2024 Transformation and Quality Strategy

July 2024

Advanced Health, LLC

289 LaClair Street

Coos Bay, Oregon 97420

www.advancedhealth.com

Contents

Project # 409 – Improved Coordination of Care for FBDE LTSS Members

Section 1: Transformation and quality projects

A. Project title: Improved Coordination of Care for FBDE LTSS Members

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

If continued, insert unique project ID from OHA: 409

B. Components addressed

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

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

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population)**: Advanced Health is currently serving approximately 29,000 Medicaid Members and of this population, there are approximately 3,200 (11%) CCO-A members who are Full Benefit Dual Eligible (FDBE), with the majority falling within the 65 years of age or older demographic. Moreover, approximately 760 of these FDBE members also require Long-Term Services and Supports (LTSS). To ensure the FDBE members receive appropriate and equitable care, an analysis of REALD (Race, Ethnicity, Language, and Disability) data was conducted. The results are as follows.

   Among Advanced Health's FBDE members 57% are female and 42% are male. Research indicates how males experience higher health loss, primarily due to premature death, while females, despite generally living longer, face higher levels of illness throughout their lives. This highlights the diverse and evolving health needs of men and women at different life stages.

   The racial composition of the FDBE population is primarily White, accounting for 81% of the membership. Additionally, 15% are categorized as Unknown or Other. The representation of other racial groups is as follows: 2% American Indian/Alaskan Native, 1% Hispanic, while the Asian, Black, and Native Hawaiian/Pacific Islander categories have insufficient numbers for reporting.

   Race information for FBDE members is prominently displayed in the header of the case management Activate Care screen. This feature helps Advanced Health, and its partners provide culturally competent care and tailor interventions to address specific health disparities, or social determinants of health, which may disproportionately affect certain racial or ethnic groups. This data enables care coordinators to better understand and address the unique challenges and healthcare needs of individuals from different racial backgrounds, ultimately enhancing the quality and effectiveness of care delivery.

   The language spoken by the FBDE members is primarily English at 99%, with Spanish being the next most common language, although with a percentage too low to report. Based on this data, a language disparity is not significantly reportable. In 2023, there were no grievances received regarding language access or accommodations issues.

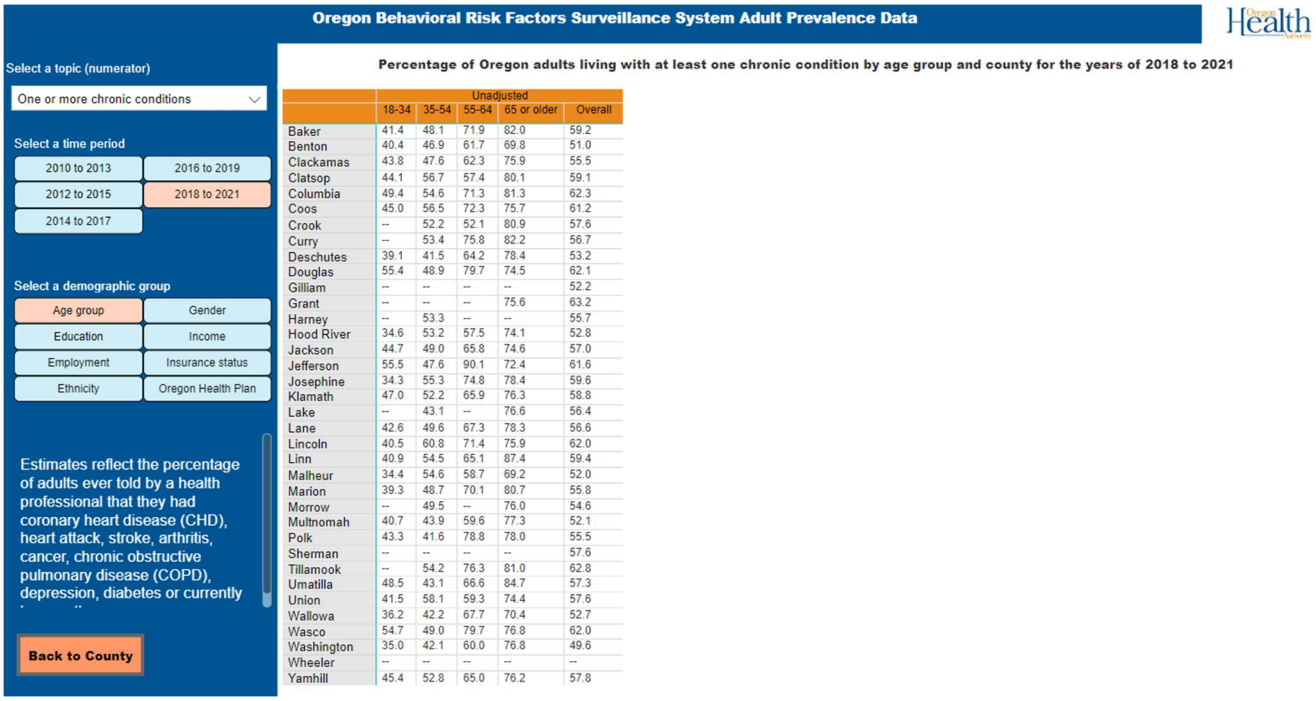
The data indicates disabilities prevalent among the FBDE population, with 38% of members experiencing one or more disabilities. The specific breakdown of these disabilities is as follows:

