OHA Transformation and Quality Strategy (TQS) 2024

CCO: Jackson Care Connect

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Contents

Section 1: Transformation and quality projects

A. Project title: Project 1: Hospital Based SUD Navigator

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

If continued, insert unique project ID from OHA: 511

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.

Continued project

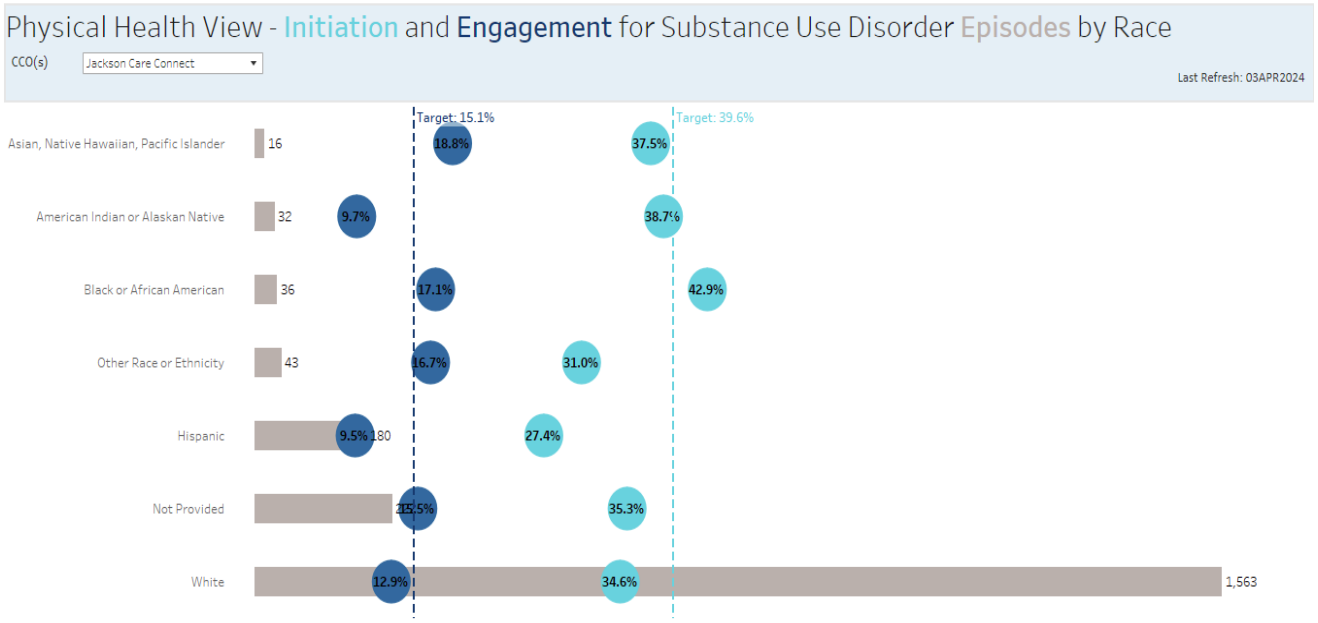
1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

Jackson Care Connect held several joint meetings with Asante and Providence teams in early 2023 to ensure alignment around the Navigator model and ongoing points of cross-system collaboration. Additional meetings with each hospital occurred as needed to check recruitment status and support braided funding asks.

Jackson Care Connect renewed the $70,000 contract with both Asante and Providence effective through December 2024 (a total $140,000 investment by JCC). In 2023, Jackson County (DHHS) agreed to support the project as a second funder and contributes $30,000 for each SUD Navigator position. Asante hired their SUD Navigator in summer 2023. Providence was unable to fill the position before the end of 2023 but has since hired and trained a navigator.

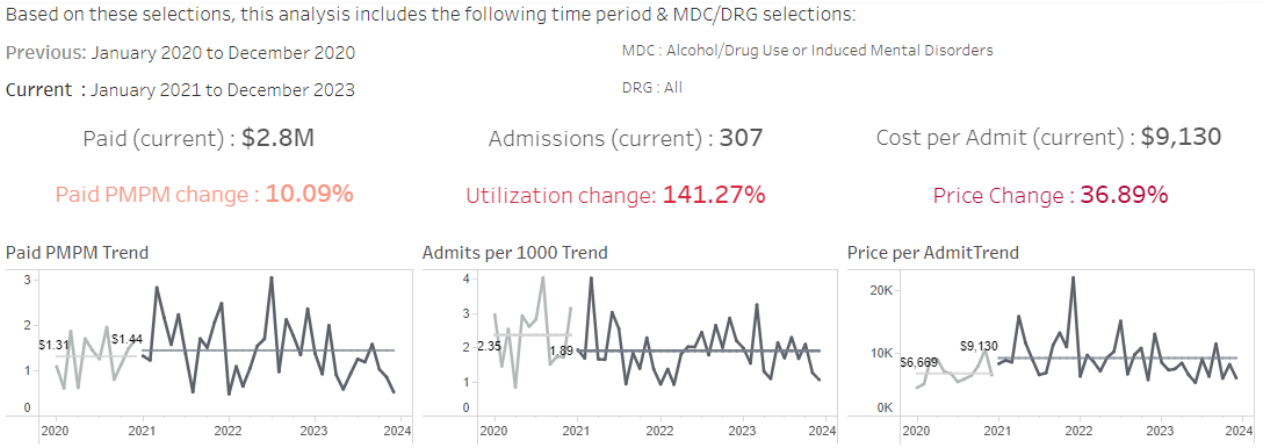
As of Q1 2024, Asante's navigator has met with 209 patients, providing assessments and coordinating critical connections to care. Both Navigators attend a monthly regional SUD meeting and the Local Alcohol and Drug Planning Council to provide updates and collaborate to maximize the position's impact in our region. Stakeholder feedback is very positive about the navigator position. The position has exceeded expectations in terms of volume of services provided and SUD care coordination from the ED to the most appropriate community-based level of care.

JCC analyzed the Initiation & Engagement metric by REALD & GI to identify disparities in which members are accessing SUD treatment. The results showed that American Indian and Alaskan Native members were less likely than other groups to initiate treatment in a timely manner but were more likely to meet the requirements for engagement. Additionally, Hispanic members were less likely to both initiate and engage in treatment which indicates that there could be additional barrier faced by this population including but not limited to language barriers. This is supported by the finding that Spanish language speakers also had lower than average initiation and engagement rates. Meaningful differences by gender were not identified although data completeness issues impacted this analysis. JCC members with cognitive or mental health related disabilities and those with two or more disabilities also had lower initiation and engagement rates. SUD navigators can be particularly effective in supporting individuals with disabilities because they offer assistance in navigating a complex system; they review/explain available services and provide warm referrals to resources. In future years, JCC will repeat this analysis to include sexual orientation as another demographic. This can help us determine whether the navigators are providing culturally competent services to LGBTQIA2S+ members.



We are disaggregating data by race and ethnicity because it is a proxy for institutional racism and structural inequities. We acknowledge that our data and this method of analysis is imperfect. However, we believe that it is a critical step to understanding how institutional racism and structural inequities impact individual and community health outcomes. When using this data, keep structural factors at the forefront and be resistant to using messages of individual responsibility or community deficiency to explain the results.

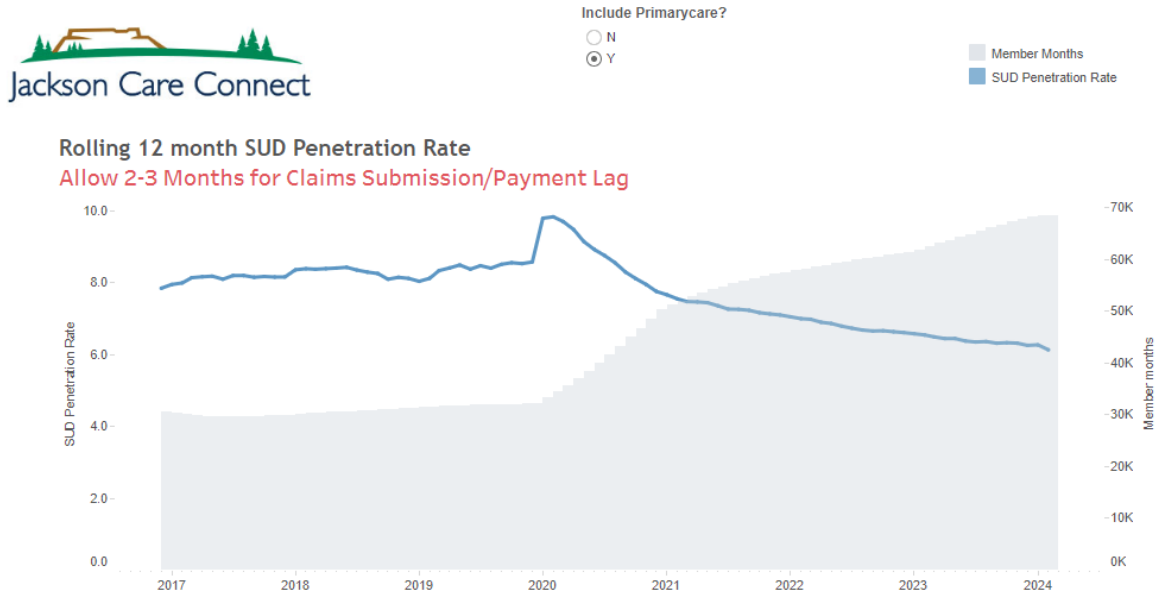
The graph below shows that overdose and substance use-related hospital visits continue in an upward trend in 2023, and like previous reports, member utilization of treatment services has decreased. This data reinforces the importance of the Hospital-based SUD navigator program as a mechanism to intervene while members are in the hospital and help connect them to appropriate SUD treatment. See corresponding inpatient admission and utilization data below.



Comparison between the selected **current** and **previous** time period with **highest Paid PMPM increase** by different stratifications

Major Diagnostic Category (MDC) Click on any cell below to filter DRGs and Facilities by MDC

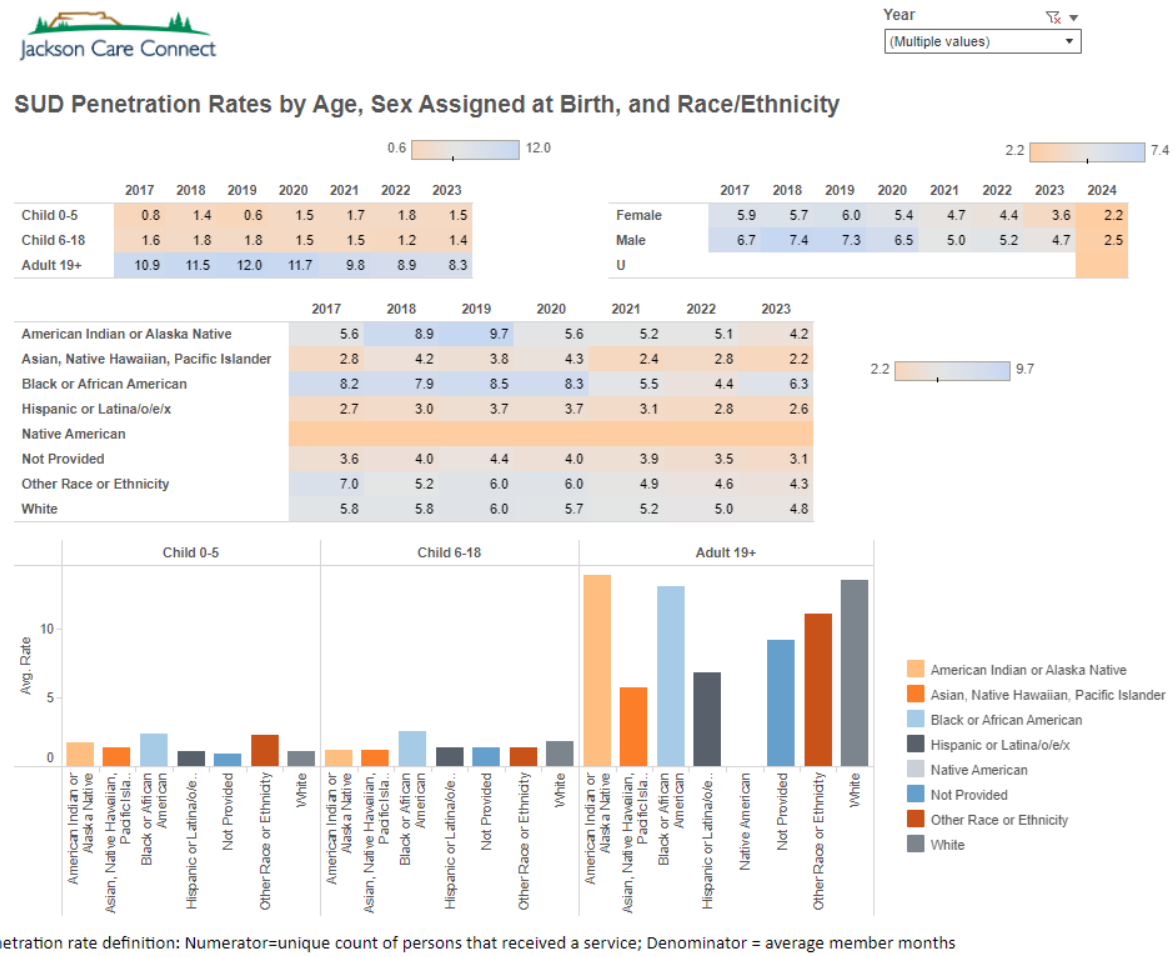
	Previous					Current				
MD Ccategory	Admissions	Paid	Admits per 1000	Price per Admit	Paid PMPM	Admissions	Paid	Admits per 1000	Price per Admit	Paid PMPM
Alcohol/Drug Use or Induced Mental Disorders	108	$720,297	2.35	$6,669	$1.31	307	$2,802,889	5.68	$9,130	$1.44



SUD Penetration Rate Yearly

Year	
2018	8.1
2019	8.6
2020	7.7
2021	7.1
2022	6.6
2023	6.2
2024	9.6

Penetration rate definition: Numerator=unique count of persons that received a service; Denominator = average member months



	2017	2018	2019	2020	2021	2022	2023
Child 0-5	0.8	1.4	0.6	1.5	1.7	1.8	1.5
Child 6-18	1.6	1.8	1.8	1.5	1.5	1.2	1.4
Adult 19+	10.9	11.5	12.0	11.7	9.8	8.9	8.3

	2017	2018	2019	2020	2021	2022	2023	2024
Female	5.9	5.7	6.0	5.4	4.7	4.4	3.6	2.2
Male	6.7	7.4	7.3	6.5	5.0	5.2	4.7	2.5
U								

	2017	2018	2019	2020	2021	2022	2023
American Indian or Alaska Native	5.6	8.9	9.7	5.6	5.2	5.1	4.2
Asian, Native Hawaiian, Pacific Islander	2.8	4.2	3.8	4.3	2.4	2.8	2.2
Black or African American	8.2	7.9	8.5	8.3	5.5	4.4	6.3
Hispanic or Latina/o/e/x	2.7	3.0	3.7	3.7	3.1	2.8	2.6
Native American							
Not Provided	3.6	4.0	4.4	4.0	3.9	3.5	3.1
Other Race or Ethnicity	7.0	5.2	6.0	6.0	4.9	4.6	4.3
White	5.8	5.8	6.0	5.7	5.2	5.0	4.8

Penetration rate definition: Numerator=unique count of persons that received a service; Denominator = average member months

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

In 2023, there were three monitoring measures for this project. For monitoring measure 1.1 Hospital SUD navigator braided funding support model, we planned to develop recommendations for a sustainable braided funding model by April 2023 and have a sustainable braided funding model with Jackson County HHS, CCO and hospital support by May 2023. Both the target and benchmark were met and contracts to support the project were signed to ensure funding for 2024. For monitoring measure 1.2 Hospital SUD navigator partnership model, we planned to coordinate the hiring and onboarding within the partnership model by July 2023 and have the SUD navigators working across systems by September 2023. These targets were partially met, with the Asante SUD navigator successfully hired, onboarded and operating in their role on target. The process with Providence hospital progressed more slowly; there had been a navigator hired for the 2nd role in Q3 of 2023, but that person was unable to maintain that obligation beyond setting a start date, hence the delay. Both hospitals struggled to hire the position for several reasons. The hospital system's services are typically either provided by licensed healthcare professionals or non-treatment admin/support staff. The concept of a SUD Navigator proposed a different type of experience or certification that was SUD heavy (i.e. CADC) and/or included peer support. The hospitals needed to work through internal system barriers associated with this new type of service and position requirements. Similarly, the local region has a limited behavioral health workforce that met the unique requirements for the position. For monitoring measure 2.1 SUD navigator performance report, we planned to define co-developed performance metrics by September 2023 and develop/share a performance report by December of 2023. Both the target and benchmark were met on time.

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

Alcohol Use Disorder has been identified as the most prevalent in Jackson County and accounts for approximately 60% of all referrals to SUD Navigation services. SUD Navigators are referring based on individual needs and utilizing a wide array of provider partners. The position's success has been due largely to the phenomenal staff hired into the role. These individuals have come from the 'right background,' with familiarity in SUD treatment services, peer support, and case management. The hospital systems' commitment to ongoing collaboration and alignment has been another key to success for this program. Both Navigators stay in constant contact and ensure that the roles, responsibilities, performance metrics, and program objectives are similar. The braided funding secured by both our CCO contribution and the local DHHS is promising, but the hospital systems themselves need to invest (and see a reason for investment) into this project at some level.

D. Brief narrative description

1. **Project population:**

Members presenting at an Asante or Providence hospital in the JCC service area with a diagnosis of SUD. Most patients seen by an SUD navigator were inpatient and referred by the hospital social worker.

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

JCC understands the importance of ensuring warm transitions between hospital visits and community-based treatment providers. It has become vital to ensure members are appropriately served. A hospital-based navigator (with a focus on serving members with SUD) promotes the connection and communication between hospital care and specialty behavioral health. In addition, this improved access allows for other needed integrated services including oral health to be assessed, referrals completed, and services provided. This project also demonstrates attention to the continuum of care through prevention efforts (connecting the member to Social Determinants of Health resources) and treatment (connecting the member to SUD treatment) that leads to maintenance and recovery for the member. Both Asante and Providence hospitals are using the Unite Us/Connect Oregon platform. This platform enables both hospital systems to engage community-based providers (CBOs) to meet member needs. The project advances integrated care by connecting members from hospital care to their specialty treatment or SDOH (Social Determinants of Health) need. The project focuses on the enhancement of tracking and monitoring tools that rely on the electronic health record/health information exchange system (EPIC) utilized by both hospitals to ensure successful referrals to external and/or internal specialty providers.

