In part due to this limitation, the priority Most Vulnerable population was further subdivided to a roster of 550 members. By the end of 2023, 100% of this first priority group had received care coordination outreach and had their care plans updated. CPCCO analyzed all elements of REALD GI data to identify gaps by these different characteristics, finding none, due to the data limitations previously discussed.

Adding to this complexity, CPCCO transitioned care management platforms from GSI to Epic Compass Rose under an uncommonly tight timeline. Newly hired care coordination staff were onboarded to one set of workflows and documentation guidelines, and then had to re-learn all of that for Epic go-live in November 2023. Reporting was also similarly affected. All care coordination dashboards and reports had to be rethought and rebuilt. As of this writing in Q2 2024, that work continues. Long term, CPCCO sees our adoption of Epic as an opportunity to better integrate payer operations, our clinical network, and the state Clinical Information Exchange (CIE).

As essential operations were established, our focus expanded in the second half of 2023 to include clinical performance improvements. We began developing a performance improvement dashboard to be used by our clinical quality governance bodies to guide project work. We launched our ED utilization project, and we also partnered with our Pharmacy Team to intervene on medication adherence. We look forward to continuing this momentum in 2024.

2. **Intervention (address each component attached):**

The illustration below combines the risk types in a visual demonstrating the relationship between the most vulnerable members, their demographics, and anticipated unique clinical interventions. To meet the needs of our most vulnerable population we have designed special services, staff training, and care planning activities.

Risk Category	Description of an Example Population	Anticipated Interventions
High Risk (5%)	• Multiple complex comorbidities • Frail elderly • Trauma care	• Intensive Care Coordination • AIC/palliative care
Rising Risk (20%)	• Chronic disease • Heart failure, COPD, ERSD, advanced DM • Active oncology treatment • Frequent ED utilization for non-emergent needs	• Intensive Care Coordination • Avoidable ED utilization outreach • In-home primary care options • COPD program • Health-Related Service Flex Funds (Medicaid benefit)
At-Risk (40%)	• Moderate care needs • Acute episodic care • Tobacco use, DM, HTN, CAD, asthma • Managing surgical admissions and follow-up	• Navigation • Medication adherence • Papa Pals social support
Healthy (35%)	• Healthy, little-to-no risk • Routine testing • Maintenance activities	

For 2024, we have selected Activities that build on and expand our 2023 achievements, with a preference for Monitoring measures that reflect and incorporate the full breadth of work and staff types. The new activities and monitoring measures reflect our desire to continuously improve outcomes for members, with an emphasis on work that deepens integration across the care continuum.

Activity 1: Engagement of prioritized members with care coordination services
In 2024, Activity 1 focuses on growth. We believe that reaching more members is an important target for the health of our population. The process starts by engaging members, offering care coordination services, and ultimately increasing the number of members actively empaneled.

Activity 2: Engagement in appropriate services as identified in Rapid Access Care Plans (RACPs), HRAs, or other means.
On the outcomes side we have decided to focus on members who may benefit from palliative care support. According to our analysis of Rapid Access Care Plan issue data and the utilization patterns of existing palliative care programs, we feel there is an opportunity to increase member participation.

On the process side, we will be looking at the percentage of members who completed a face-to-face encounter with a qualifying provider, because this measure better encompasses the interdisciplinary continuum of care available to our members. A qualifying provider is defined by our Model of Care as a physician, nurse, social worker, care coordinator, dentist, PT/OT, community or traditional health worker, and other roles.

Activity 3: Improve health outcomes of the most vulnerable population
CPCCO was pleased with the progress made in 2023 on these two quality improvement projects. The work in 2024 will be to build on that success. Avoiding unnecessary ED utilization will remain a cornerstone intervention for its value in indicating multiple different dynamics, from member health literacy to PCP access. CPCCO also will focus on helping members remain stable on prescribed medications, given the role that prescribers play in transitions of care and chronic disease management.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Engagement of prioritized members with care coordination services.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Percentage of MOC Most Vulnerable cohorts that received coordination.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
By the end of 2023, 100% of the MOC Most Vulnerable First Focus Group cohort had received care coordination outreach.	100% of Q1 and Q2 MOC Most Vulnerable cohorts will receive care coordination outreach to (a) update their care plan and (b) offer care coordination services	07/2024	100% of Q3 and Q4 MOC Most Vulnerable cohorts will receive care coordination outreach to (a) update their care plan and (b) offer care coordination services	12/2024
Monitoring measure 1.2	Panel sizes of RCT care coordinators who are working with MOC Most Vulnerable-identified members.			

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Baseline is 50 active members per individual panel	Establish a target for the number of members empaneled needed to achieve SNP plan goals	7/2024	By the end of 2024, we will have begun implementation of the panel size expansion project	12/2024

Activity 2 description: Engagement in appropriate services as identified in Rapid Access Care Plans (RACPs), HRAs, or other means.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Number of accepted Advanced Illness Care (AIC) referrals.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently, 3-5 members are evaluated for referral by the AIC referral workgroup every month	Establish a baseline for number of accepted AIC referrals and formalize and refine referral criteria	07/2024	Increase the number of accepted AIC referrals by 25%	12/2024
Monitoring measure 2.2	The percentage of members with a completed, qualifying face-to-face (f2f) encounter in the past 12 months, or else have declined engagement or are unable to be reached.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
As of December 2023, approximately 50% of all COA members met the goal	75% of COA members will have had a f2f encounter in the past 12 months	07/2024	100% of COA members will have had a f2f encounter in the past 12 months	12/2024

Activity 3 description: Improve health outcomes of the most vulnerable population

☐ Short term or ☒ Long term

Monitoring measure 3.1	Percentage of avoidable ED Visits.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 baseline = 22.2% are avoidable ED visits	5% lower than expected avoidable ED visits	12/2024	7% lower than expected avoidable ED visits	12/2025
Monitoring measure 3.2	Percentage improvement with medication adherence for disease management.			

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
By the end of 2023, achieved 1% improvement over 2022 performance	2% improvement over 2023 performance for: • RASA • Statins • Diabetes	12/2024	2% improvement over 2024 performance for: • RASA • Statins • Diabetes	12/2025