- 9% are blind.
- 9% are deaf.
- 11% have difficulty walking or climbing stairs.
- 17% have difficulty with dressing or bathing.
- 20% have difficulty performing errands.
- 8% have issues with memory.
- 14% have limited activity in any way.
- 12% have an unknown disability.

This data highlights the diverse and significant needs of the FBDE population emphasizing the importance of tailored care plans and support services to address these varied disabilities. It also suggests how a substantial portion of this population requires assistance with daily living activities and mobility, as well as sensory and cognitive support.

Advanced Health acknowledges the technical assistance provided by OHA on this project. OHA suggested that Advanced Health analyze the chronic and behavioral health conditions of approximately 760 disabled members to better understand their health care needs. This analysis could help identify additional short-term tracking measures to achieve goals of reducing ED visits, hospitalizations, and readmissions. The technical assistance was received on July 1st, which does not leave enough time to create a report tracking this population separately from all dual members by July 15th when this report is due. However, we will still take the suggested action and conduct an analysis to determine if targeted actions, such as medication refills, participation in falls prevention or diabetes self-management classes, and other health improvement goals, will best ensure progress toward these long-term goals. We will create a Tableau dashboard to provide us with a clear understanding of each of the 760 members, their health conditions, and potential needs based on a deeper dive into the data. This will prepare us to present a new activity to address the identified needs in the 2025 TQS.

In the recently concluded Community Health Assessments, both Coos and Curry counties have a higher proportion of residents aged 65 and older compared to the state average. Data from the Oregon Behavioral Risk Factors Surveillance System (BRFSS), provided by the Oregon Health Authority (OHA), indicates how the prevalence of chronic conditions among individuals aged 65 and older is a significant health concern. In Coos County, 75.7% of individuals in this age group have one or more chronic health conditions, while in Curry County, this figure rises to 82.2%. Chronic health conditions include arthritis, asthma, diabetes, cancer, and heart diseases. However, these conditions can be managed or improved through self-management strategies and by adopting a healthy lifestyle.



*Data source:
https://app.powerbigov.us/view?r=eyJrIjoiNTI2NjQwNzktNWQxNy00YjQzLWI5ZmEtMTBlZjczOWE0NWY3IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWRjOTQ1MmY0YyJ9

In response to the BRFSS data on chronic conditions and to more closely align with OHA's criteria for this component, Advanced Health will refine its approach for this component by transitioning towards a more evidence-based strategy aimed at enhancing the health outcomes of our FDBE members who utilize Long-Term Services and Supports (LTSS) and also have Special Health Care Needs (SHCN). We will expand beyond our previous focus on depression screening and instead adopt a more comprehensive, whole-person-centered integrative approach to healthcare. Our objective is to elevate the well-being of our LTSS members by integrating their personal goals and priorities into their healthcare decisions, while maintaining our commitment to delivering high-quality disease management services. This entails bolstering our efforts to encompass mental health, primary care, and social factors while recognizing their equal significance in addressing the needs of our aging and vulnerable LTSS population.

The FBDE members requiring LTSS encompass a diverse group, ranging from older adults to younger individuals with intellectual and developmental disabilities, physical disabilities, behavioral health diagnoses, spinal cord or traumatic brain injuries, and disabling chronic conditions. These members often encounter numerous Social Determinants of Health (SDOH) barriers, including poverty, transportation challenges, and limited access to medical providers. Because the LTSS population experiences a variety of inequities, it remains imperative for Advanced Health to prioritize depression screening for this population to ensure they receive appropriate follow-up peer support and mental health care.

At Advanced Health, FBDE individuals with chronic conditions and SDOH needs receiving LTSS are identified as a priority population group known as Special Health Care Needs (SHCN). These individuals are given precedence for referral to our Care Coordination (CC) program.