During the SUD Summit in May 2022, stakeholder discussions brought up the lack of immediate and warm care coordination when an individual was ready for change. JCC met with Asante and Providence leadership teams to gauge interest in hiring SUD Navigators that came up as solutions to this problem. Both hospital systems were interested in working together to hire the positions and provide SUD navigation services prior to discharge (including follow up post discharge). JCC met with both hospital systems in early 2023 to discuss performance metrics, position roles/responsibilities, and project scope that would inform the contract to fund $70,000 per position. This seed funding enabled each hospital to move forward with posting the positions and jointly planning their onboarding and partnership structure. Providence and Asante were selected as national study sites for implementing Hospital Based Opioid Treatment (HBOT) with technical assistance provided by Oregon Health Sciences University (OHSU) Department of Addiction Medicine. The study provides specialized medical expertise, education of hospital medical providers regarding identification treatment and management and pragmatic assistance (e.g., order sets, workflows, etc.) to improve care and treat patients hospitalized with OUD (Opioid Use Disorder). The SUD Navigators are considered an essential component of HBOT and are included in related meetings, training, and consultation. At a very high level, the Navigators engage patients, build trust, provide a warm connection to outpatient resources, and follow-up post-discharge to assure patients have engaged in outpatient care. During the first year, JCC and the hospital system defined specific, measurable performance metrics that can be evaluated for member impact:

- Number of patients identified with SUDs, including substances used
- Number of patients offered services
- Number of patients who accepted services

- Number of patients who declined services
- Reason(s) patients declined services
- Number of encounters between Navigator and patient
- Number of referrals/warm handoffs to outpatient treatment providers
- Number of patients with confirmed follow-up to outpatient treatment providers (if patients consent to Release of Information)
- Number of return ED visits in 30 days
- LOS from Navigator referral to discharge
- Number of 30-day readmissions
- Other community resource referral types
- Number of patients given or connected to Naloxone at discharge
- Number of AMA discharges/AMA discharges prevented

As the SUD Navigators provide a comprehensive and joint tracking report on these data points within a system that allows for aggregated analysis, more program evaluation will be possible in 2024. During the last TQS year, only Asante data was collected and reviewed since Providence had not hired their navigator. Asante reported that as of April 2024, 237 patients had been referred to SUD Navigator services:

- 75% were referred to SUD treatment successfully;
- They had on average 3 encounters (with anomalies at 11-16 encounters).
- 15% were also referred to higher acuity mental health services and housing resources.
- 15% either discharged before being served, denied having a substance use problem, or declined services.
- 80% did not have a readmission to the hospital (of the 20% that were re-admitted to the hospital that year, half were re-admitted for a SUD primary reason).
- Alcohol Use Disorder was the main presenting problem for 60% of patients referred to SUD Navigator services, followed by OUD and lastly methamphetamine.

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

Activity 1 description: JCC will continue developing the collaborative hospital Navigator model to ensure a sustainable funding model and refine performance outcomes. JCC will track the coordination of braided funding proposals and will provide technical assistance for the outcomes reporting template/analysis.

☒ Short term or ☐ Long term

Monitoring measure 1.1	The amount of braided funding secured for 2025 that includes hospital investment, both CCO's, and continued DHHS involvement.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
One CCO (JCC) & Jackson County DHHS provide funding for the SUD Navigator positions.	JCC and DHHS will continue to provide funding support.	12/2024	Braided funding will expand to include the second CCO (AllCare) and contribution from the Asante and Providence hospital systems.	01/2025
Monitoring measure 1.2	Number of outcome reports with a similar template for performance metrics.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

Asante SUD Navigator submits 1 outcome report per month.	Providence SUD navigator will submit one outcome report per month.	06/2024	SUD Navigators will share a similar reporting template that captures their performance metrics.	12/2024

Activity 2 description: JCC will use performance metric data to engage hospitals in next steps for quality improvement. Specifically, data analysis will steer performance metrics towards a particular use disorder and/or population of focus.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Number of SUD Navigator performance metrics informed by data analysis and used to develop a quality improvement strategy.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Performance reports are not analyzed for a quality improvement strategy.	Perform data analysis on performance reports.	01/2025	Develop and implement a quality improvement strategy based on the data analysis.	12/2025

A. Project title: Project 2: Supporting the Communication Needs for Members

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

If continued, insert unique project ID from OHA: 129

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 project

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

Jackson Care Connect recognizes that supporting communication needs for our members goes beyond meeting minimum language accessibility requirements. We are committed to overcoming barriers our members have and strive to offer culturally responsive care in our constant pursuit of achieving more equitable health outcomes for our community. Through ongoing efforts and developing new strategies and activities to support these goals, JCC is leading the way in innovation around language accessibility for providers in the network and the thousands of members we serve daily.

In 2023, JCC saw an increase in membership of 1,761 (2.8%), from 63,108 members in 2022 to 64,869 members at the end of 2023. Those who identify as Hispanic grew by 1,940 members or 18.5%, from 9,529 in 2022 to 11,469 at the end of 2023. Those who self-identified with Spanish as their preferred language also increased by 1,939 members or 35.6%, from 4,485 in 2022 to 6,424 at the end of 2023. In 2023, 2,787 JCC members were enrolled through Healthier Oregon. The majority of interpretation requests for JCC members were for Spanish at 88%, with ASL (American Sign Language) representing another other 10%.

As shown in the table below, the rate of growth of both Hispanic and Spanish-speaking membership continues to grow at a faster rate than overall JCC membership. In particular, the growth rate of Spanish-speaking members increased over the three-year period where the total membership growth rate has slowed.

	Total JCC Membership			Members Identifying as Hispanic			Members with Preferred Language of Spanish		
	Count	Difference from Prior Year	% Change from Prior Year	Count	Difference from Prior Year	% Change from Prior Year	Count	Difference from Prior Year	% Change from Prior Year
2020	55141	N/A	N/A	7278	N/A	N/A	3572	N/A	N/A
2021	59699	4558	8.3%	8382	1004	13.6%	3907	335	9.4%
2022	63108	3409	5.7%	9529	1147	13.7%	4485	578	14.8%
2023	64869	1761	2.8%	11469	1940	18.5%	6424	1939	35.6%

Within the Spanish-speaking population 54% of members are female and 46% are male. Within our total member population, 6.2% identify as disabled. Specifically, 0.5% of our total population, or 7.6% of those with disabilities, experience hearing loss. We've detailed our hearing loop project in this section and the intervention section to

address inequities within this demographic. When sexual orientation data is available, this analysis will be repeated including that data. Any findings would be used to support the development of culturally competent interventions.

LOA (Letter of Agreement) with La Clinica for interpretation by trained staff interpreters:

In 2021, JCC launched a reimbursement pilot with La Clinica, an FQHC (Federally Qualified Health Center) serving LEP (Limited English Proficient) members in our county. This project continues as JCC works to ensure sustainability of providers who approach health care with best-practice models.

Hearing Loops:

In January 2022, during a JCC Community Advisory Council (CAC) meeting, a JCC member with hearing loss elevated a concern about health inequities experienced by our deaf and hard of hearing community members. A discussion was held about hearing loops as a potential low-cost solution to improve the experience of members with hearing loss, prompting JCC to further explore strategies to reduce inequities among this population. While we now contract with a language service provider that specializes in medical ASL interpretation, there is still a significant gap in service to our community members with hearing loss. Feedback from both our CAC and a local Deaf and Hard of Hearing workgroup suggested we explore the value of supplying and installing hearing loop systems in our region. We recognize that even under the best circumstances, hearing in everyday situations can be challenging for people with hearing loss, and ease in accessing health care and services has been further impacted by the COVID-19 pandemic that brought widespread additions of plexiglass, masks, and social distancing measures. In 2023, JCC successfully installed hearing loops in the following locations: Jackson County Health and Human Services including at the main check-in desk, Public Health and Veterans Services; Rogue Valley Council of Governments including at the check-in desk and a large multi-use conference room; two Rogue Community Health pharmacies; and Addictions Recovery Center at their check-in desk and in a large conference room.

Health care interpreter training scholarships:

To further increase the pool of locally available qualified/certified medical interpreters, JCC will continue to offer the current opportunity to healthcare providers and workers who would like to become a qualified/certified health care interpreter, as well as cover the cost of the proficiency testing for medical providers to serve patients in their target language.

Quarterly member survey with interpretation services questions:

In addition to reviewing claims data, strengthening payment models with critical service providers, and providing scholarship opportunities for providers to become a Qualified/Certified Health Care Interpreter. Staff also reviewed current data from our 2023 quarterly member experience survey to further inform our strategic language access interventions and strategies.

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

In 2023, JCC did not meet its target benchmarks for the number of certified/qualified interpreter trainings funded. JCC did however, provide two scholarships for individuals to become qualified/certified Health Care Interpreters. The target language for both individuals were for languages of lesser diffusion including Arabic, Kurdish, Russian and Ukrainian. Both individuals live outside of JCC's service area; however, they intend to contract with one of JCC's language vendors to serve JCC members.

The primary reason this target was not met was lacking a viable funding mechanism for external partners, (individuals not embedded within JCC's contracted provider network) that could pursue the scholarship opportunity. Furthermore, due to staff turnover and capacity, the scholarship program remained stagnant, with little

promotion/visibility needed to engage potential participants. This is expected to change in 2024, however, with the newly hired Community Health Manager and Equity, Diversity and Inclusion Manager positions being filled, increasing JCC's capacity to advance these efforts.

Monitoring Measure 2.1:
JCC met this Monitoring measure of Tracking number of qualified/certified internal staff at one of our FQHCs (Federally Qualified Health Center). In December of 2022 there were 36 qualified/certified medical interpreters employed by La Clinica. In June of 2024, that number has increased to 58, a 61% increase by the FQHC.

Monitoring Measure 2.2
In 2024, JCC met and exceeded its tracking goal of number of interpreted visits from La Clinica, our FQHC provider. During this past year, La Clinica improved its number of interpreted visits from 412 visits to 496, an increase of 20%. Robust internal training efforts by the FQHC to increase their pool of qualified or certified interpreters were the largest contributing factor to ensuring this monitoring measure was met. The expansion of Healthier Oregon also led to a higher number of interpreted visits by La Clinica staff, due to their training efforts, the FQHC was able to effectively meet members' needs.

Monitoring Measure 3.1
Due to staff turnover and capacity on both JCC staff and La Clinica, a member satisfaction survey from the FQHC was not launched in 2023. JCC continued with its customer engagement survey, which included asking questions about language access vendor satisfaction. Data remained consistent in 2023 and 2024 with those filling out the survey who have used interpretation services ranking their average satisfaction of 9.5 out of 10; 100% reported feeling respected in the sense of their personal identity and culture; and 5.7% of survey respondents reported having to wait. Of those that had to wait, 25% had to wait 1-3 days; 50% more than 7 days; and the rest reporting to not know, or too hard to say.

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

Several lessons were learned for 2023 regarding JCC's language access efforts, positioning JCC in an ideal situation to make meaningful changes. Most notably, was the staff capacity needed to move many of these existing initiatives forward, course correct as needed, as well as develop new innovative interventions and strategies to support communication needs for our members. In September of 2023, JCC hired a Health Equity Diversity and Inclusion Manager. This role works closely with JCC's other recent hire in August of 2023, the Community Health Manager who is a Qualified Health Care Interpreter. These manager positions work together with JCC's Bilingual Community Outreach Program Coordinator, who is also a qualified Health Care interpreter. All three of these positions collaborate with our provider facing staff to advance the implementation of existing strategies and interventions, develop new ones, and work with our provider network to assure quality language access is available to all members requiring those services. We also discovered that there were logistical barriers to providing scholarship opportunities to external participants because of contracting and billing systems in place. These barriers resulted in lower-than-expected results for JCC's interpretation scholarship program.

Through conversations with many of our clinicians and Social Determinants of Health providers, JCC learned of the need for support in the translation of the 6 vital medical documents according to Title IV of the Civil Rights Act of 1964. Smaller practices, with fewer resources, are struggling to adhere to the translation requirements which creates barriers for LEP members in accessing care.

Due to the success of La Clinica's ability to recruit, train, and retain internal qualified/certified healthcare interpreters, monitoring measure 2.1 will be adjusted from tracking the overall number of qualified/certified interpreters employed by the FQHC, towards developing a reimbursement model between the FQHC and JCC to pay for the interpretation services provided by the FQHC to JCC members. Historically, CareOregon/JCC has only paid for interpretation services for its members through several language access vendors. However, through the

partnership JCC has built with La Clinica, the need for JCC/CareOregon to develop an alternative method to reimburse providers offering high quality, best practice methods of language access have become a priority. Therefore, JCC/CareOregon and La Clinica will work together to develop a reimbursement model for appointments with providers in language, and/or with qualified/certified interpreters for JCC members. This will be accomplished by upskilling staff and technology systems to provide more robust documentation and reporting, allowing the FQHC to bill JCC for the in-language services provided.

With the eligibility expansion of OHA's Healthier Oregon Program, JCC has seen a larger than expected increase in the number of LEP members enrolled. As part of our strategies and intervention we learned that more opportunities are needed to share about JCC members' benefits, and through collaboration with trusted community partners we hope to engage in more community presentations, as well as host our community meetings to provide additional education on how members can make the most of their benefits.

D. Brief narrative description

1. **Project population:** The project population this TQS project serves includes all JCC members, especially those with additional needs regarding language accessibility.

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

Scholarships (Activity 1):

To continue to increase the pool of certified/qualified interpreters available in our region, JCC will continue to offer scholarships for the training to anyone who is committed to obtaining the OHA Interpreter Credential and works in an organization that serves JCC members, or contracts with a language vendor that serves JCC members. To increase accessibility to external participants, JCC will establish a contract with La Clinica in Q2 to reserve ten Health Care Interpreter slots in the OHA Certified Qualified Health Care Interpreter training class. These slots will be offered and promoted to community members including graduating high school seniors and local college students. The training will allow up to 10 local participants to complete and become qualified healthcare interpreters, who we anticipate then contract with one of JCC's contracted language vendors or provider clinics. Through the expansion of this scholarship program to community members, JCC will partner with local High schools with graduating students, as well as local colleges such as Rogue Community College and Southern Oregon University to promote this opportunity to students as a low-barrier opportunity for workforce development for those looking to start a career in the healthcare industry.

In House Interpretation Services (Activity 2):

JCC continues to contract with La Clinica to provide in-house interpretation for Spanish members accessing care at their clinic. In 2024, we will improve the billing process with the goal of increasing the payment model's sustainability. This will include partnering with La Clinica to improve documentation and reporting on the provision of interpretation services. JCC is working with our internal language access and member experience departments to advocate for solutions to support in-house interpreters across our networks, as well as general billing beyond our preferred interpreter vendors. In 2024, JCC will continue meeting with La Clinica to identify any infrastructure support that may be necessary to contract for a more sustainable funding pathway to reimburse for these services.

Due to increased staffing capacity, JCC's monthly Language Access workgroup resumed, with the first meeting occurring in January 2024. This workgroup continues to be a multi-departmental space to discuss the Meaningful Language Access Metric. The workgroup is also critical in the design and collaboration on new meaningful language access initiatives that impact JCC members, community partners, and providers.

Translation of Key Documents (Activity 3):

In 2024, JCC will be developing and launching a new process for smaller clinics and certain SDoH providers to submit an application for a scholarship to aid in the assistance of the 6 vital documents. This will ensure that JCC members,

and other individuals in the Jackson County area, are able to access critical health information in their own language upon request.

Hearing Loops (Activity 4):
Hearing loops are a simple and cost-effective way to improve accessibility of health care for people with hearing loss. Hearing loops are a special sound system that broadcasts sound cleanly and directly to the person's hearing device. They are more hygienic than other solutions as they do not require people to use shared headphones or ear buds. During 2024, JCC plans to educate the community including Medicaid members, providers, community-based organizations, and hearing aid distributors. There is still limited awareness of hearing loop technology. At JCC's Spring Conference in May of 2024, this technology was utilized and promoted. Additionally, JCC plans to expand the pilot installation project to include new primary care settings.

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

Activity 1 description: JCC will award scholarships to community members to complete training to become a qualified/certified Health Care Interpreter. All applicants will be considered, with Spanish language interpretation prioritized.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of certified/qualified interpretation trainings funded through JCC scholarships.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Two scholarships for healthcare interpreter training were awarded in 2023.	JCC has awarded ten scholarships for health care interpreter training in 2024.	12/2024	JCC has awarded twenty additional scholarships for health care interpreter training.	12/2026

Activity 2 description: JCC will work with La Clinica to develop a contract that will allow the FQHC to bill JCC for interpreted visits, or for visits where a provider proficient in the patient's language is utilized.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Develop a reimbursement model between JCC and our FQHC partner to reimburse for in language appointments provided to JCC members.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
This will be a new activity launching, no current data exists.	Provide technical assistance to FQHC to upskill the staffing and technology needed for FQHC to bill JCC for in language services.	12/2024	Finalize contract to begin reimbursement between JCC and FQHC	12/2025
Monitoring measure 2.2	Tracking number of interpreter visits provided by La Clinica FQHC.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
496 interpreted visits.	Increase of 10% over baseline	12/2024	Increase of 15% over baseline	12/2025

Activity 3 description: JCC will award translation scholarships to community partners/health care providers for vital document translation assistance. All applicants will be considered, with Spanish language interpretation prioritized.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Number of community partners/ health care providers funded through JCC for vital document translation assistance.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
This will be a new program launching, no current data exists.	JCC has awarded 6 scholarships to community-based organizations and/or clinics for the translation of any of the sic vital documents.	12/2024	JCC has awarded twenty additional scholarships for the translation of any of the six vital documents.	12/2026

Activity 4 description: Work with our CAC and community partners to explore potential sites, work with vendor and contract for installation of hearing loops in our region.

☒ Short term or ☐ Long term

Monitoring measure 4.1	Hearing Loops-Select primary care sites and secure contracts to fund installation and operationalization of hearing loops systems.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
There are currently no locations with hearing loop systems installed at primary care locations in Jackson County	Site surveys take place at a minimum of three primary care sites to identify technological needs, including providing training and education to sites regarding the usage of hearing loop systems. Commitments secured from at least two sites.	10/2024	Hearing Loops are installed at a minimum of two primary care locations.	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: 431

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 projects

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

Jackson Care Connect/CareOregon 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 (Primary Care Physicians) 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, JCC/CareOregon 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 (Community Based Organizations), and maternity providers. As the number of engaged PCPs sending referrals to dental continues to increase, we became solutions 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:

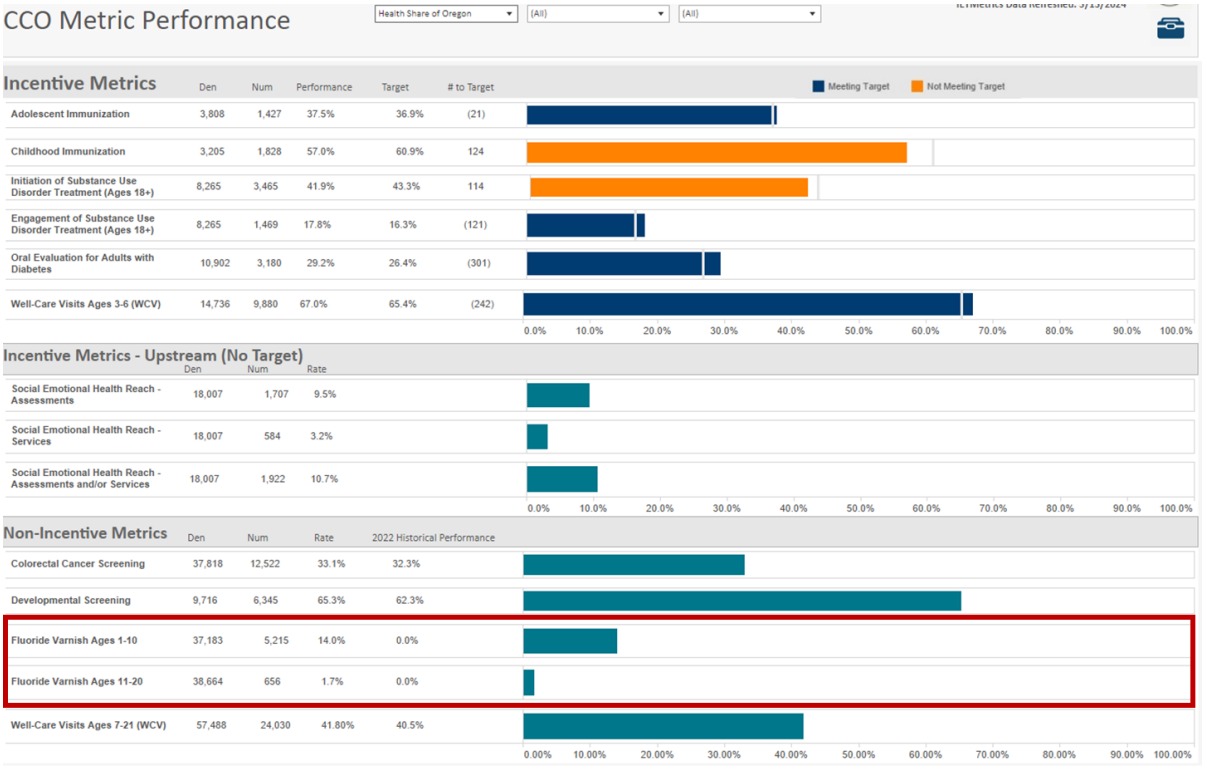
Activity 1) Enhancing HIT: Add dental engagement data to PCP dashboards. Data to include dental visit information, preventive dental services metric data by PCP and dental plan/clinic assignment.

Monitoring Measure 1.1

- The addition of actionable dental data on PCP dashboards was met by the target timeline.

Monitoring Measure 1.2

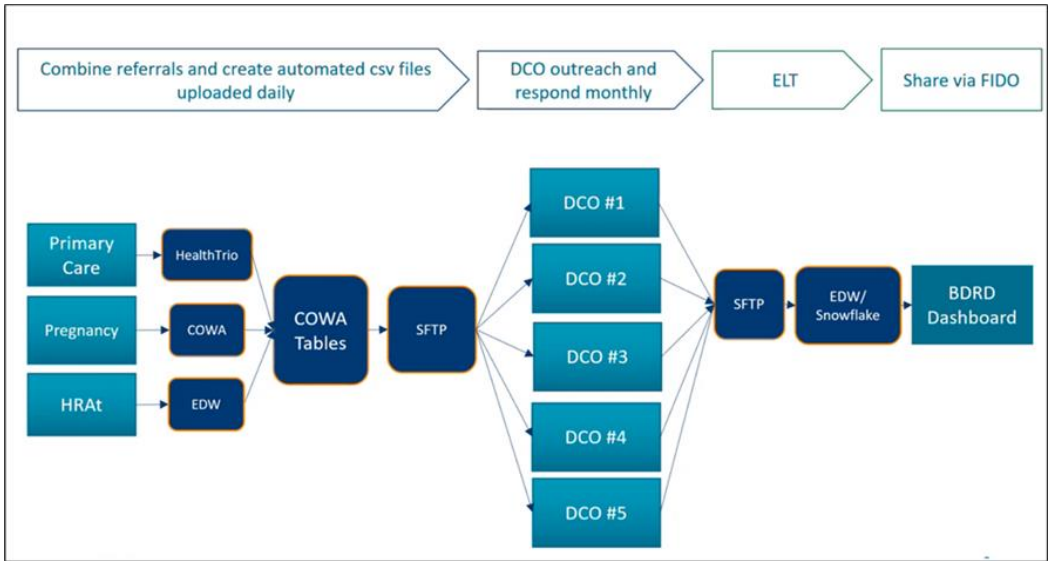
- Four (4) provider sites trained on the use of the actionable dashboard were met by target timeline.

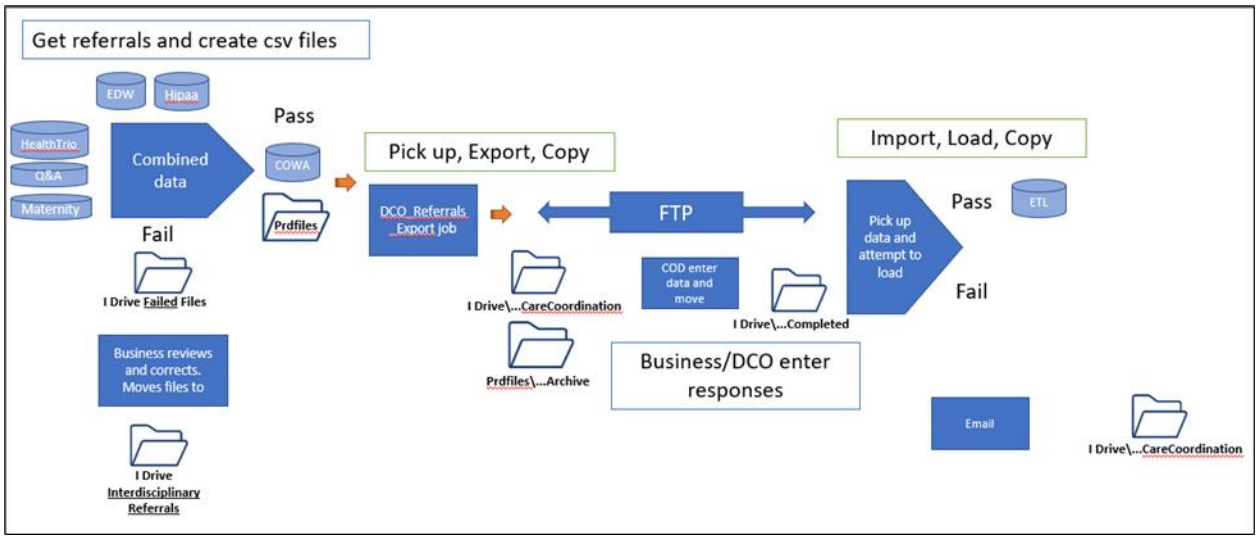


Activity 2) Enhancing HIT: Work with the analytics team to determine the number and percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit, and to develop a data dashboard visualization.

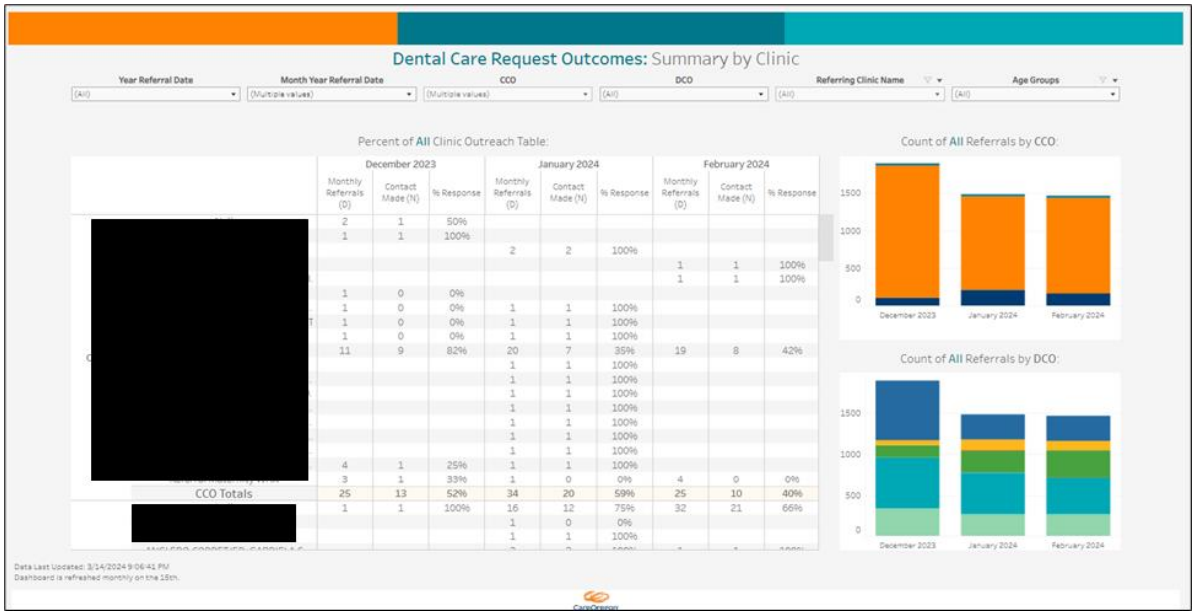
Monitoring Measure 2.1

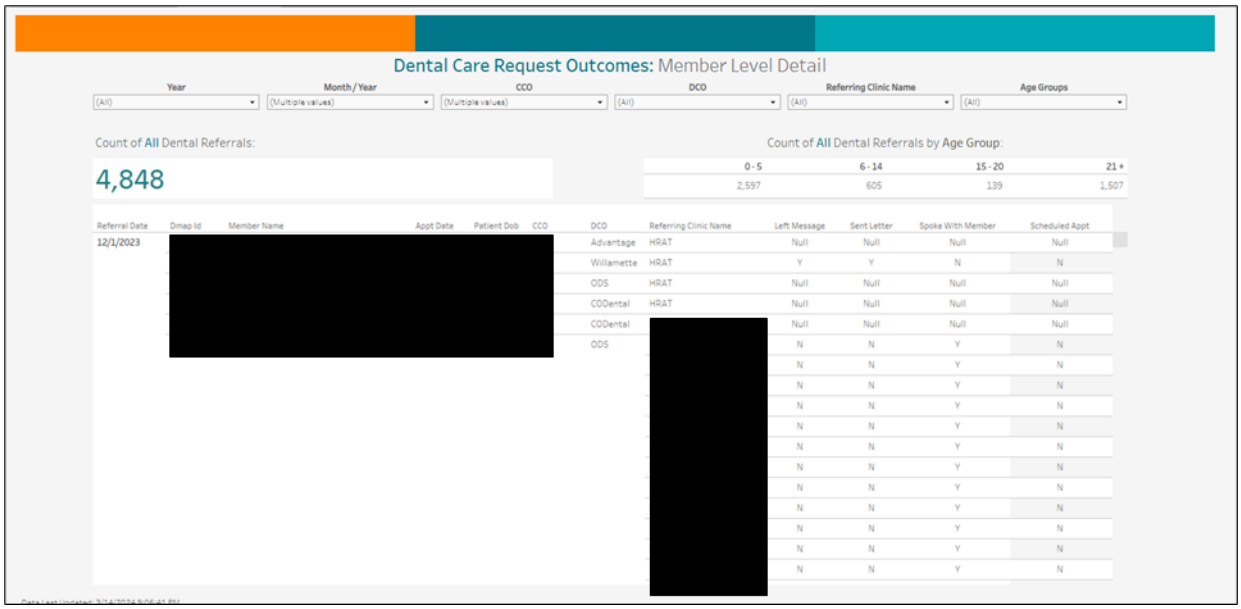
- Completion of a dashboard to visualize dental care requests is in progress, but not completed by the target date. A draft dashboard has been completed and is undergoing improvements. Included also below are the process flow visuals for dashboard build out. The draft Dashboard Landing page and Summary by Clinic and Member Level Detail pages are being enhanced prior to launch.




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
Import, Load, Copy
Pick up data and attempt to load
Pass
ETL
Fail
Business/DCO enter responses
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.


Dental Care Request Outcomes: Summary by Clinic
Year Referral Date
Month Year Referral Date
CCO
DCO
Referring Clinic Name
Age Groups
Percent of All Clinic Outreach Table:
December 2023
January 2024
February 2024
Monthly Referrals (D)
Contact Made (N)
% Response
CCO Totals
Count of All Referrals by CCO:
Count of All Referrals by DCO:
Data Last Updated: 3/14/2024 9:06:41 PM
Dashboard is refreshed monthly on the 15th.



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.

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

Monitoring measure 3.1

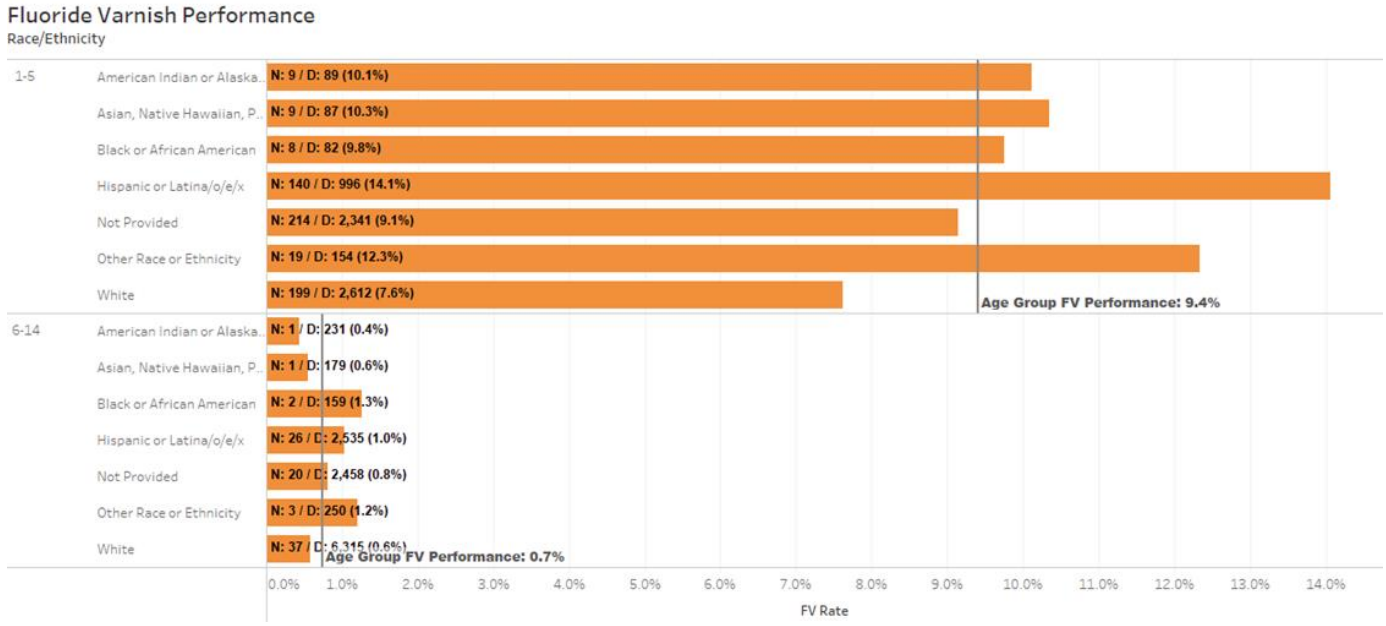
- Determine baseline performance at the PCP-level of sites applying fluoride varnish in primary care and determine an improvement target for fluoride varnish applications in 2024 has been met by the target timeline. Fluoride varnish application in primary care data has been disaggregated by REALD for analysis. At this time, we do not have access to Jackson Care Connect's OHA SOGI (Sexual Orientation and Gender Identity) data to include in reporting. This data represents only members receiving varnish in primary care and does not include dental provider contributions.