Upon receiving a referral, our CC program initiates care planning and gathers pertinent information through the administration of our initial CC referral screening and social needs assessment, utilizing the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) for every

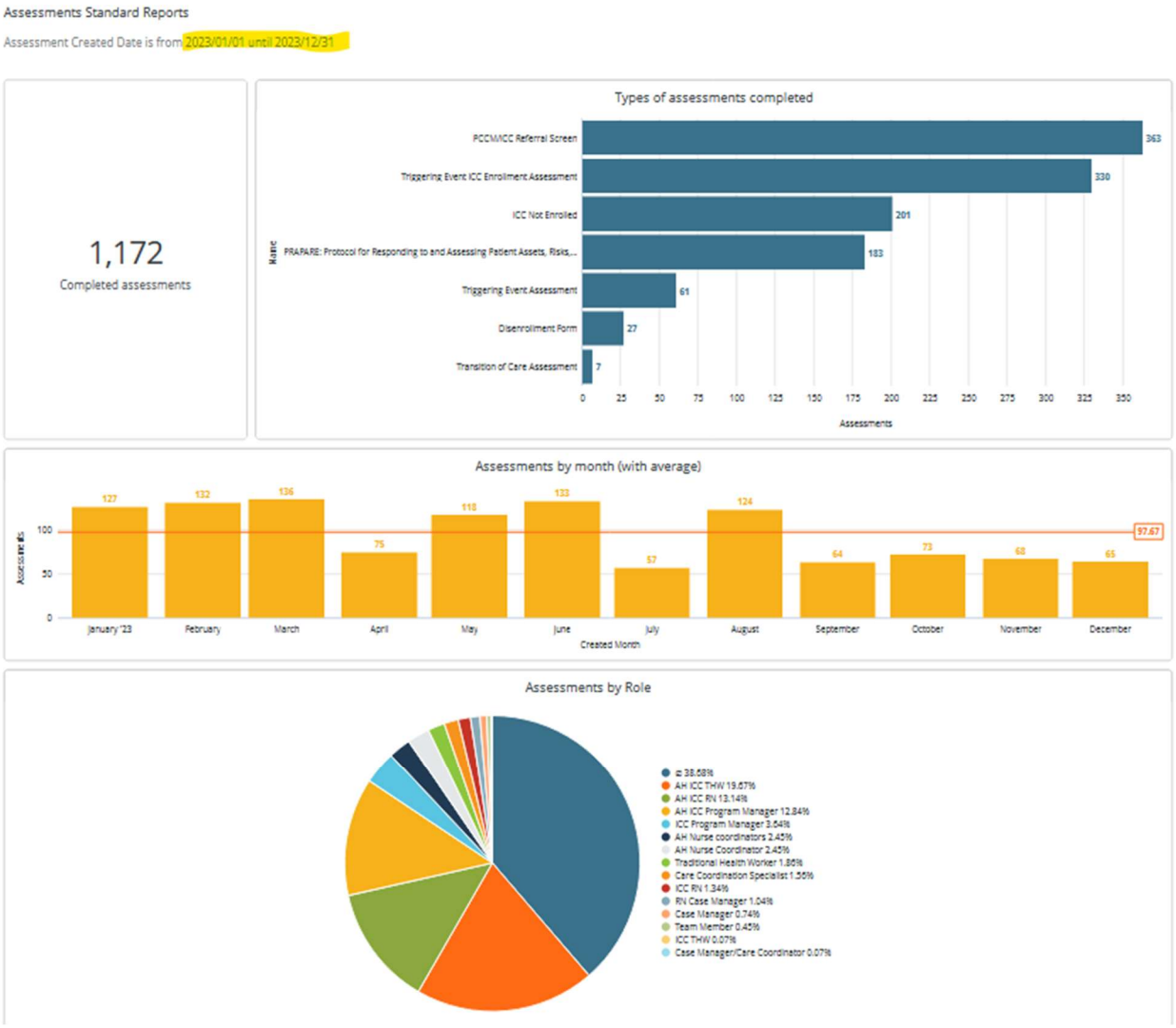
participating member. A comprehensive assessment is conducted, tailored to the member's complex health conditions and may encompass various elements such as discharge planning, coordination of follow-up appointments, medication management, depression screening, establishment of primary care, and assistance from a Traditional Health Worker (THW). These assessments form the basis for developing individualized care plans designed to address the specific needs of each member, outlining a course of treatment or regular care monitoring. Care plans are shared via Collective Medical with the primary care provider and discussed within the Interdisciplinary Team (IDT) as deemed appropriate.