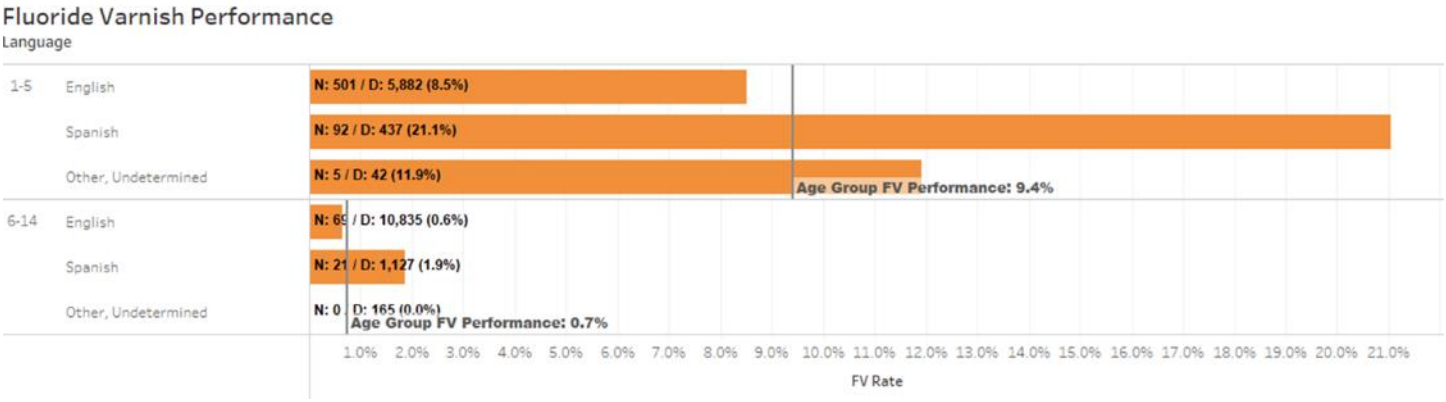
Monitoring measure 3.2

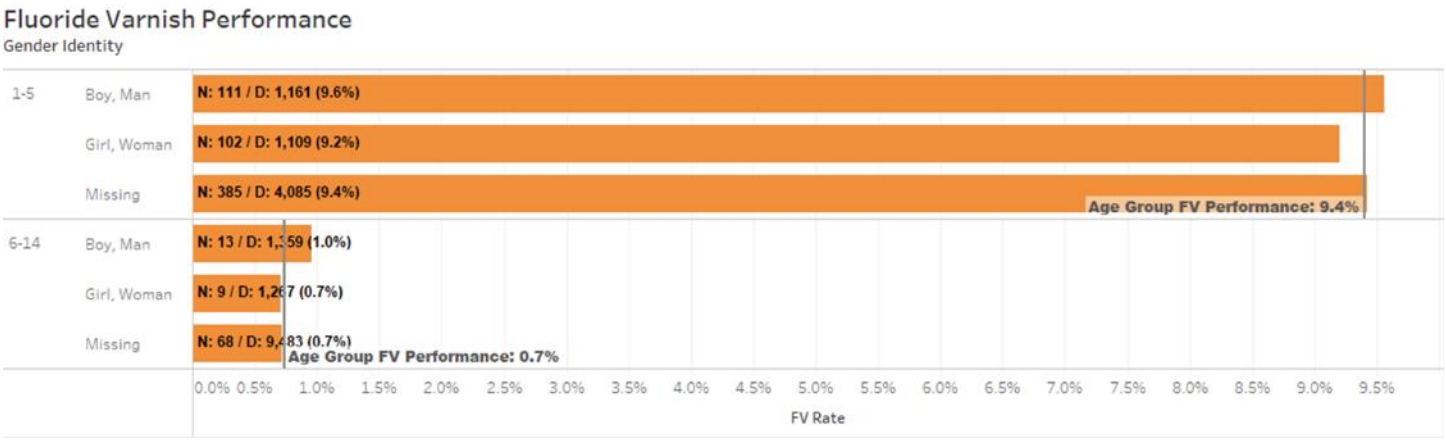
- Dental claims in physical health data analysis developed and reported is on track to be met by target timeline of 6/2024.

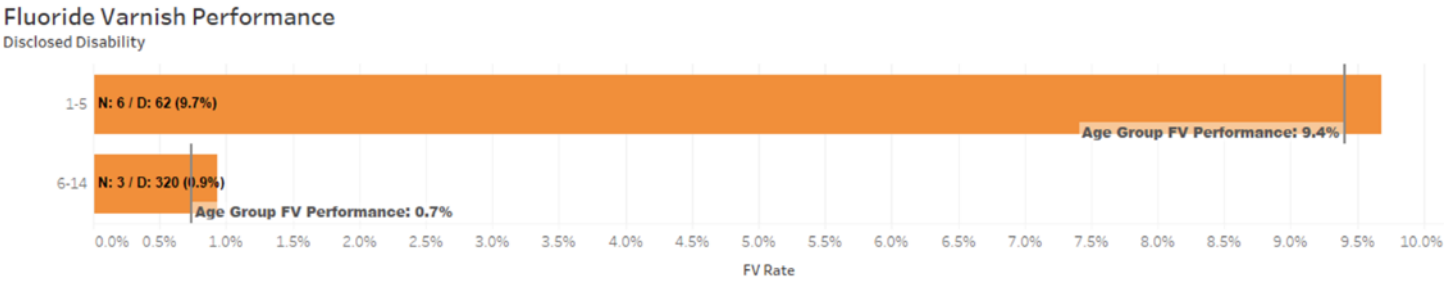
Monitoring measure 3.3

- 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 Alaska..
N: 9 / D: 89 (10.1%)
Asian, Native Hawaiian, P..
N: 9 / D: 87 (10.3%)
Black or African American
N: 8 / D: 82 (9.8%)
Hispanic or Latina/o/e/x
N: 140 / D: 996 (14.1%)
Not Provided
N: 214 / D: 2,341 (9.1%)
Other Race or Ethnicity
N: 19 / D: 154 (12.3%)
White
N: 199 / D: 2,612 (7.6%)
Age Group FV Performance: 9.4%
6-14
American Indian or Alaska..
N: 1 / D: 231 (0.4%)
Asian, Native Hawaiian, P..
N: 1 / D: 179 (0.6%)
Black or African American
N: 2 / D: 159 (1.3%)
Hispanic or Latina/o/e/x
N: 26 / D: 2,535 (1.0%)
Not Provided
N: 20 / D: 2,458 (0.8%)
Other Race or Ethnicity
N: 3 / D: 250 (1.2%)
White
N: 37 / D: 6,315 (0.6%)
Age Group FV Performance: 0.7%
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%
FV Rate


Fluoride Varnish Performance
Language
1-5
English
N: 501 / D: 5,882 (8.5%)
Spanish
N: 92 / D: 437 (21.1%)
Other, Undetermined
N: 5 / D: 42 (11.9%)
Age Group FV Performance: 9.4%
6-14
English
N: 69 / D: 10,835 (0.6%)
Spanish
N: 21 / D: 1,127 (1.9%)
Other, Undetermined
N: 0 / D: 165 (0.0%)
Age Group FV Performance: 0.7%
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% 16.0% 17.0% 18.0% 19.0% 20.0% 21.0%
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, JCC/CareOregon 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 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 & SOGI 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 PCP settings. In 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	05/2025	Dashboard created	05/2025
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 SOGI) 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 SOGI) 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: Patient-Centered Primary Care Home (PCPCH) Member Assignment

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

If continued, insert unique project ID from OHA: 131

B. Components addressed

1. Component 1: PCPCH: Member enrollment
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, JCC continued to work on refinement of the auto assignment algorithm to implement a preferential assignment process. During this process, it was identified that JCC also needed to work with providers to ensure that clinic capacity was reflected in the algorithm. Progress towards this goal has been slower than anticipated due to resourcing challenges. In response to this, JCC will be resourcing this work differently. A Provider Network Operations (PNO) team was established in October 2023 in order to take responsibility for leading the preferential assignment work along with network adequacy and oversight. The first role for this team was filled in December 2023, and JCC added an additional Provider Relations Specialist position to facilitate communications with our network. Historically, network adequacy work was conducted across multiple teams, increasing potential for variability in processes and challenges in quickly obtaining a comprehensive view of the network. The creation of this centralized team marks a significant step toward standardizing and streamlining our network adequacy efforts including the preferential assignment process. By leveraging disaggregated REALD (Race, Ethnicity, Language, Disability) and SOGI (Sexual Orientation and Gender Identity) data, the PNO team will also ensure our services are tailored to meet the diverse needs of our community.

Additional improvements in 2023 were also made to the per member per month payment CareOregon makes to PCPCH recognized clinics.

At the end of 2023, 87% of JCC members were assigned to a Tier 3 clinic or above with 19% in a Tier 3, 44% in a Tier 4 and 24% in a Tier 5 clinic. When PCPCH membership was disaggregated by Race and Ethnicity, we found that Hispanic members were more likely than other groups to be assigned to a Tier 5 clinic. No other meaningful differences by race and language were identified. Additionally, no significant differences in PCPCH enrollment were found based on disability status or gender identity. However, data completion issues with gender identity data affected the reliability of this analysis. Future analysis will also include sexual orientation data to help identify needs for targeted technical assistance.

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

Monitoring measure 1.1:

The Innovation Specialist – Primary Care (IS-PC) will assist in facilitation and support the clinics in meeting their goals and objectives from learning collaboratives for PCPCHs on implementing model attributes. The target/benchmark was to implement the learning collaborative with at least two JCC PCPCH-recognized clinics by 12/2023 and this goal was successfully met by the target date.

Monitoring measure 2.1:

The IS-PC will outreach to clinics not yet recognized to offer technical assistance and practice coaching for PCPCH recognition. This had four targets/benchmarks. The target was to identify clinics to offer technical assistance to by

5/2023 and outreach to those clinics by 12/2023. Both goals were met. Also, JCC offered technical assistance to clinics who, due to the proposed changes in the PCPCH recognition process, were concerned they would see a reduced tier level.

Monitoring measure 3.1:
The IS-PC will provide technical assistance and practice coaching by interpreting program elements, researching questions, and recommending workflows to clinics not yet recognized had a target of providing TA (Technical Assistance) to half of clinics interested in receiving it by 8/2023 and to 100% by 12/2023. This target and benchmark were met.

Monitoring measure 4.1:
JCC will develop preferential assignment procedures. A test pilot in two clinics had a target of developing a preferential assignment procedure by 7/2023, beginning the pilot at two clinics by 12/2023. The target also included exploring the impact on school-based health centers (SBHCs) by 9/2023, and developing criteria, if feasible, for adding SBHCs to preferential assignment by 12/2023. JCC did complete an analysis of the impact adding in a preferential assignment would have on SBHCs. Due to the referenced challenges with auto-assignment and staffing, JCC did not test the preferential assignment process. This will be part of the PNO plan with an implementation target for 2025.

Monitoring measure 4.2:
Leveraging preferential assignment to increase members assigned to PCPCH clinics had a target/benchmark of returning to the pre-COVID numbers of 87% of members assigned to a Tier 3 or above by 12/2023. As of 12/2023, 86.5% of members were assigned to a PCPCH tier 3 or above, just shy of the target. However, the weighted average remains significantly below the OHA's 85% threshold (~70%). This is an area JCC will continue to focus on in the coming year.

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

The major lesson learned last year was that it was challenging to implement the preferential assignment process with the staffing support allocated to it. This created a significant barrier to implementing the process as originally planned. The Provider Network Operations team is being built in response to this barrier. Another lesson learned is that Primary Care Clinics that are not already PCPCH recognized, remain uninterested in pursuing recognition. In the Jackson Care Connect service area, many smaller primary care practices do not have the resources to pursue PCPCH recognition and they do not have enough JCC membership for JCC's incentives to have a meaningful financial impact. This is reaffirming that mechanisms that increase enrollment to existing high tier PCPCHs is the primary strategy available to impact enrollment in PCPCHs.

D. Brief narrative description

1. **Project population:** Primary Care Clinics in the Jackson Care Connect Service Area

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

The preferential assignment process is an automated mechanism that preferentially assigns new members to Primary Care Clinics that have demonstrated that they provide high quality care, including through PCPCH recognition. When the process is in effect, it results in a higher proportion of new members being assigned to PCPCH recognized clinics.

The preferential assignment process will be overseen by the new Provider Network Operation Team. The Provider Network Operations team comprises a Network Adequacy Analyst, a Senior Planning and Operations Specialist, a Provider Network Communications Specialist, and a Training Specialist. This team operates under the leadership of the Provider Network Operations Manager, who reports through the newly appointed Senior Vice President of Operations, with support from a Vice President of Provider Network and a Director of Network Operations. Both the VP of Provider Network and Director of Network Operations positions are expected to be filled in 2024. The Training

Specialist will focus on internal team training, with additional support for external provider training as needed. A critical charge of this team is to integrate REALD and SOGI data into our network adequacy and assignment management practices. This integration will enable us to identify and address health disparities more effectively, ensuring our services are tailored to meet the diverse needs of our community. Moreover, the creation of an intake request form for primary care auto-assignment and auto-reassignment concerns will allow for streamlined handling of issues and enhancement requests. This will provide us with actionable insights to optimize our processes, ultimately leading to increased assignment to PCPCH clinics and better response to member needs and behaviors. Additionally, the PNO team will develop and implement a centralized intake request form for issues, concerns, or enhancement requests related to our primary care auto-assignment and auto-reassignment algorithms, including preferential assignment issues. This tracker will be created this year, advertised to the organization, and will serve as a centralized tool, owned, maintained, and operated by PNO, that will provide better insights into patterns, trends, and improvements. The aim is to increase assignments to PCPCH clinics and optimize responses to member behavior, thereby improving access to higher-quality care.

Jackson Care Connect also uses Value Based Payments as a mechanism to incentivize high tier PCPCH clinics to remain open to the assignment of new members. JCC provides a per member per month payment for PCPCH recognition. Additionally, the Primary Care Payment Model (PCPM) program usually includes Tier 4 or 5 recognition status as an entry requirement. In 2024, that requirement has been removed as clinics are preparing to transition to the new PCPCH standards; however, this requirement is expected to be reincluded in future years.

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

Activity 1 description: JCC will use the preferential assignment algorithm to increase assignment of members to PCPCH recognized providers

☐ Short term or ☒ Long term

Monitoring measure 1.1	% of members assigned to PCPCH recognized clinics			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 baseline 87.1%	89.1%	12/2024	90%	12/2025
Monitoring measure 2.1	OHA PCPCH Enrollment Metric			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 baseline 70.7%	75%	12/2024	85%	12/2026

Activity 2 description: Establish and fully staff the Provider Network Operations team

☒ Short term or ☐ Long term

Monitoring measure 2.1	Completion of recruitment, hiring, training and evaluation of scope and roles			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Incomplete team with roles in the process of being filled and defined	Fully staffed team with roles implemented as identified in 2024	1/2025	Fully staffed team with roles implemented as identified in 2024	1/2025

Activity 3 description: Develop and implement an intake request form for primary care auto-assignment and auto-reassignment issues and enhancements, owned, maintained, and managed by PNO.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Create and advertise the intake request form and use it to track and analyze requests.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No centralized form or tracker for assignment issues	Fully functional form and tracking system providing actionable insights into assignment patterns and trends	1/2025	Provider network is trained on intake form process	6/2025

Activity 4 description: Integrate REALD and SOGI data into network adequacy tools and recurring reviews.

☐ Short term or ☒ Long term

Monitoring measure 4.1	**Integration of REALD & SOGI data into Network Adequacy Data Analysis**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Minimal integration of REALD and SOGI data in current network adequacy tools	Regular integration and analysis of REALD and SOGI data in network adequacy reviews to identify potential gaps in care	07/2025	Regular integration and analysis of REALD and SOGI data in network adequacy reviews to identify potential gaps in care	07/2025

A. Project title: Project 5: Patient-Centered Primary Care Home (PCPCH) Tier Advancement

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

If continued, insert unique project ID from OHA: 379

B. Components addressed

1. Component 1: PCPCH: Tier advancement
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):**

We reached out to clinics to participate in the PCPCT training in early 2023. Out of those we provided outreach to, one clinic decided to attend. La Clinica sent one participant to the Spring training, and JCC paid for their attendance. Our follow up goal was to have at least one clinic continue to the second half of the training in the summer. This training was cancelled by the PCPCT organizers due to low registration; therefore, it was not available. The Primary Care and Integrated Behavioral Health Innovation Specialists were available throughout 2023 to provide TA around PCPCH tier advancement as requested. We did have a staffing change in the summer/fall of 2023; however, we were able to provide cross coverage and did not experience a disruption in TA support to the network.

We were successful in having two clinics participate in the CHW (Community Health Workers) Collaborative. Rogue Community Health and La Clinica attended the first CHW Collaborative by February 2023. The CHW Collaborative is scheduled to be complete in June 2024. Rogue Community Health and La Clinica have stayed actively engaged in the work throughout 2023, are continuing the work into 2024, and are expected to complete their final projects in June.

Currently JCC's distribution of PCPCH clinics categorizes 19% of the total population under Tier 3, 44% under Tier 4, and 24% under Tier 5. Based on this information we can conclude that 87% of JCC's member population receives care from a PCPCH clinic, the majority of them ranked as Tier 4, aligning with the graphic below. It is also apparent that the Hispanic population makes up the largest portion of Tier 5 at 30.30%, which we attribute to La Clinica's commitment to culturally appropriate care and language services. Another significant success for us lies in the distribution of our population with two or more disabilities, with 44.55% ranked in Tier 4 and 25.62% in Tier 5, and the distribution of our population that is hearing only, with 45.05% ranked in Tier 4 and 26.98% ranked in Tier 5. Overall, the majority of JCC'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 JCC

Race(Group)	Not PCPCH R..	Tier 3	Tier 4	Tier 5
Afro-Caribbean	12.50%	19.32%	45.45%	22.73%
American Indian or Alaskan Native	17.16%	17.92%	41.13%	23.79%
Asian	20.42%	14.30%	41.17%	24.10%
Black or African American	17.75%	18.44%	40.84%	22.97%
Hispanic	13.78%	18.67%	37.25%	30.30%
Middle Eastern/North African	21.69%	14.37%	40.00%	23.94%
Native Hawaiian or Pacific Islander	17.16%	19.10%	40.77%	22.97%
Not Provided	21.91%	20.54%	40.74%	16.81%
Other Race or Ethnicity	20.17%	16.31%	43.56%	19.96%
South American	15.45%	13.41%	41.87%	29.27%
White / European	20.06%	16.46%	43.23%	20.25%

PCPCH by Disability - JCC

Disability	Not PCPCH R..	Tier 3	Tier 4	Tier 5
2+	15.65%	14.17%	44.55%	25.62%
CognOnly	17.99%	15.87%	41.95%	24.19%
CommOnly	17.65%	25.21%	36.97%	20.17%
Declined'	24.02%	14.22%	44.61%	17.16%
HearOnly	13.61%	14.36%	45.05%	26.98%
IndLiv/SelfCare	17.94%	10.67%	45.73%	25.66%
LearnOnly	18.75%	15.62%	46.88%	18.75%
MHD Only	17.32%	10.39%	46.32%	25.97%
Missing'	18.30%	20.46%	43.54%	17.71%
Non-disabled	18.87%	17.99%	40.78%	22.36%
Not Provided	25.44%	19.48%	37.50%	17.59%
PhysOnly	14.06%	12.24%	49.51%	24.19%
Unknown'	16.62%	23.10%	38.03%	22.25%
VisionOnly	16.52%	12.95%	39.73%	30.80%

We will analyze PCPCH data disaggregated by sexual orientation when it is 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):**

Monitoring Measure 1.1:
JCC will support clinics in participating in the PCPCT training and had the following goals: Reach out to three health systems to offer attendance at 2023 PCPCT training by 3/2023; have two out of the three health systems attend PCPCPT training in the spring of 2023; and have at least one of these clinics participate the summer 2023 training. The first two goals were met; however, no clinics were able to attend the summer 2023 PCPCT training because it was canceled by the PCPCT organizers due to low registration. We also had the goal of reaching out to non-PCPCH participating clinics to determine interest in PCPCPT training by 3/2023 and provide individualized TA to the clinics after participation by 12/2023. The first goal was met, however no non-PCPCH participating clinics joined PCPCT training, so no follow up TA was provided.

Monitoring measure 2.1:
JCC will support clinics in participating in the CHW collaborative with OPCA and had a target of attending the first CHW collaborative workgroup with two identified health systems to support their attendance by 2/2023 and that both clinics would complete the collaborative by 02/2024. We met the target and are on track to meet the benchmark in 2024, although the new benchmark date will be June 2024.

Monitoring measure 3.1:
Implementation of preferential assignment to increase eligibility for the PCPM program and the associated financial incentives had a goal of developing preferential assignment procedures for two PCPCH recognized clinics by 09/2023 and implement the preferential assignment process by 12/2023. This was not met due to staffing capacity and will continue to be worked on by the PNO (Provider Network Operations) team.

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

The primary lesson learned relates to the PCPCT Training team. They learned that spreading the training out over a year and breaking it into two sessions does not result in a high level of participant retention. For 2024, the training team has decided to host the PCPCT trainings in one block so that participants can engage in the full learning series in hopes of better participant retention. They are also offering a discounted rate to those who attended last year's first block of training but were unable to attend the second half. This has been valuable feedback as we progress in delivering learning-centered content to our network.

D. Brief narrative description

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

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

Activity 1:
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, technical assistance meetings and larger learning collaborative sessions. One-on-one meetings are designed to provide tailored support specific to the clinic's needs allowing innovation specialists and the clinic to 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 can be included as 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 2:
Learning Collaboratives are a place for the JCC network to learn from one another. In these spaces clinics learn about innovative practices happening within their region, ask questions, and gain insight and ideas on how to improve their practices from 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 JCC clinics in advancing PCPCH tiers through outreach and technical assistance.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Number of JCC clinics that completed attestation for 2024.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Three clinic systems have clinics that need to attest in 2024 (Rogue, Providence, and one additional identified clinic)	Provide at least two outreach attempts and general support to clinics to assure re-attestation in 2024	12/2024	All three clinics have submitted their attestation	12/2024
Monitoring measure 1.2	Number of JCC 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)**
Four clinic systems will need to attest in 2025 (Oasis, Providence, Rogue,	Provide at least two outreach attempts and general support to clinics, informing	12/2024	All four clinics have submitted their attestation	12/2025

and Southern Oregon Pediatrics)	them of new 2025 PCPCH standards			

Activity 2 description: Supporting Tier Advancement through the CWH Collaborative.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Number of JCC 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)**
Two clinics (Rogue Community Health and La Clinica) are engaged in the CHW Learning Collaborative	Rogue Community Health and La Clinica complete the CHW learning collaborative.	06/2024	Rogue Community Health and La Clinica complete the CHW learning collaborative	6/2024

A. Project title: Project 6: Strategic Healthcare Investment for Transformation (SHIFT)

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

B. Components addressed

1. Component 1: Serious and persistent mental illness
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.

Table 1 (below) shows the prevalence of JCC members that have various mental health diagnoses. Of our total JCC membership (58,539), 10,880 are noted as experiencing severe mental illness, which is 17% of total JCC membership. Additional diagnoses also associated with SPMI (Severe and Persistent Mental Illness) are included.

Table 1. JCC Members with a Mental Health Diagnosis by Adult/Youth

	Total	Adults (19+)		Youth (<19)	
	N	N	%	N	%
All Members	58,539	34,670	59.2%	23,869	40.8%
Mbrs with Any Mental Health Diagnoses	15,531	11,479	73.9%	4,052	26.1%
Anxiety	8,175	6,482	79.3%	1,693	20.7%
Bipolar	1,097	1,036	94.4%	61	5.6%
Depression	10,328	8,677	84.0%	1,651	16.0%
Schizophrenia	629	608	96.7%	21	3.3%
Severe Mental Illness	10,880	9,208	84.6%	1,672	15.4%
Other Psych	11,143	7,611	68.3%	3,532	31.7%

Note: members may have multiple mental health diagnoses; data source: April 2024 JCC population segmentation data.

Table 2 (below) shows the rates of inpatient admits or emergency department (ED) visits per 100 JCC members across mental health diagnoses. Adults with a depression diagnosis had on average 17.4 inpatient admissions per 100 members in the last 12 months.

Table 2. No. of Inpatient Admits and Emergency Department Visits per 100 Members by Mental Health Diagnosis and Adult/Youth

	No. of Inpatient Admits per 100 Members			No. of ED Visits per 100 Members		
	Total	Adults (19+)	Youth (<19)	Total	Adults (19+)	Youth (<19)
All Members	7.2	8.7	5.1	40.9	49.5	28.4
Mbrs with Any Mental Health Diagnoses	12.7	15.9	3.8	76.2	87.4	44.4
Anxiety	13.5	15.8	4.4	88.3	98.1	50.8
Bipolar	28.0	29.0	11.5	135.0	135.7	123.0
Depression	15.3	17.4	4.1	82.7	88.1	54.2
Schizophrenia	33.7	33.9	28.6	209.2	208.7	223.8
Severe Mental Illness	15.5	17.6	4.3	85.4	90.8	55.6
Other Psych	12.5	16.4	4.0	82.3	99.4	45.5

Notes: The numbers in the table are rates (total visits per 100 members with a specific mental health condition); data source: April 2024 JCC population segmentation data.

The average mental health treatment utilization rate in both specialty behavioral health and primary care settings for 2023 was 20% of total membership. Treatment outcomes for individuals experiencing SPMI are typically poor due to low medication adherence and limited engagement in programming. The resulting utilization of ED/inpatient over outpatient services is not only costly to the system but compounds the determinant to the health of the individual.

The SHIFT project was chosen for this TQS component because it aims to improve member outcomes by requiring the build out of services and supports that are grounded in models that are proven to be highly effective for the SPMI population, including: multi-disciplinary staffing support, wrap-around team-based care with enhanced care coordination, and feedback informed treatment. The Care Oregon/Jackson Care Connect SHIFT grant provides executive-level consultation and technical assistance that supports an organization through this transformative growth into client-driven, trauma-informed, whole-person care.

REALD and Gender Identity data was analyzed for the population of members receiving care at the SHIFT grant site. This analysis is being used to collaboratively identify possible areas where subpopulations may have specialized needs and/or possible areas of disparities. The analysis will be repeated in subsequent annual TQS reports to ensure that the REALD, Gender Identity, minoritized populations see outcomes improvement consistent with or better than majority populations. The results of this baseline analysis are included in the project population section. In the future, sexual orientation data will be included in analysis and review process.

D. Brief narrative description

1. **Project population:** The project population includes those JCC members served by Columbia Care, an anchor specialty behavioral health organization that serves adults with mental health as the primary diagnosis. Columbia Care was selected for the SHIFT project grant in 2024 for the JCC region. Please refer to the Columbia Care SHIFT application for a comprehensive overview of this organization and their responses confirming "readiness" for this project. Columbia Care Services provides care for over 500 members. As indicated in the tables below, Columbia Care serves members who are experiencing high mental health acuity. In fact, 30% identify as having a disability.

Table 3. Adult JCC Members with Any Utilization at ***ColumbiaCare*** in 2023 with a Mental Health Diagnosis by Mental Health Grouping/Diagnosis

	Total Members		No. of Inpatient Admissions per 100 Members	No. of ED Visits per 100 Members
	n	%		
Any MH Diagnosis*	518	100.0	31.5	186.5
Anxiety	308	59.5	40.3	241.9
Bipolar	134	25.9	44.0	232.8
Depression	428	82.6	32.0	201.1
Schizophrenia	132	25.5	54.6	322.7
Severe Mental Illness	497	95.9	32.8	191.1
Other Psych	386	74.5	39.1	230.6

Notes: All members in database are adults; *mental health categories *are not* mutually exclusive - members can have more than one flag/diagnosis; data sources: Medical Claims data among JCC members with any ColumbiaCare Utilization in 2023, READ & Repository Data, and JCC population segmentation data, April 2024.

Table 4. Adult JCC Members with Any Utilization at ***ColumbiaCare*** in 2023 with a Mental Health Diagnosis by Sex, Gender Identity, Race and Ethnicity, Primary Language, and Disability Status

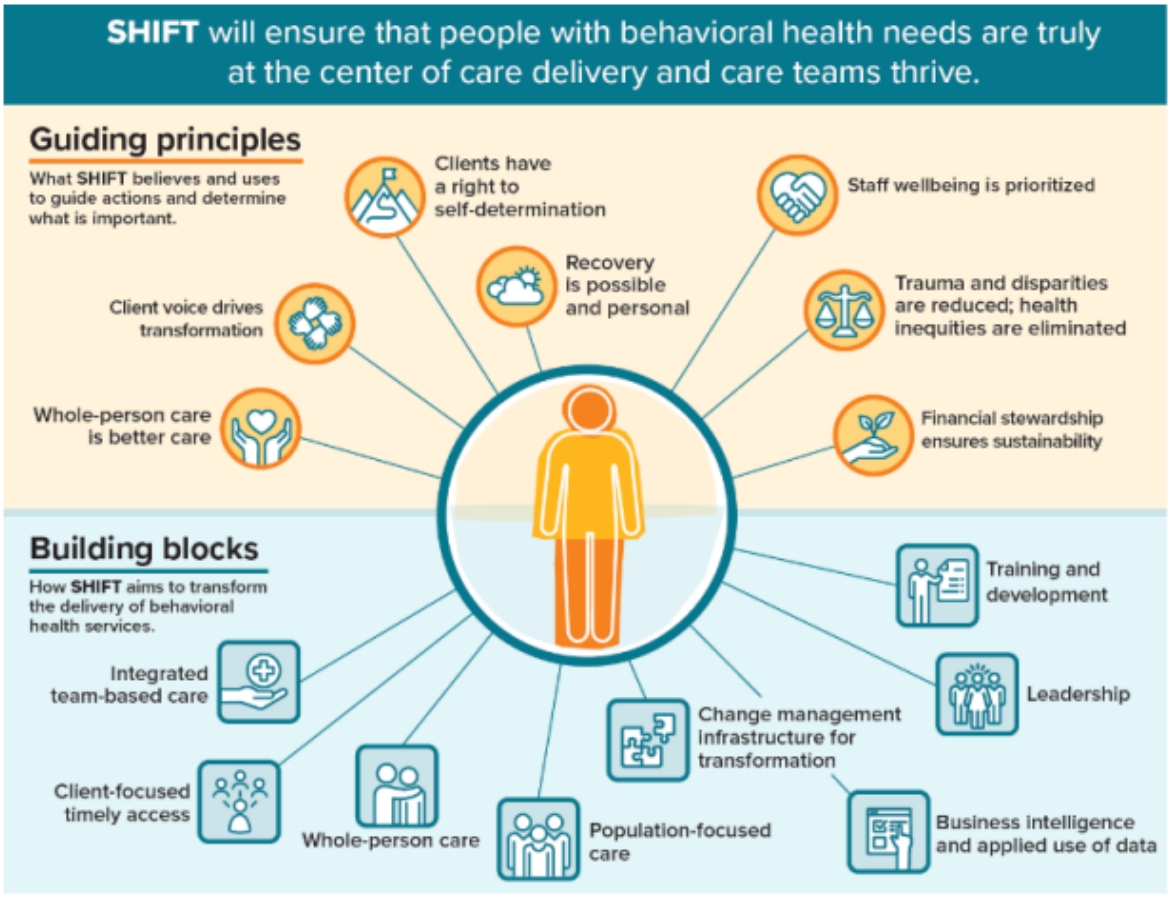
Characteristics	Total Members		No. of Inpatient Admissions per 100 Members	No. of ED Visits per 100 Members
	n	%		
Total Members	518	100.0	31.5	186.5
Sex				
Female	310	59.8	31.3	163.9
Male	208	40.2	31.7	220.2
Gender Identity				
Woman	59	11.4	10.2	111.9
Man	37	7.1	40.5	175.7
Non-Binary	2	0.4	-	-
Not Reported	420	81.1	33.8	198.6
Race and Ethnicity				
American Indian/Alaskan Native	9	1.7	0.0	11.1
Asian/Pacific Islander	7	1.4	71.4	71.4
Black	12	2.3	25.0	125.00
Hispanic	31	6.0	45.2	232.3
Other	9	1.7	33.3	144.4
White	345	66.6	27.8	207.0
Not Reported	105	20.3	40.0	139.0
Spoken Language				
English	514	99.2	31.5	187.9
Spanish	4	0.8	-	-
Disability Status				
Disabled	153	29.5	29.4	256.9
Non-Disabled	228	44.0	32.0	150.4
Not Reported	137	26.4	32.8	167.9

Notes: All members in database are adults; ED/IP rates were not reported for groups with <5 people; data sources: Medical Claims data among JCC members with any ColumbiaCare Utilization in 2023, REALD & Repository Data, and JCC population segmentation data, April 2024.

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

SHIFT stands for "Strategic Health Initiative for Transformation;" the grant program aims to transform how behavioral health services are delivered through member-driven and outcomes-focused team-based care models. The models seek to reduce health disparities and prepare providers for advanced value-based payments. Jackson Care Connect is investing in Columbia Care as the local behavioral organization to implement SHIFT.

SHIFT began in January of 2024 with preparation and planning. JCC will work collaboratively with the participating organization to assess their current state and redesign a new future state through the development of a SHIFT business plan. Implementation will begin on September 1, 2024, and continue until December 31, 2026. JCC and Columbia Care will design a business plan that is aligned with the SHFIT programs guiding principles and building blocks. Please see the attached business plan template for more details. The guiding principles and building blocks of SHIFT are:



SHIFT is foundationally committed to ensuring that Behavioral Healthcare Transformation supports member self-determination, person-centered care, and the advancement of integration as demonstrated by the guiding principles and building blocks of the program. SHIFT seeks to build an organization's capacity to provide team-based care and timely access to the most appropriate level of care. SHIFT requires that the organization create a business plan to drive their implementation of these building blocks and measure/evaluate client outcomes. SHIFT will analyze client outcome data related to timely initiation and engagement within the first 30-day window, as well as retention for therapeutic effect (six or more MH (Mental Health) encounters during the first six months following the initial treatment initiation visit). Specifically for clients experiencing schizophrenia, the SHIFT program will monitor the percentage of those who receive at least one approved case management service for every 90 days in service. Case management connects individuals to critical resources and supports related to their social determinants of health. SHIFT believes case management is a critical and key service component that ensures the integrated and holistic nature of an individual's health is addressed by their behavioral health provider.

Please refer to the Columbia Care SHIFT Application for detailed organizational description and readiness for SHIFT.

Please refer to the SHIFT Business Plan template for an example of what will be completed in the activity deliverables.

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

Activity 1 description: Columbia Care will complete the SHIFT Business Plan. The business plan will identify 4-5 high level goals that guide the agency's 2024-2026 implementation of SHIFT. Key deliverables will include: 1.) planning around leadership capacity and continued engagement, 2.) assigning internal subject matter experts in equity, diversity, & inclusion, trauma informed care, quality improvement, and program development, 3.) allocating resources to data

management infrastructure and processes, and 3.) program planning. The program planning element will include activities related to team-based care, services and supports that address the individual's social determinants of health. JCC will provide executive coaching and consultation to the SHIFT agency in order to meet the deliverables of this activity.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Perform a 'current state' assessment of adherence to guiding principles and SHIFT building blocks.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Columbia Care has not assessed their care delivery system against the guiding principles and building blocks	Columbia Care will have assessed their care delivery system against the guiding principles and building blocks	06/24	Columbia Care will use their assessment findings to set goals toward the guiding principles and building blocks	08/24
Monitoring measure 1.2	Set 4-5 high level goals that shore the gap in guiding principles and building blocks that transform the delivery of care.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Columbia Care has not used an assessment of their care delivery system to identify gaps/room for improvement that follow guiding principles and building blocks	Columbia Care will use the assessment of their care delivery system to identify gaps/room for improvement that follow guiding principles and building blocks	06/24	Columbia Care will use their analysis to set 4-5 high level goals that transform the delivery of care	08/24

Activity 2 description: Design the implementation of the SHIFT Business Plan. The implementation plan is a three-year quarterly forecast that outlines tasks, deliverables, and milestones towards achieving agency goals to transform the care delivery system. JCC will provide executive coaching and consultation to the SHIFT agency to meet the deliverables of this activity.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Monitor implementation deliverables that transform the delivery of care.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Columbia Care does not currently have an implementation plan that forecasts how they will transform the delivery of care	Columbia Care has an implementation plan that forecasts key deliverables needed to transform the delivery of care	08/24	Columbia Care is supported in meeting quarterly deliverables that transform the delivery of care	12/26

A. Project title: Project 7: Vulnerability Framework and Rapid Access Care Planning

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

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.