The CC screening process identifies Social Determinants of Health (SDOH) needs, which are addressed through the UniteUs referral system. Advanced Health recently began using UniteUs for Health-Related Social Needs (HRSN), and the implementation of HRSN services in March 2024 was successful. We are preparing to offer the HRSN housing benefit in November to our members, including the FDBE LTSS population. CC also refers to flexible health-related services, which can be managed through UniteUs if applicable. We are actively increasing the number of community organizations using UniteUs and boosting CC-initiated referrals for SDOH needs.

Collaboration continues between Advanced Health and the local Aging and People with Disabilities (APD) office to enhance care coordination and health outcomes, ensuring accessible, integrated, and high-quality long-term services. A Memorandum of Understanding (MOU) has been in place since 2018, facilitating a structured process for case review and referrals.

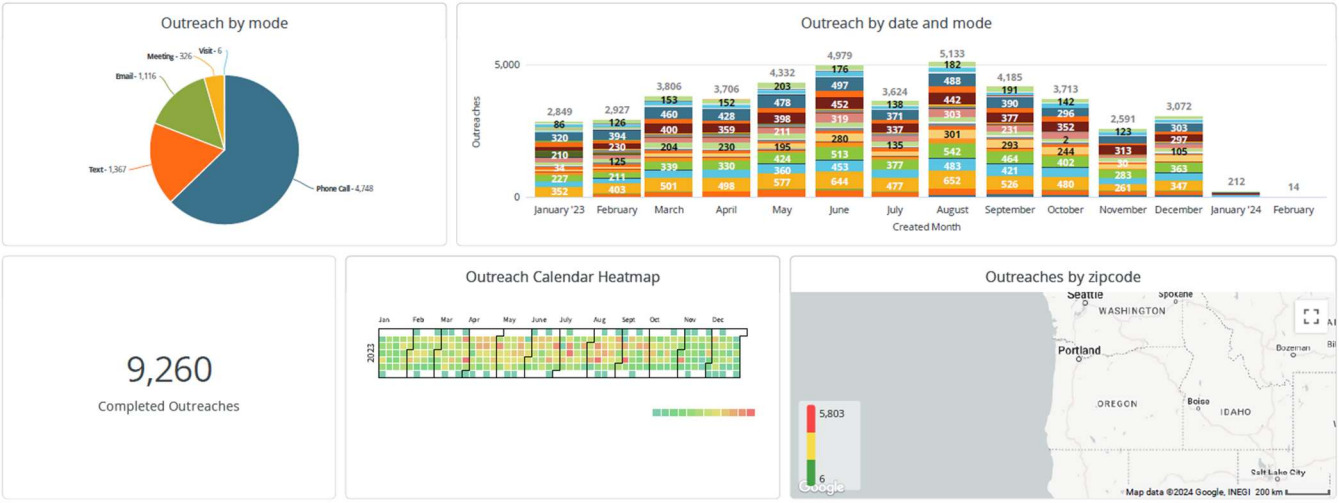
The monthly Interdisciplinary Team (IDT) meetings, which bring together Advanced Health Care Coordination (CC), Regence Medicare Advantage, APD, and Coos Health and Wellness (mental health) have been successfully established. These meetings provide a platform for the interdisciplinary review of complex cases, ensuring that LTSS members receive comprehensive care planning, coordinated care transitions, and attention to their identified needs. To enhance this collaborative approach's effectiveness, Advanced Health will commission a report to identify utilization trends and prevalent health conditions among the LTSS population. This data will inform targeted interventions aimed at improving health outcomes such as reducing unnecessary emergency department (ED) visits, hospitalizations or readmissions, and enhancing core health variables for members with chronic conditions or disabilities. The top health concerns identified for the LTSS population will be reviewed during these monthly meetings, further increasing integrated care coordination, including the affiliated Medicare Advantage plan for the FBDE LTSS members.

In 2023, Advanced Health’s CC program completed 1,172 comprehensive assessments. These assessments include detailed discharge planning, coordination of follow-up appointments, medication management, establishment of primary care, and assistance from a Traditional Health Worker (THW) or other assistance identified. See graph below for a visualization of assessments by month and staff role.