New projects

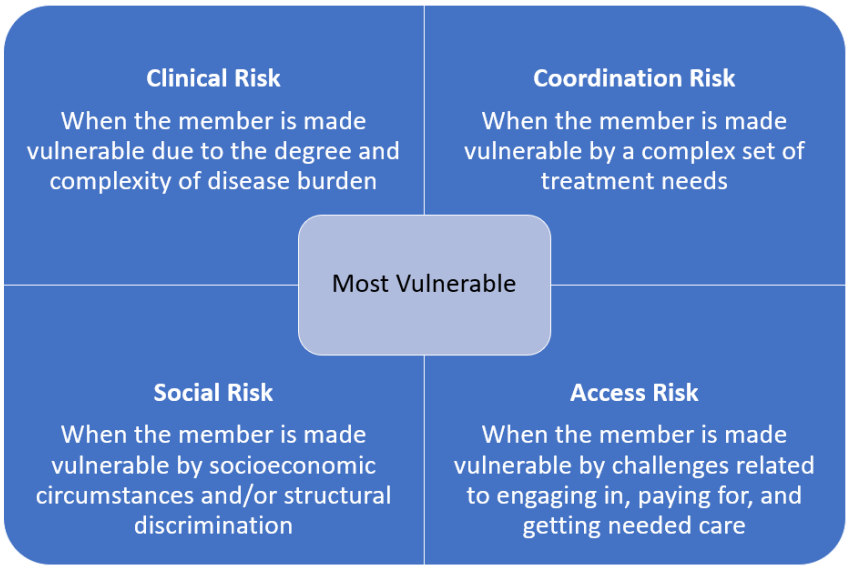
Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

CareOregon Advantage is the partner D-SNP plan for Jackson Care Connect. While all CareOregon Advantage members could be considered as having special health care needs, this project focuses on improving health outcomes for the "most vulnerable" members within our D-SNP population.

CareOregon Advantage uses a vulnerability framework to identify members for the CCIP Intervention. The goals of this framework are:

- **Descriptive Power:** Use highly reliable and accurate individualized data points to indicate member vulnerability.
- **Prescriptive Power:** Use a combination of data points to create a clear picture of actual member needs that can drive precise and individualized action plans.

CareOregon Advantage identifies the most vulnerable D-SNP members by examining various risk elements such as clinical risk, social risk, coordination risk and access risk. These risk categories are summarized in the graphic below.



The following definitions are used to identify members with clinical, coordination, social and access risk:

Risk Type	Methodology Used

Clinical Risk	• Any 30-day readmission in the last year OR any of the following: • Two hospitalizations during the previous 12 months • SPMI or SUD and a high risk of future inpatient needs in the next six months utilizing Johns Hopkins ACG. • Three or more of the following chronic conditions ○ Cancer ○ Cerebrovascular disease ○ Chronic kidney disease ○ Chronic obstructive pulmonary disease ○ Chronic liver disease ○ Diabetes ○ Congestive heart failure ○ Persistent asthma ○ Depression ○ Schizophrenia ○ HIV ○ Ischemic Heart Disease • OR identified through clinical judgment of Medical Directors or medical provider as needing a higher level of care management
Access Risk	• No provider visits in the last twelve months OR • Johns Hopkins ACG flag for frailty*, cognitive decline, assistive device or paralysis related to diagnosis or DME claim OR • More than five ED visits in the last 12 months that resulted in discharge home OR • Health Risk Assessment Tool (HRAT) indication that member has difficulty taking medications or has no support to overcome ADL (Activities of Daily Living) barriers
Coordination Risk	• Drug Therapy Coordination Risk (DTCR)** flag of yes and a polypharmacy flag of yes in the measurement period • Clinical complexity that indicates the need for care coordination between specialist-driven care and drug therapy coordination risk defined above
Social Risk	• BIPOC (Black, Indigenous and People of Color) race or ethnicity OR • Primary language other than English OR • Age greater than 85 OR • HRAT indications of housing instability or food insecurity

We define the sickest and most vulnerable D-SNP members as those who have clinical risk accompanied with one additional risk (social, coordination or access). These most vulnerable members represent about 21% of the overall D-SNP population. In 2023, 582 members met the criteria for most-vulnerable D-SNP members. The most vulnerable cohort was disaggregated by REALD and Gender Identity.

Race/Ethnicity	Percent of Cohort
American Indian or Alaska Native	4.4%
Asian	5.5%

Black or African American	1.5%
Latino/a/x/e	7.6%
Multi/other	1.5%
Native Hawaiian or Pacific Islander	0.4%
White, Middle Eastern or North African	72.8%
Missing Data	6.3%
Primary Spoken Language	Percent of Cohort
English	94.5%
Spanish	3.5%
Chinese	0.4%
Missing Data	1.7%
Disability Status	Percent of Cohort
2+ Disabilities	7.4%
Cognitive Disability	2.4%
Communication Disability	0.2%
Hearing Disability	0.9%
Independent Living/Self Care Disability	31.4%
Learning Disability	0.2%
Mental Health Disability	0.4%
Non-Disabled	43.8%
Physical Disability	4.8%
Vision Disability	0.7%
Missing or Unknown	7.7%
Gender Identity	Percent of Cohort
Boy, Man	5.4%
Girl, Woman	9.4%
Missing Data	88.2%

The analysis showed that White, Middle Eastern or North African was the largest racial or ethnic identity followed by a small but significant percentage of members identifying as Latino/a/x, Asian and American Indian or Alaska Native. Approximately half of the most vulnerable cohorts had at least one disability with 7.4% identifying as having two or more disabilities. Independent living disabilities are the most commonly reported. In future years, sexual orientation data will also be included in this analysis.

D. Brief narrative description

1. **Project population:**

CareOregon Advantage, JCC/CareOregon's Dually Eligible-Special Needs (D-SNP) 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 CareOregon Advantage's mission of making health care work for everyone. CareOregon Advantage and JCC directly collaborate

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.

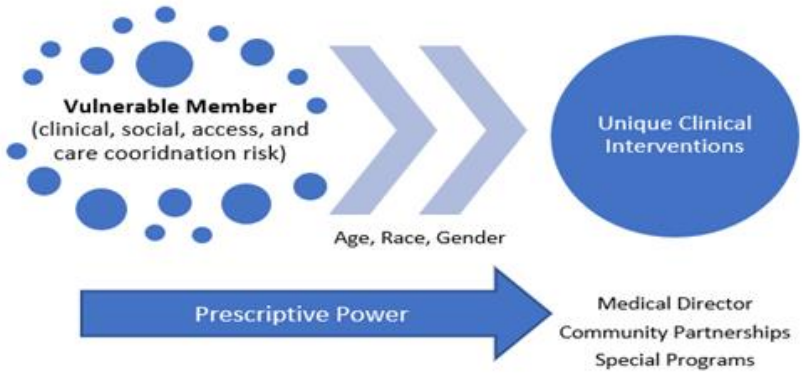
The member risk stratification methodology is outlined in Section C.

Applying this risk stratification method to the full COA population, members are 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

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.

Each month, a report is run to identify any new members who meet our most vulnerable criteria. Our special services then begin by assigning each member to the appropriate intervention, including an Intensive Care Coordinator (ICC), who maintains a caseload for intensive support. Depending on the need, the member may be assigned to ICCs specializing in physical health, behavioral health, or social health. This Intensive Care Coordinator will be the single point of contact for the member, and the member remains on their caseload as long as needed. In addition to the standard training received by all care coordinators (Trauma-Informed Care and Motivational Interviewing), the ICC receives special training relevant to the most vulnerable population.

The special training covers:

- Supporting the aging population
- Palliative care
- Social health
- Women's health

The ICC meets with the member on the phone or in person to conduct an initial assessment, create a collaborative Rapid Access Care Plan and consult with the Medical Director. The success of the ICC depends on their ability to become familiar with all aspects of the members' lives and support medical providers. The member has direct access to their ICC, and they work collaboratively to proactively address any needs or issues by building the Rapid Access Care Plan together.

Through the prescriptive power of our algorithm, we know there are critical elements of care to be considered for this vulnerable population, such as clinical, access, social and care coordination risk. We also know that immediate and proactive access to care and services is paramount to supporting this population. We utilize the prescriptive power within our vulnerability algorithm to develop targeted interventions. The Rapid Access Care Plan is a critical component of the intervention. The specialized care plan template uses questions designed with this population to guide the ICC in creating a proactive set of interventions. Examples of these interventions are in the table below. The purpose is to pre-plan what the member is likely to need based on their medical, behavioral, or social presentation. While the ICC will also address current issues, they are trained to work with the ICT (Interdisciplinary Care Team) to predict the members' needs in the next three to six months. This includes but is not limited to specialist referrals, medical equipment, prior authorizations, social health needs or specialized services that fall outside the normal process. The ICC uses the Rapid Access Care Plan (see template below) to proactively submit referrals, match specialty services, or gain authorizations before they become acutely needed. The Rapid Access Care Plan is reviewed every 90 days, or sooner, depending on the needs of each member.

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	

The Regional Care Team (RCT) focused on the dual eligible population launched in 2023. The Care Coordination Department also implemented a new EHR (Electronic Health Records), Epic Compass Rose, which allows for improved integration of social needs data. These capabilities are critical for the work of this special RCT. However, given the incredibly tight timeline that we had to bring Epic online, the rebuilding of many key reports is expected to continue through 2024.

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 MOC (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
JCC 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. JCC 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	100% of Q1 and Q2 MOC Most Vulnerable cohorts will receive care coordination outreach	07/2024	100% of Q3 and Q4 MOC Most Vulnerable cohorts will receive care coordination outreach to (a)	12/2024

cohort had received care coordination outreach	to (a) update their care plan and (b) offer care coordination services		update their care plan and (b) offer care coordination services	
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)**
2023 current state RASA = 87% Statins = 87% Diabetes = 88%	2% improvement over 2023 performance for: • RASA • Statins • Diabetes	12/2024	2% improvement over 2024 performance for: • RASA • Statins • Diabetes	12/2025

A. Project title: Project 8: Post Acute Residential Treatment

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

If continued, insert unique project ID from OHA: 446

B. Components addressed

1. Component 1: SHCN: Non-duals Medicaid
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):**

This project is reviewed regularly during an established and recurring SUD collaborative in our region. This collaborative of anchor SUD providers expanded to include referring partners that serve members with the specific need for IVAB (intravenous antibiotic treatment). The following agencies are represented regularly in attendance at the monthly meeting: Mercy Flights, ARC (Addiction Recovery Center), Providence, Asante, JCC and Allcare. During this meeting, providers review referral trends, including elements of eligibility criteria and policy barriers that might be impacting referrals. The group also works together to solve system barriers, update each other on new and/or changing programs, discuss observed changes in local drug supply and substance-using practices, and develop referral pathways. ARC works closely with the hospital-based SUD navigators at both Asante and Providence hospitals. The navigators are considered the primary referral coordinators, and hold/track the referral data for this population. Admissions into the program have been very low and not as forecasted.

Data was analyzed disaggregating demographics on JCC members who had an inpatient hospitalization in 2023 with a substance use disorder. Disorders such as alcohol, nicotine and inhalants which are unlikely or impossible to be injected were excluded from the analysis.

Characteristics	Total Members	
	n	%
Total Members	481	100.0
Sex		
Female	240	49.9
Male	241	50.1
Gender Identity		
Woman	54	11.2
Man	42	8.7
Non-Binary	0	0.0
Not Reported	385	80.0
Race and Ethnicity		
American Indian/Alaskan Native	27	5.6
Asian/Pacific Islander	25	5.2
Black	22	4.6
Hispanic	38	7.9
Other	6	1.2
White	325	67.6
Not Reported	38	7.9
Spoken Language		
English	474	98.5
Spanish	3	0.6
Other	4	0.8
Disability Status		
Disabled	77	16.0
Non-Disabled	354	73.6
Not Reported	50	10.4

The race, gender, and sex assigned at birth data did not provide any clues as to why enrollment in the program has been low. The majority of members with an inpatient admission were English speakers, with only 7 members speaking a language other than English. This likely rules out language access as a potential barrier. However, 16% of these members do identify as having a disability. Analysis of more granular disability data did not reveal any patterns; however, it is possible that accessibility has played a small role in low enrollment in the program. Future analysis could seek to identify members eligible for the program and break down by demographics. This could allow us to explore whether demographics are connected to the likelihood of enrolling in the program, but multiple years of data would likely be needed in order to produce a large enough population to disaggregate. Sexual orientation data could be added to the analysis to explore whether that has any effect on likelihood of enrolling in the program.

The SUD Collaborative has identified three main reasons for low utilization based on experience with the program. First, clients often decline admission after assessment and counseling. Second, Asante and Providence have very few admissions of people who inject drugs.

Professionals are attributing the substantial decrease in IV drug use to an increase in smoking as the preferred form. Patients report favoring smoking as the preferred method due to fear of overdose from undetected Fentanyl in the drug supply. While this is not a decrease in SUD, nor in the use of fentanyl/opiates, this is a decrease in intravenous administration because of the publicized significant danger of fatal overdose associated specifically with intravenous use. ARC reports that the third most common reason for low referrals has been the low number of eligible clients who meet criteria for residential (either in timing, motivation, or medical or mental health acuity). In some instances, ARC has enrolled clients who were referred because of the program, *just not while they were undergoing IVAB infusion*. The SUD collaborative finds value in maintaining the monthly meetings, and meeting minutes reflect active and dynamic discussion related to potential referrals, as well as a review of processes and eligibility criteria to ensure barrier-free access.

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

Hospitalists and SUD navigators identified eligible patients and worked with the Peer Support Specialist to determine if enrollment in program is appropriate. This project did expand access via a contract with Providence so that both hospital systems are involved toward the target. There were various difficulties in meeting the majority of last year's benchmarks due to extremely low hospital admissions whose preferred method of use was intravenous.

Monitoring measure 1.1:

This measure had a target/benchmark of enrolling 8 patients into the program by 12/2023. In 2023, 4 patients were admitted into the program, so this goal was not met. Possible reasons for low enrollment were discussed in the progress to date section.

Monitoring measure 1.2:

A target/benchmark of 75% of the patients admitted completed the prescribed course of IVAB in the SUD setting without leaving AMA. Two out of the four patients, or 50%, completed the prescribed course, so this goal was not met. Out of the four participants, one was switched to oral antibiotics and discharged, and a second was admitted into inpatient care. A 12-month retrospective analysis of inpatient SUD-induced hospital utilization for patients who completed the program by end of 2023 was completed; however, a major challenge for data tracking was data lag and small numbers. In 2022, there was one JCC member enrolled in the program and in 2023, only four. Out of those five members, two did not complete the program. For the remaining three members, one had two readmissions within 12 months of finishing the course of antibiotics. The other two did not remain enrolled with JCC for 12 months post completing the program. This made it impossible to determine a meaningful readmission rate.

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

Despite low numbers, this project has built a strong, multi-system partnership between an anchor residential provider and the hospital systems in our region. The SUD collaborative meets regularly and continues to coordinate possible referrals and refine the process to ensure access. The project is critical from a systems perspective; it has built workflows and referral relationships that support improved access to residential beds for high-need members with high-risk, co-occurring conditions while preserving precious hospital beds. JCC chose to continue the project into 2024 because 1.) Providence has recently been added to the collaborative project, and 2.) The reported decrease of IV admissions and changing local substance use trends required more analysis to inform growth of the project.

Because of redetermination and because of the nature of the target population, we found that it was unlikely that a large proportion of the individuals enrolled in the program would remain covered by JCC for a full 12-months post discharge. That combined with the small numbers, rendered our health outcome analysis plan ineffective. We have shifted the long-term health outcome to address this challenge.

D. Brief narrative description

1. **Project population:**

Historically, safe hospital transitions for homeless patients with a substance use disorder diagnosis pose increased challenges for hospitals due to the limited access to post-acute residential settings, such as Skilled Nursing Facilities. The population of focus for this pilot are patients who cannot be safely discharged from the hospital due to behavioral and social needs barriers, have been prescribed several weeks of intravenous antibiotic treatment (IVAB), and who are active in their substance use, particularly intravenous drug use, which puts them at heightened risk of fatality if discharged with a central line. To complete their full course of treatment, they require a supervised setting until the PICC line (the intravenous port that stays in place until treatment is complete) is safely removed.

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

The IVAB pilot identifies and bridges patients to residential SUD treatment directly from an inpatient hospital setting due to an acute drug-related incident. This project can help these patients during a key window in their recovery. It can also provide an opportunity to engage in needed services when they might be more contemplative of change. The integration of services, particularly medical to community, wraps needed care around patients with complex and co-occurring needs like substance use disorders, mental illness, and housing instability. JCC partnered with Asante Hospital (ARRMC), Addictions Recovery Center (ARC) and Mercy Flights Mobile Integrated Health program to develop the IVAB pilot intended to improve health outcomes, increase hospital capacity, improve engagement in needed SUD treatment, reduce cost, and prevent hospital readmissions for patients who are homeless and active in their substance use. Asante hospitalists from the three regional hospitals identify patients eligible for the program and medically stable to be discharged with proper medical oversight. These patients require a PICC line to complete their course of IV antibiotics, but due to active substance use, are unsafe to discharge to the streets or other residential settings. This prompts the ARC Peer Support Specialist (PSS), a Traditional Health Worker with lived experience, to complete a bedside assessment to identify level of appropriateness and readiness for placement at the Addictions Recovery Center while they complete their treatment. This can serve as a bridge to ongoing outpatient or residential treatment to address the underlying SUD drivers that resulted in the original hospital admission. During this intervention, the participants' social needs are assessed, and referrals are made to ensure awareness and connectivity to culturally appropriate primary care setting, mental health services and other needs as identified. The ARC has two treatment beds dedicated to this pilot with Asante hospital specifically, with the goal of increasing capacity over time and expanding to additional hospital systems.

Since the beginning of the project, the IVAB Pilot steering committee has met monthly, as described in section E, and collectively reviews referrals, trends, and needs of the collaborative partners. The hospital-based SUD navigators track the referrals and data (i.e., reasons for decline or ineligibility).

While initially predicting a much higher volume of eligible referrals, the collaborative recognizes that IV drug use has declined, and the timing of an individual's hospital discharge rarely aligns with their eligibility for residential admission. However, JCC has continued this TQS project for one final year to analyze and close out the observed trends in preferred form of use and referrals who are eligible for residential. Additionally, we believe expanding the pilot project to include Providence hospital should facilitate a higher volume of eligible referrals into the program.

Please refer to the IVAB Infusions Procedure for a detailed description of the intervention workflow.

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

Activity 1 description: Hospital navigators identify eligible patients and work the PSS to determine if enrollment in program is appropriate. Patients meeting requirements are enrolled and receive IVAB in the SUD setting.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Volume of eligible referrals, meeting criteria for both IVAB and SUD residential.

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
4	6	12/2024	14	12/2025
Monitoring measure 1.2	Percent of patients who complete full course of their IVAB treatment in this post-acute setting (do not leave AMA or opt out before treatment course complete).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
50%	50% of the patients admitted to this program (more than double the volume in 2022), will complete the prescribed course of IVAB in the SUD setting without leaving AMA or before course completed	12/2024	75% of the patients admitted to this program will complete the prescribed course of IVAB in the SUD setting without leaving AMA or before course completed	12/2025
Monitoring measure 1.3	Percent of patients enrolled in the program with a readmission within 3 months			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
100%	75%	12/2024	50%	12/2025

Section 2: Supporting information (optional)

Attach other documents relevant to the TQS components or your TQS projects, such as driver diagrams, root-cause analysis diagrams, data to support problem statement, or member materials. Please add any attachments to the table of contents.

A. **Supplemental Materials for Project 6: Columbia Care SHIFT Application**
B. **Supplemental Materials for Project 6: SHIFT Business Plan Template**
C. **Supplemental Materials for Project 8: IVAB Infusions Procedure**

CareOregon

Application

Part I: Organizational profile

Agency name:	ColumbiaCare Services, Inc
CEO or executive director:	Stacy L. Ferrell
Primary administrative address:	3587 Heathrow Way, Medford OR 97504
Contracted network provider for: (check all that apply)	☐ Columbia Pacific CCO
	☐ Health Share of Oregon CCO
	☒ Jackson Care Connect CCO
	☐ CareOregon Advantage (Medicare)
Key contact person (name/title):	Ben Solheim, Clinical Director
Key contact person (phone/email):	503.654.7654/bsolheim@columbiacare.org
Secondary contact for SHIFT application (name/title):	Jennifer Sewitsky, Communications Director
Secondary contact for SHIFT application (phone/email):	541.858.8170/jsewitsky@columbiacare.org
Counties in which the agency operates outpatient behavioral health programming (please list)	Jackson County
Number of outpatient behavioral health program locations	2
Is the agency a culturally or linguistically specific agency?[1] Yes/no, list	No
Does the agency operate a culturally or linguistically specific program?[2] Yes/no; if yes, please list the distinct minoritized community or communities served	No

[1]An outpatient entity or institution that is structured to provide culturally and linguistically specific behavioral health services in its entirety as evidenced by its organizational mission.

[2]A division or associated component of an organization that provides culturally and linguistically specific behavioral health services as evidenced by the program mission, that exists within the subset of services provided by an organization whose mission does not focus on a distinct minoritized community.

Service continuum. Please list the services provided in the agency's continuum of care.	Residential Treatment Programs Supportive and Integrated Housing Rental Assistance Programs Crisis Facilities Crisis Stablization Veterans Housing Veterans Case Management Outpatient Services Array Outpatient Substance Use Disorder Treatment Peer Delivered Services Intensive Case Management Supported Education & Employment
Accreditation. Please list any existing accreditation the agency has, or plans to obtain accreditation including timeline (e.g., CARF, Joint Commission, Council on Accreditation)	N/A
CCBHC status. Is the agency a Certified Community Behavioral Health Clinic? If yes, please indicate if state certified or a SAMHSA grantee (or both) (Yes/No, list)	No
FQHC status. Is the agency a Federally Qualified Health Center? (Yes/no)	No
Electronic health records. Dotes the agency currently have an electronic health record system or plans to adopt one? Please include timeline if in process.	Yes, we use CareLogic EHR
Health information exchange. Does the agency currently participate in any health information exchange or have plans to? Please include timeline if in process.	Yes, PointClickCare
Financial audit history. In the agency's most recent audit report, did the auditor issue a going concern opinion?	No

Staffing	Current FTE count (including vacancies)	Active vacancies count
Agency executive leadership (including, for example, CEO, CFO, CMO, COO)	7	0
Outpatient behavioral health program leadership (may be same as agency executive leadership, including, for example, clinical director, operations director, quality director)	10	1
Outpatient behavioral health programs	54	11
Non-outpatient BH staff count (clinical and non-clinical)	439	47

** Agency may submit an organizational chart with vacancies noted if it is easier to convey this information in another format.*

Part II: Clients profile

Outpatient services and population *Inclusive of fidelity services captured in next table*	**Unique clients served annually**	**Percent who are CareOregon-affiliated[3] health plan members**
Mental health – youth, 0-17	N/A	N/A
Mental health – adult, 18+	1307	87%
Substance Use Disorder – youth, 0-17	N/A	N/A
Substance Use Disorder – adult, 18+	32	100%
Outpatient fidelity and level of care services[4]	**Unique clients served annually**	**Percent who are CareOregon-affiliated[3] health plan members**
Assertive community treatment	N/A	N/A
Intensive case management	37	100%
In-home behavioral health treatment	N/A	N/A
Wraparound	N/A	N/A
Other: _____	N/A	N/A
Race/ethnicity of clients served in outpatient care	**Unique clients served annually**	**Percent who are CareOregon-affiliated[3] health plan members**
American Indian / Alaskan Native	38	3%
Asian	15	1%
Black/African American	25	2%
Hispanic/Latinx	88	7%
Pacific Islander / Native Hawaiian	6	0.5%
White	1105	85%
Unknown	N/A	N/A

[3]Columbia Pacific CCO, Jackson Care Connect CCO, Health Share of Oregon CCO, CareOregon Advantage

[4]As described in the introduction to the Integrated Team-Based Care Building Block, "Intensive Case Management, Assertive Community Treatment, Wraparound and Intensive In-Home Behavioral Health Treatment (IIBHT) models are not currently a focus of the Integrated Team Based Care Building Block because of model-specific fidelity requirements and focus on populations with defined level of care needs. Nonetheless, agencies will find benefit from applying the principles and practices of integrated team-based care to their existing teams. These principles include a psychologically safe environment to work and receive care, FIT, shared goals, clear roles, effective communication, mutual trust and measurable processes and outcomes across all members of the team (including clients)." (SHIFT Building Blocks Framework, page 7)

Languages spoken of clients served in outpatient care *Use additional lines to indicate other languages that are in the top five of prevalence amongst clients served*	Unique clients served annually	Percent who are CareOregon-affiliated[3] health plan members
Cantonese	N/A	N/A
English	1301	99.5%
Mandarin	N/A	N/A
Russian	N/A	N/A
Somali	N/A	N/A
Spanish	6	0.5%
Ukrainian	N/A	N/A
Vietnamese	N/A	N/A

Part III: Data reporting capacity

Data reporting. Various data reports will be needed as part of SHIFT-participating agencies' planning and design work. What of the following reports are already part of the agency's standard reporting, and what would need to be developed as we go? What of them can be disaggregated by race, ethnicity, language, gender and sexual identity?

	Standard reporting		Would need to be developed	
	General population	Disaggregated	General population	Disaggregated
Age, gender, race, ethnicity, and preferred language of patients	X			
Socioeconomic status, housing, education, employment status				X
Primary and secondary payers (guarantors of payment)	X			
Symptom severity and change over time (using standardized scales)				X
ORS/SRS or ACORN scores	X			
Timeliness of access	X			
Engagement/ retention in services	X			
Percent of clients provided services in their preferred language (not via interpreter)				X
Number of outpatient visits by staff type	X			

Number of outpatient visits by populations and levels of care	X			
Number of new clients by populations and level of care	X			
Number of closed clients by population and level of care	X			
Average duration of engagement in services by level of care				X
Hospital admission and readmission rates	X			
Emergency department visits related to behavioral health and physical health	X			
Utilization of telehealth services	X			
Medication adherence				X
Primary care engagement				X
Oral health engagement				X

Part IV: Narrative responses

Please answer in a separate document and submit as an attachment with this application.

1. Describe your agency's motivation for applying for the SHIFT program. How and why do the aims of SHIFT align with your organization's mission and strategic priorities? What gaps would it fill? How do the cross-cutting values align with your agency's values? Please include with your application a copy of your agency's most recent strategic plan or similar document. [Max 300 words]

2. Describe one or more major change initiatives that your agency has undertaken in the last 3-7 years, such as agency accreditation, launching a new service line, implementation of trauma-informed care, adoption of Feedback Informed Treatment, or becoming a Certified Community Behavioral Health Clinic. What was it, what people-centered change management strategies were employed, what lessons learned did the agency experience, and how is the program/initiative faring today? Are the same leaders present today? [Max 250 words]

3. Describe the value that team-based care would bring to your agency, including clients and staff. (Refer to the Integrated Team Based Care section of the SHIFT Building Blocks Framework.) Has your agency engaged in previous efforts to implement team-based care? If so, what was the outcome? [Max 250 words]

4. What staffing types does the agency currently employ to support clients in outpatient care? Is there a role you would like to add to your client-facing staff to enhance the agency's ability to meet the needs of clients? For example: peer support specialistspeer wellness specialists, community health workers, MDs, NPs, pharmacists, CADCs, QMHAs, QMHPs. Please list. [Max 150 words]

5. Please share examples of ways that your agency is fostering a data-driven culture. Examples might include training staff of different levels and functions in use of data reports, dedicated roles at the agency, development of specialized dashboards that can visualize client progress, examining disaggregated data to understand health disparities, use of client-reported outcomes to drive care decisions, training of clinical managers on review of revenue and budget performance, training of financial team members on clinical program performance. Please feel free to attach sample dashboards or de-identified reports that are used at the agency. [Max 250 words]

6. What other major change activities are underway or forecasted in the next three years that might impact ongoing engagement in the SHIFT program? Examples might include forecasted leadership changes, major capital campaigns or investments, service line growth, EHR adoption. [Max 200 words]

7. Please share examples of ways that your agency is developing or using standards, protocols, practice agreements, and technology to improve prompt access to care. What problems are you trying to solve? What are ways that your agency is exploring barriers and opportunities for making these changes. [Max 200 words]

8. The Building Blocks are interconnected and cannot be addressed in isolation. Based on your agency's initial self-assessment, what do you see as the priority areas of focus for your agency when launching work under SHIFT? [Max 200 words]

9. Please note that initial self-assessment scoring has no bearing on the evaluation of your agency's application to the SHIFT program; the purpose of this exercise is to support agencies to engage in self-reflection and facilitate an early dialogue with CareOregon. It is more important to be honest and transparent in the self-assessment than to focus on the scoring.

10. Describe how your agency is engaged in advancing equity, diversity and inclusion practices in care delivery. Examples might include new program design focused on marginalized populations, reducing barriers to services, outreach/engagement efforts, cultural events, incorporation of client feedback. [Max 250 words]

11. Describe how your agency is engaged in advancing equity, diversity, and inclusion practices internally in support of creating a fair, inclusive and diverse work environment for staff, volunteers and other stakeholders. Examples might include hiring and retention practices, professional development, supervision strategies, employee resource groups, compensation analyses, leadership coaching. Please consider including copies of any EDI-focused planning documents. [Max 250 words]

12. Provide evidence or examples of your agency's readiness to adopt a whole health approach to health care, integrating both medical and social health partnerships. Include, for example, any established care coordination practices with external entities, designated staff roles in place or forecasted, service array changes, and/or use of ConnectOregon. [Max 250 words]

13. How does your agency incorporate the perspectives of your clients or individuals with lived experience into decision-making processes at the client, program and organizational levels? For example, does the agency employ Feedback Informed Treatment? How do you ensure client voice, feedback, and outcome data is being used to inform individual care, and how is that same client feedback being used for identifying agency QI opportunities? Are clients and/or individuals with lived experience represented in any leadership, board, or community advisory groups? Provide specific examples. [Max 250 words]

14. Workforce stability has been especially challenging for many behavioral health agencies over the last three years. Please describe your agency's current state, how staff have been employed in problem-solving, and trends and strategies being employed to promote workforce wellness, retention and stability. What potential obstacles related to workforce do you see in your agency's ability to engage in the SHIFT program? [Max 250 words]

15. While SHIFT funding can be used to hire and retain new staff (or backfill for staff newly focused on SHIFT implementation) and consultants to support the initiative, please describe any existing staff/resources that would be dedicated to the initiative to fulfill the roles of program and/or project management, and the availability of existing leaders and key staff to be part of the initiative design and implementation work. Who would likely serve in the role as primary executive sponsor? [Max 200 words]

Part V: Attachments and supplementary materials

Please include the following supplementary materials:

- ▣ Narrative responses for Part IV **(required)**
- ▣ Copy of a completed Initial Self-Assessment Tool **(required)**
- ▣ Copy of latest organizational strategic plan **(recommended**)
- ▣ Copy of latest materials speaking to diversity, equity and inclusion strategy **(recommended)**
- ▣ To relieve burden of some written narrative responses, please feel free to submit copies of committee descriptions, client testimonies, policies, etc. or other supplementary materials **(as needed)**

Part VI: Applicant checklist and signature

By checking these boxes below, I affirm the following:

☒ To the best of my knowledge, if selected and provided the resources and supports described, our organization will be able to participate in the level of effort described earlier in SHIFT Supports and Participant Expectations

☒ Our board of directors supports our application to the SHIFT program

Name Stacy L. Ferrell

Title Executive Director Date 9/27/23

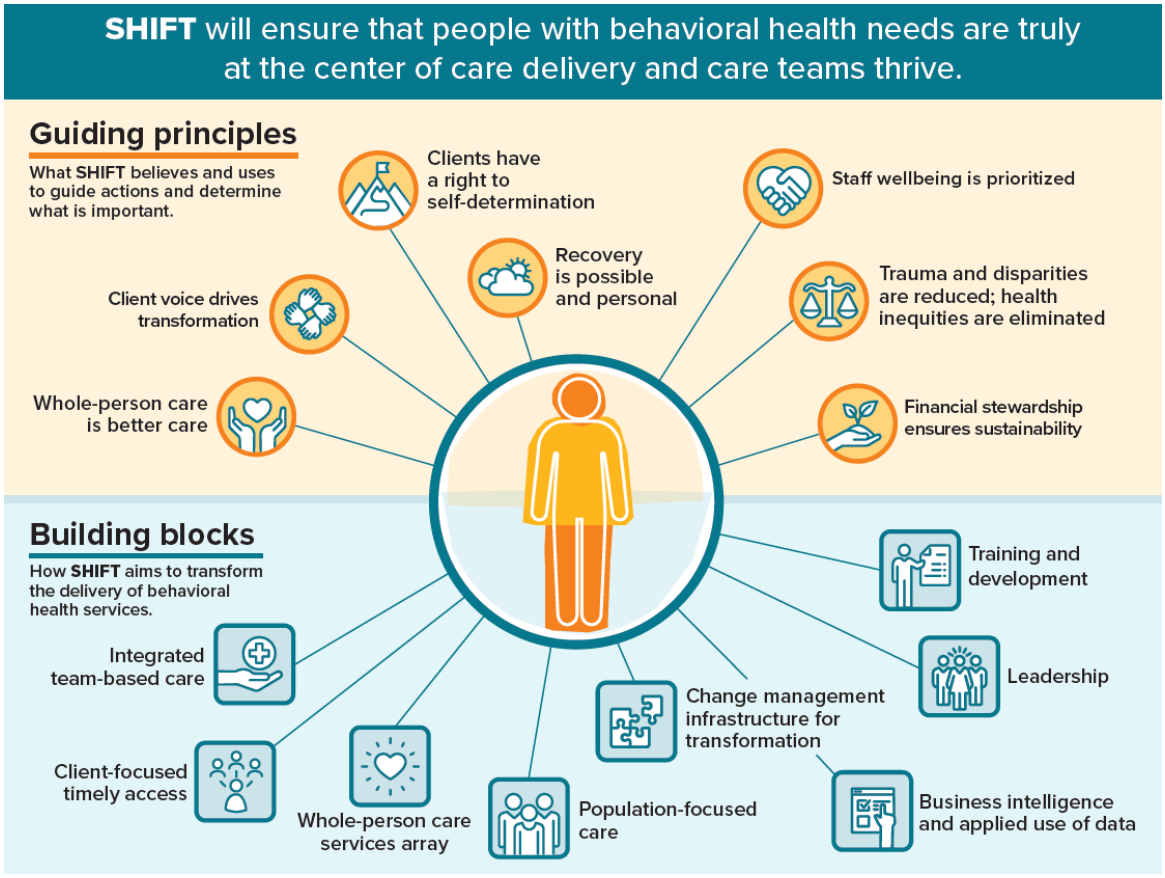
SHIFT Business Plan Template and Instructions

Business Plan Overview

The SHIFT business plan lays the framework for the agency's 2024-2026 SHIFT implementation work. Goals are defined along with detailed objectives and milestones. Implementation plans, communication plans, and project roles are defined.

Before completing the business plan, assess current state gaps and determine focus areas. The SHIFT Planning Guide is a tool to support agencies through this assessment and planning process. Agencies will partner with CareOregon and consultant partners to guide current state assessment and business plan development, including scope of work development, defining success measures, and planning for implementation. In addition, agencies may use Phase 1 funding to hire additional consulting support.

As the business plan is developed, ensure the SHIFT Guiding Principles guide actions and support decision making processes.



Remember that Feedback Informed Treatment (FIT) is the backbone for a successful SHIFT initiative. SHIFT goals and implementation plans should be well aligned with FIT goals and implementation plans.

This business plan template is to be completed by each agency. Each section includes instructions and examples. Once the business plan is complete, agencies will do a full review with CareOregon and CareOregon will provide final approval. The business plan needs to be finalized and approved no later than August 31st, 2024. A complete submission will include:

- Completed version of this template
- Implementation plan and measures tracker
- Change management plan
- Communication plan (if documented in a separate file)

Table of Contents

Executive Summary

Agency Name	

Agency Context and Vision

In the space below, provide a summary of where your agency is today related to the SHIFT building blocks and guiding principles and describe the vision you are aiming to achieve through the SHIFT implementation. What do you hope to achieve by the end of 2026 and what are the longer term aims? Where is your agency at with its FIT implementation and what are the next steps?

2024-2026 SHIFT Goals, Objectives, and Strategies

What are Goals, Objectives, and Strategies?

Goals, objectives, and strategies are critical in shaping the SHIFT work and providing structure to understand if the work is on track throughout the initiative.

It's important to understand each goal setting term and how it will be used in the business plan and throughout SHIFT initiative management.