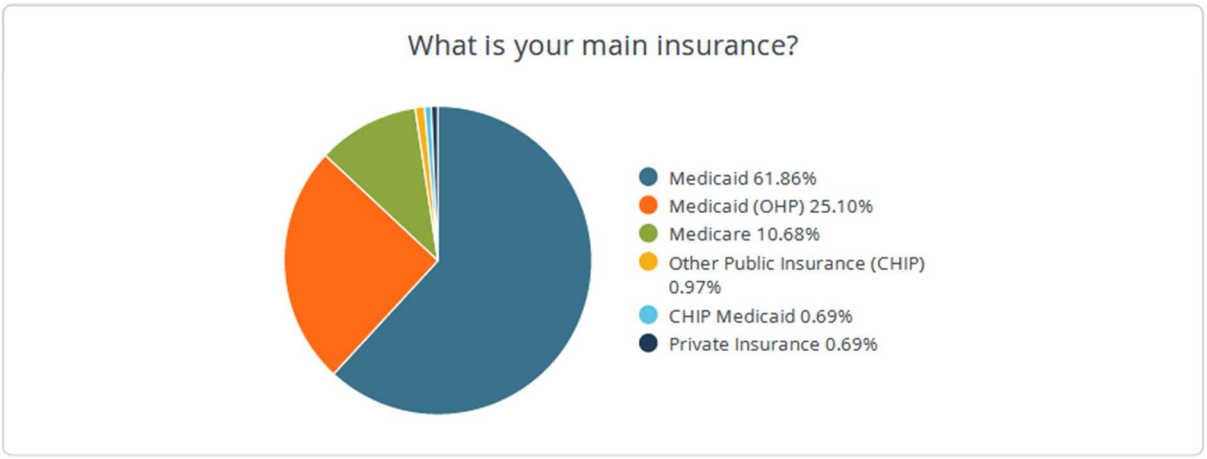
These comprehensive assessments and tailored care plans create a cohesive and coordinated healthcare experience for our FBDE LTSS members. This integrated approach addresses their multifaceted needs, resulting in better management of chronic conditions, improved mental health, increased member satisfaction and ultimately, better health outcomes. Proactive identification and ongoing monitoring of potential health issues by CC and healthcare providers help prevent the escalation of chronic conditions, reduce ED visits, and avoid hospitalizations.

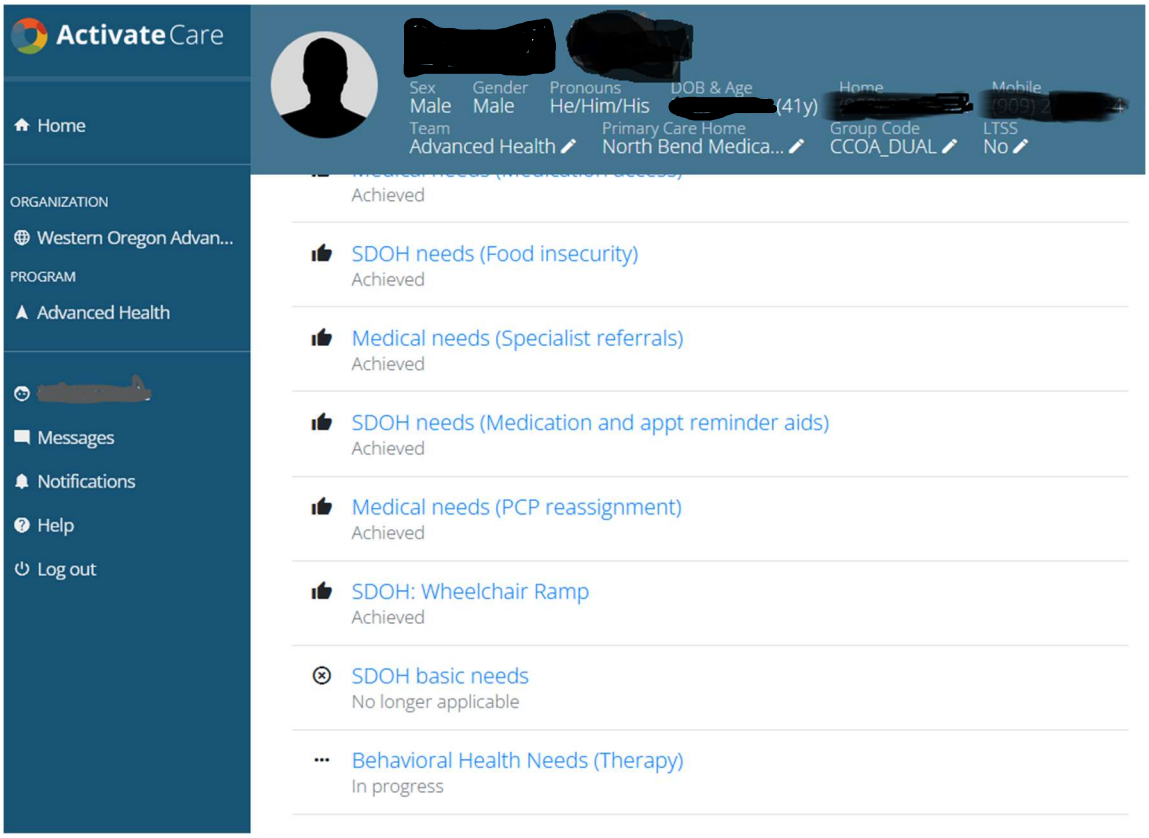
In conjunction with these assessments, the CC program emphasizes member outreach and consistent touchpoints facilitated by the CC staff. In 2023, there were 9,260 instances of member outreach. The most common methods of outreach included phone calls, text messages, emails, meetings, and in-person visits. See graph below for a visualization of the outreaches by month and mode.



Proactive outreach by care coordinators is crucial for improving health outcomes. Regular contact ensures members receive continuous support throughout their healthcare journey by addressing potential barriers promptly. By maintaining communication, care coordinators can monitor adherence to treatment plans, provide timely interventions, and offer personalized support. This consistent engagement helps identify and manage health issues early thus leading to better management of chronic conditions, reduced hospital readmissions, and overall improved health and well-being for our members.

Advanced Health's CC program uses the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) for initial referral screening and social needs assessments. This identifies SDOH for each assessed member. PRAPARE results show approximately 10% of CC Program members are FDBE (Medicare beneficiaries), as shown in the "What is Your Insurance" graph below, which aligns with the overall FDBE population ratio of 11%. The PRAPARE assessment also allows for targeted care coordination, improving health outcomes and reducing costs. Identified needs are incorporated into the member's care plan and tracked in Advanced Health's care coordination platform, Activate Care. See the second print-screen of Activate Care screenshot below for details.





Some notable features of the case management system Activate Care include consolidating data from various community systems into a unified Community Care Record. This comprehensive record supports person-centered care teams in managing tasks, setting and tracking goals, identifying gaps in care, and adapting to changes in the member's status over time. It also facilitates team-based care planning and coordination including tracking and closing referrals. Additionally, Activate Care offers a messaging platform for communication between partners involved in care delivery. Moreover, the system provides external access for both members and healthcare providers fostering collaboration on care plans and ensuring seamless coordination. APD currently uses this feature to upload care plans for the FBDE LTSS members.

2. **Describe whether last year's targets and benchmarks were met (if not, why):** In 2023, Advanced Health made significant progress in enhancing coordination of care and implementing increased depression screening and follow-up for FDBE LTSS members. Throughout the year, our efforts have been concentrated on delivering comprehensive care, coordinating services, developing treatment plans, refining care transition processes, and ensuring appropriate follow-up with our affiliated Medicare Advantage Plan and Aging and People with Disabilities (APD) to enhance health outcomes. Our success is evidenced by the implementation of various initiatives and fruitful collaborations.

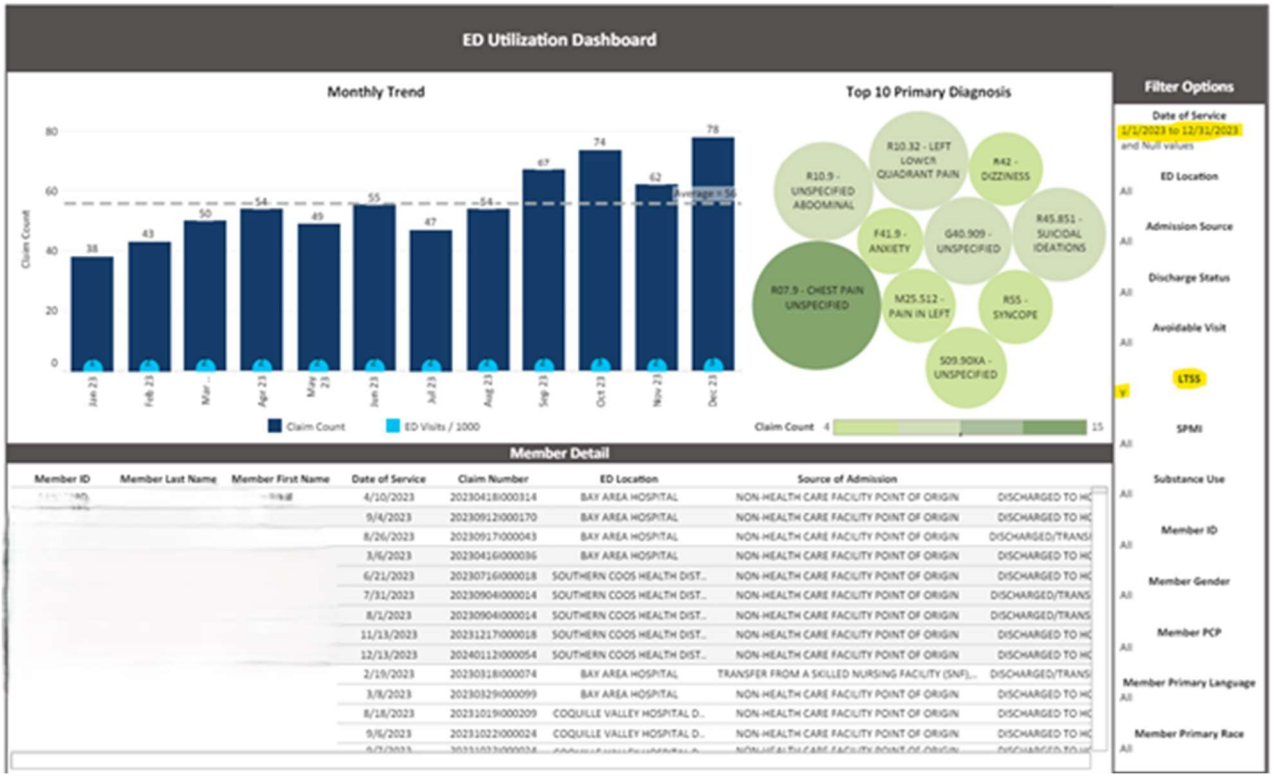
   Advanced Health is on track to complete activity 1.1, which involves training CC staff in Mental Health First Aid (MHFA) by December 2024. Currently, 50% of staff have received MHFA training and can identify, understand, and respond to signs of mental health and substance use challenges faced by our members. With this training initiative nearing completion by the end of this year, we are poised to