Key Terms

Term	Definition
Goals	Broad, long-term measurable outcomes.
Objectives	The "how" we'll achieve the goal.
Strategies	Detailed measurable actions taken to achieve objectives and goals.
Milestones	A measurable and important accomplishment necessary to achieve a goal.

Example

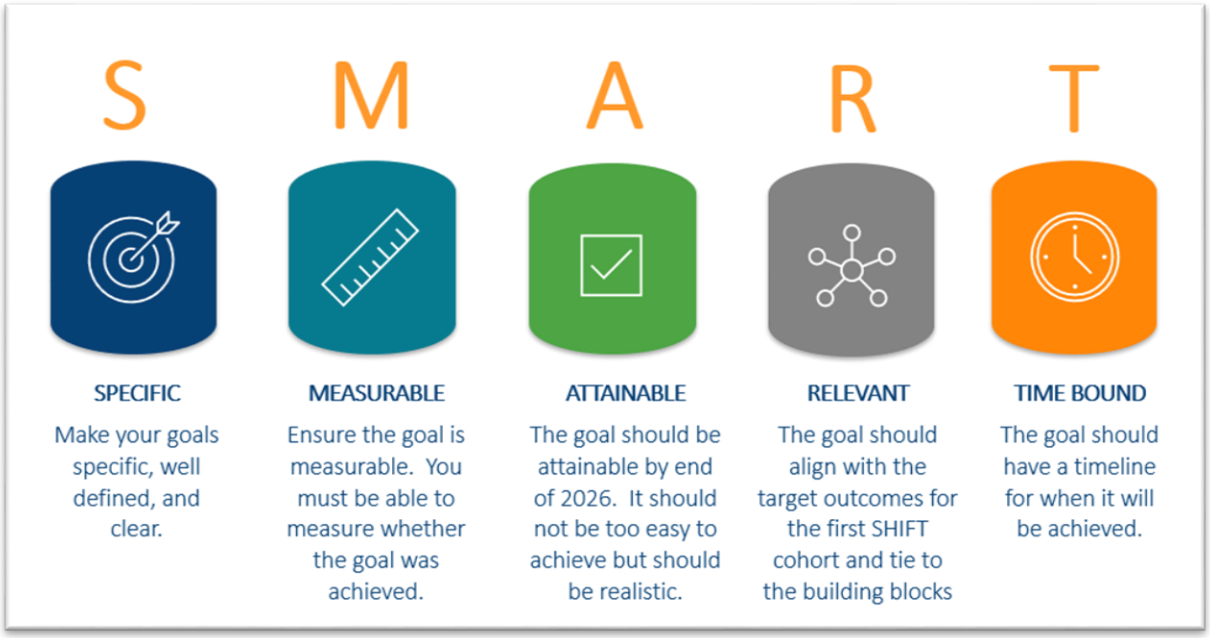
Here is an example of how goals, objectives, and strategies tie together:

Setting Goals, Strategies, and Objectives.

Develop four to five goals that will span 2024-2026. These should be big picture two-to-three-year outcomes your agency is aiming to achieve through SHIFT. The goals should align with closely with FIT implementation plans. Once those are defined, set more granular objectives and strategies that will be tracked and measured along the way to ensure the long-term goals are met.

The Planning Guide provides guidance on determining the right goals and objectives for your agency. The goals should align with the CORE targeted outcomes for 2024-2026.

When setting goals and objectives, follow the SMART guidelines below.



Goals

Use the table below to document your agency's SHIFT goals. These should be developed based off of your current state assessment work and should be tied to the building blocks. Enter the SMART goal in the first column of the table below. In the second column, list all of the building blocks the goal ties to. In the third column, list any building blocks, platform elements, or other supports that must be in place or improved to ensure success of this goal. These are considered dependencies.

#	Enter your 4-5 Goals Below.	Enter the building block(s) the goal ties to	Enter critical dependencies (i.e., what has to be done before this goal can be completed?
1			
2			

3			
4			
5			

Objectives and Strategies

Define objectives and strategies for each goal. Objectives are short-term goals that align with long-term goals. Then define strategies which are detailed measurable actions taken to achieve the objectives and goals. Note, each objective can have more than one strategy.

Enter each goal you defined in the goals section into the top blue row of each table below. Enter the corresponding objectives your agency will use to achieve the goal. Enter measurable strategies next to each objective.

Goal 1:	
Objectives	**Strategies**
1.	1. 2.
2.	1. 2.
3.	1. 2.
4.	1. 2.
5.	1. 2.

Goal 2:	
Objectives	**Strategies**
1.	1. 2.
2.	1. 2.
3.	1. 2.

4.	1. 2.
5.	1. 2.

Goal 3:	
Objectives	**Strategies**
1.	1. 2.
2.	1. 2.
3.	1. 2.
4.	1. 2.
5.	1. 2.

Goal 4:	
Objectives	**Strategies**
1.	1. 2.
2.	1. 2.
3.	1. 2.
4.	1. 2.
5.	1. 2.

Goal 5:	
Objectives	**Strategies**
1.	1. 2.
2.	1. 2.

3.	1. 2.
4.	1. 2.
5.	1. 2.

Platform Element Plans

Platform elements are the minimum requirements expected to support successful planning and implementation of the SHIFT initiative. A full description of the Platform Elements and implementation considerations and requirements can be found in the SHIFT Program Guide.

In the table below, describe how your agency will address the considerations and requirements. Plans to resource the platform element can include existing capacity and/or new or added capacity so long as each element is satisfactorily addressed.

Platform Element	Implementation Requirements	Agency Plan to Address Considerations and Requirements	Estimated Costs
Leadership Capacity and Continued Engagement	• Plan in place to dedicate appropriate leadership time to SHIFT (could include additional leadership FTE, consultant support, etc.) • Strategic planning process in place • Change management tools and methodologies in place or supported by a consultant. • External consultant resource in place to provide executive coaching.	•	•
Subject Matter Expertise	SMEs are required in each of the areas listed below. These can be internal experts with time explicitly dedicated to SHIFT or gaps can be filled with external resources. One SME can cover multiple areas if they have the knowledge and skill set to do so: • Equity, Diversity, & Inclusion expert • Trauma informed care expert • Quality improvement expert • Program development expert	•	•
Data Management Infrastructure / Process	• Resource allocated to data management infrastructure and processes (internal expert or external consultant) • Infrastructure needs assessment and planning to address identified needs (internal expert or external consultant)	•	•

Platform Element	Implementation Requirements	Agency Plan to Address Considerations and Requirements	Estimated Costs
Program Planning	• Dedicated project management resource (internal or external) • Defined project management processes and tools (internal or developed with consultant partners) • Infrastructure for staff feedback and feedback from individuals receiving services	•	•

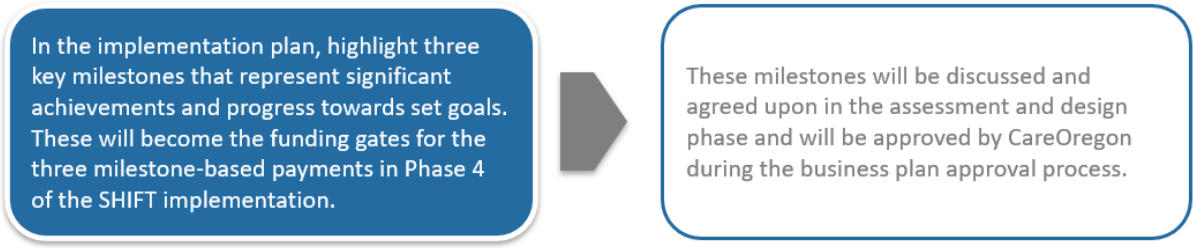
Implementation Plan

Overview

Each agency will create an implementation plan using the Implementation Plan Template. **The implementation plan is a three year quarterly forecast of the timing of deliverable completion.** The implementation plan will layout the tasks, deliverables, and milestones aligned with laying the foundational platform elements and achieving the agency goals. All tasks and deliverables that impact goal and objective achievement should be listed.

The implementation plan should closely align with your agency's FIT workplan.

Funding Milestones



Implementation Plan Updates

The implementation plan will be used and updated throughout the SHIFT implementation. Each agency will review the implementation plan with CareOregon on a quarterly basis. Any deviations from set timelines and deliverables will be discussed. The plan can be adjusted quarterly by mutual agreement based on learnings.

Use the Implementation Plan Template and follow the instructions provided in the template. The completed initial implementation plan should be submitted with the business plan.

Measures

Agencies will identify and track a set of measures and report data on a quarterly basis during the quarterly status report out. Measures are quantitative indicators of performance. For example, if an organization is working to increase access, the organization might track the number of new patients seen monthly as an indicator of success. Agency-specific measures will be tracked in the Implementation Plan Template on the measures tracking tab.

CORE will also engage with SHIFT agencies to finalize quantitative measures that will be tracked across the SHIFT cohort as part of learning & evaluation plans. The proposed quantitative measures rely primarily on existing data sources such as claims or FIT standard documents and reporting mechanisms to minimize agency reporting burden; see the SHIFT Program Guide for more information.

Status Reports

Each agency will provide and walk through monthly or quarterly status reports with CareOregon and consultant partners.

Halfway through the assessment and design phase, agencies will provide a mid-point status report covering progress on current state assessments for FIT and SHIFT and draft business plan content. Once the business plan is approved, a more formal status report will be developed and reviewed with CareOregon. Given the importance of the platform elements, status reports will be monthly during the platform element implementation phase. Status reports will transition to quarterly once the agency is in full implementation.

Details on the content and timing of the quarterly reports can be found in the SHIFT Program Guide. The template for the status reports can be found XXX.

SHIFT Initiative Team

Each Agency will establish a leadership and governance structure to support the SHIFT transformation as outlined in the SHIFT Planning Guide. Once roles are assigned, complete the table below.

Add rows as needed to represent the full team working on the SHIFT initiative.

Role	Name	Title	% of Time Dedicated to SHIFT	Lived Experience (Y/N)
Initiative Sponsor				
Clinical Lead				
Administrative Lead				
Project Manager				
Executive Coach				
Project Analyst				
EDI Expert				
TIC Expert				
Quality Improvement Expert				
Program Development Expert				
Project Team Member				
Project Team Member				
Project Team Member				
Project Team Member				
Subject Matter Expert				
Subject Matter Expert				
Subject Matter Expert				

Communication Plan

Each agency will develop a SHIFT Communication Plan. A project communication plan sets clear guidelines for how and when information will be shared, as well as who's responsible for and needs to be looped in on each project communication.

Review the Initiative Communications Plan section of the SHIFT Planning Guide and then complete the communication plan below. An example of how to use this format to document the communication plan is provided. The example provides only a few rows for reference, the actual communication plan will be more robust. If preferred, this template can be copied into Excel for ease of use. If a separate document is created, please attach to the business plan submission.

Include all types of communication (e.g., email, meetings, website, teams/SharePoint, etc.) and include all types of audiences, both internal and external. Thoroughly think through who needs to know what and when. The communication plan can and should be updated over time as needs change.

Example:

Communication	Method	Frequency	Goal	Owner	Audience
Initiative Leadership Meeting	Meeting	Bi-Weekly	Review project status, progress, and barriers	Project Sponsor	Initiative Leadership Team
Workgroup Meeting	Meeting	Bi-Weekly	Develop deliverables, implementation plan review	Project Manager	Workgroup
SHIFT Update	Email	Monthly	Inform all staff on SHIFT progress and highlights	Project Manager	All agency
Project Status Report	Email	Bi-Weekly	Inform project participants	Project Manager	Initiative Leadership Team and Workgroup

Agency Communication Plan:

Communication	Method	Frequency	Goal	Owner	Audience

Change Management Plan

SHIFT is significant, transformational work that impacts almost every area of an agency. SHIFT requires culture change throughout the organization. Managing change and creating true culture change can be challenging but are necessary for transformation and sustainability.

Various Change Management methodologies exist, such as ADKAR, Bridges, and Kotter's Theory. Agencies need to assess current change management capabilities and develop a change management plan. The plan will look different depending on the methodology your agency uses.

If your agency is new to structured change management, an external consultant resource may be helpful. Describe your agency's change management approach below and attach a detailed change management plan.

Procedure:	**INTRAVENOUS ANTIBIOTIC (IVAB) INFUSIONS**		
Effective Date:	March 11, 2022	Last Revised/Review Date:	February 20, 2024
Regulatory References:			
Applies To:	3.5-Residential		
Associated Policies:			
Associated Documents:			

BACKGROUND

In partnership with Asante, Providence, Mercy Flights, Jackson Care Connect and Allcare, Addictions Recovery Center (ARC) can admit clients who are actively undergoing IVAB therapy via a PICC* line. IVAB clients are typically restricted to long-term hospitalization due to increased vulnerability. Contingent on agency participation as outlined below, clients who meet criteria can safely participate in residential treatment for their substance use disorder while still undergoing IVAB infusions.

**Peripherally Inserted Central Catheter*

ROLES OVERVIEW (AGENCY PARTICIPATION)

- Hospital: identification of IVAB patients who might benefit from residential treatment, referral, and care coordination. Provider orders medication.
- CCO: Provides care coordination and billing support/collaboration.
- Addictions Recovery Center: Provides care coordination, assessment, and treatment for substance use disorders. Ensures adherence to safety protocols developed by the partnership.
- Mercy Flights: Delivers medication, administers infusions, and monitors client. Coordinates as needed with provider, including removal of the PICC line.

ADMISSION CRITERIA

- The client meets criteria for residential treatment which includes their level of readiness.
- They require no more than two infusions per day, or they have a CADD pump.
- They meet their hospital's discharge criteria.
- They are a member of Jackson Care Connect or All care.
- The client agrees in advance of their discharge from the hospital that if they choose to leave the residential program unexpectedly, they must allow ARC staff to coordinate the removal of their PICC line. If they do not, the client will also be informed that ARC may need to call law enforcement when other interventions are unapplicable or unsuccessful.

ASSESSMENT WORKFLOW & WARM HANDOFF

- A hospital representative, usually the Discharge Planner or Navigator, calls ARC's Community Response Team. The Community Response Team is made up of Certified Recovery Mentors (CRM) and is available Monday-Friday, 8am to 5pm. Due to fluctuating assessment appointment wait times, referrals should be made as soon as possible.

- ARC's dedicated phone number is: 541-779-1282 Option #2. ARC's general response time is within 24 hours Monday through Friday, and no more than 48 hours on weekends.
- ARC's Community Response Team responds in-person or by virtual means to the patient for an initial outreach encounter.
- The client will be scheduled for an assessment. The scheduling time for assessments is 1-2 weeks but will be prioritized or accelerated depending on patient acuity and available resources.
- Mercy Flights will engage with patients before their discharge from the hospital to build rapport.

ADMISSION

- Additional medical evaluation and coordination occurs upon admission to an ARC residential treatment facility.
- An ARC team member will pick up the patient from the hospital as needed and by request from the hospital's discharge planner for transport to the associated ARC residential treatment facility.

PHYSICAL SPACE FOR INFUSIONS

- At least one room will be dedicated for antibiotic infusions or patient evaluations by Mercy Flights within each of ARC's two residential locations. Each room will provide sufficient space and privacy to administer infusions and monitor clients. The Mercy Flights representative and client will have access to Wi-Fi.
- The Mercy Flight's representative will stay with the patient for the duration of the infusion or evaluation, and ARC staff will provide support within their scope as needed.

PHYSICAL ACTIVITY

- Unless there is a stated medical limitation, clients can participate in regular residential activities including treatment services, cleaning, hiking and other outings. Strenuous activities and water activities should be avoided.

COMMUNITY PARTNER ACCESS TO BUILDING

- All residential clients and their visitors are informed of the following:
    - Visiting hours are every Sunday from 1:30-4:30 p.m. For everyone's safety, visitors must sign in at the unit office. Items such as bags, purses, cell phones, etc. will be dropped off in the unit office or left in the visitor's car. Visiting children will always remain with their attending adult. Out of respect for their peers and other guests, clients and visitors will display only appropriate forms of affection.
- A confidentiality agreement is in place with Mercy Flights and will be reviewed and updated as needed.

FUNDING

- No additional funding is required by ARC to admit clients undergoing antibiotic infusion therapy and is instead covered by the already established per diem rate for residential treatment which

is covered by Medicaid, some private insurances, sliding fee scale or limited contract funding where clients are eligible.

MINIMIZING RISK OF POTENTIAL USE OF ILLICIT SUBSTANCES

- ARC's Residential facilities are locked and staffed with at least two trained support staff members at any time, 24/7.
- Clinical interventions by certified providers are frequent through group, one-on-one, educational and/or process-based sessions, both planned and unplanned.
- Camera surveillance is maintained and monitored throughout public areas, both indoors and outdoors.
- Urine Drug Screening
- All clients' personal belongings, including items delivered during their stay, are searched, and documented.
- Behavior Agreements are initiated as needed.
- Visitation and Security Protocols are in place.
- To mitigate the danger of a client self-injecting non-prescribed substances through their PICC line, every IVAB residential client will always be accompanied by an ARC staff member, as opposed to using TransLink or Ready Ride, when participating in offsite activities, including their transport from the hospital to ARC upon discharge as well as any off-site medical appointments throughout their residential stay.

STAFF TRAINING

- Facility security and access for Mercy Flights
- Warning signs of infection
- How to respond if a client complains of pain or infection
- ARC's standard emergency response protocol includes ease of use/drug use response, basic first aid training and CPR.
- Procedure for notifying 911 dispatch if client leaves with their PICC line still intact when other interventions are unapplicable or unsuccessful.

DISCHARGE FROM RESIDENTIAL AND REMOVAL OF PICC LINE

- Depending on the time of day, Mercy Flights (7:00am to 7pm, Monday through Friday response time is not set but considered urgent), 911 dispatch or our own clinical providers will coordinate the safe removal of the PICC line.
- ARC staff or Mercy Flights will notify the provider in charge which is listed on the hospital discharge paperwork.

MEDICATION

- The provider completes antibiotic orders.
- The hospital's Discharge Planner sends the referral to Providence Pharmacy and Home Infusion
- Once Medication is ready, Mercy Flights will pick up for delivery to ARC.

- Once course of treatment is completed, Mercy Flights will collaborate with the provider to discontinue the PICC line