initiate depression screenings for FDBE LTSS members identified as needing one during the care plan or by Regence, our affiliated Medicare Advantage plan.

Our collaboration with Aging and People with Disabilities (APD) remains strong, and we actively monitor the number of referrals made by APD to our CC Program, as required in activity 2.1. The referral rate has risen from two per month in 2022 to three per month at the end of 2023. Members who are referred to our program and opt to participate receive personalized care planning, including a comprehensive social needs assessment using the PRAPARE tool to identify SDOH needs, REALD, and SOGI factors. An analysis of the referrals received based on REALD and SOGI data revealed the majority members were white and primarily English-speaking.

Following a recent analysis, we have identified the importance of establishing a bidirectional referral process for our FDBE LTSS members. To achieve this, we will be shifting our focus towards initiating referrals for these members. Our care coordinators will be actively referring members to APD for services and potential case management.

Activity 2.2, which aimed to monitor and increase the rate of depression screenings and referrals to primary care for FBDE LTSS members by 2%, was not completed. While referrals to primary care were made as part of the care plan, tracking these referrals specifically to Primary Care Providers (PCPs) was not done separately due to the administrative burden of manual counting. Additionally, universal depression screenings for all FBDE LTSS members were deemed unnecessary as the main reasons for ED admissions among them do not typically warrant depression screenings. The main reasons for ED admissions among LTSS members are typically chest pain, unspecified abdominal pain, and left lower quadrant abdominal pain (please see dashboard below for details). With this lesson learned, depression screenings will be conducted as indicated by the member's health condition and this activity will be replaced with a different initiative aimed at reducing ED admissions.



Activities 3.1 and 3.2, involving establishing process and outcome evaluations for our shared FBDE Medicare Advantage Pacific Source Members for tracking and improving depression screening, were not completed. This is partly due to the change in the affiliated Medicare Advantage plan from Pacific Source to Regence. Additionally, the collaborative review of LTSS member cases now has a broader focus than just depression screening. A comprehensive assessment is conducted based on the member's complex or chronic health conditions including discharge planning, managing follow-up appointments, medication management, establishing primary care, and assistance from a THW. Due to this holistic approach, the previous goal of screening all LTSS members for depression by June 2024 is no longer applicable, with the new focus being on determining individualized treatment courses and regular care monitoring for hospitalized LTSS members.

Activity 4.1, which involves maintaining monthly CCO/APD Interdisciplinary Team (IDT) meetings to coordinate FBDE LTSS members, is on track to be completed in 2024. However, the goal has been revised to prioritize maintaining a consistent meeting cadence rather than increasing frequency. While in 2022 these meetings were irregular, by the end of 2023 they were successfully scheduled monthly with no meetings missed. Each meeting, involving all relevant entities (CC, APD, Mental Health, Medicare Advantage), lasts over an hour. Scheduling more than one IDT meeting per month is deemed unnecessary, as frequent case-specific meetings are also held among those directly involved, ensuring more efficient resource utilization.

Additionally, Activity 4.2, aiming to increase the number of LTSS cases reviewed at these IDT meetings, was not met. Reviewing eighteen cases, the average number in a 90-minute meeting is already a practical limit. Efforts to increase the number of cases reviewed have been abandoned in favor of maintaining the current cadence and ensuring balanced representation among attendees.

Activity 5, involving building an Activate Care workflow to incorporate PHQ-9 screenings for FBDE LTSS CC members, was not completed. This was due to a combination of technical challenges that required Data Analytics staff to make changes to the Activate Care database. The Data Analytics department was understaffed in 2023, leading to resource constraints. Consequently, PHQ-9 screenings for FBDE LTSS CC members were not integrated into the workflow. Efforts are being redirected to activities tailored to individual member health statuses and outcomes.

Activity 6 is a new initiative replacing previous initiatives 2.2, 4.2, and 5. It focuses on establishing a cohort within PointClickCare for the FDBE LTSS members to monitor emergency department (ED) hospital utilization. This initiative involves analyzing admission reasons to develop strategies to reduce ED visits, thereby improving health outcomes. The established cohort will serve as a trigger for care coordination notifications. Each member within this cohort will undergo a thorough review and screening by a care coordinator, utilizing PRAPARE for social needs assessment, PHQ-9 for mental health evaluation, and HRA for physical health needs. All assessment results will be meticulously tracked and managed within Activate Care to ensure comprehensive and equitable care coordination.

An end-of-year review will be conducted to assess the cohort's establishment, data accuracy, and use the data analysis, with a 12-month lookback period, to formulate a plan for effectively reducing ED admissions. This will ultimately contribute to improved health outcomes for FDBE LTSS members. Additionally, we will conduct a review to ensure the cohort is established and perform an analysis to identify and address disparities based on REALD and SOGI data to ensure equitable care and outcomes. Our goal is to reduce ED utilization among this cohort by 10% compared to baseline data.

3. **Lessons learned over the last year:** In 2023 and into 2024, Advanced Health made significant strides in improving care coordination and addressing the needs of FBDE LTSS members. Several key lessons emerged from our initiatives and activities throughout the year:
    - Importance of Steady Coordination: Regular monthly Interdisciplinary Team (IDT) meetings have proven essential for effective coordination among all entities involved in a member's care. The consistent schedule and participation helped streamline communication and care planning, emphasizing the importance of maintaining a steady meeting cadence over increasing frequency.
    - Targeted Screening Approach: The realization not all FBDE LTSS members require universal depression screenings led to a more targeted approach. Identifying screenings based on individual health conditions and specific care needs is more efficient and directly beneficial to health outcomes, as opposed to a blanket approach.
    - Resource Allocation and Workflow Integration: Technical and staffing challenges highlighted the need for adequate resource allocation and integration of new workflows. The understaffing in the Data Analytics department impeded the incorporation of PHQ-9 screenings into the Activate Care workflow, underscoring the need for sufficient resources and support when implementing new processes.
    - Holistic and Individualized Care: Shifting the focus from specific metrics like depression screening to a more holistic, individualized care approach, proved to be more effective. Comprehensive assessments which consider a wide range of health conditions and social determinants of health lead to more personalized, member collaborative and impactful care plans.

- Collaborative Efforts and Referral Tracking: Strong collaboration with APD and increased referral rates to the CC Program have demonstrated the value of joint efforts. However, it was identified there is also a need to initiate referrals to APD, rather than solely accepting referrals from them.
- Adapting to Changes: The change in the affiliated Medicare Advantage plan from Pacific Source to Regence required adaptability. The broader focus in collaborative reviews now includes a comprehensive assessment of members' health conditions, which has proven to be more beneficial than focusing solely on depression screenings.
- Addressing Disparities: Analyzing referral data based on REALD and SOGI factors revealed disparities which need to be addressed to ensure equitable care. This lesson underlined the importance of continuous monitoring and addressing social determinants of health to improve outcomes for all members.
- New Initiatives for Inpatient and ED Utilization: Activity 6 introduces a new initiative to monitor ED hospital utilization among the FDBE LTSS members aiming to reduce ED visits through strategic analysis and care coordination.

Overall, Advanced Health employs adaptive strategies and member-focused holistic care to enhance care coordination, implement targeted screenings, and develop comprehensive care plans, all of which contribute to improved health outcomes for FBDE LTSS members. Shifting from a singular focus on depression screening to a more comprehensive, individualized care approach enables better management of complex health conditions. This adaptive strategy ensures care plans are tailored to meet the specific needs of each member, thereby enhancing intervention effectiveness and improving overall health outcomes. These learned lessons will guide Advanced Health's future initiatives, ensuring more effective and efficient care coordination, targeted interventions, and equitable health outcomes for FBDE LTSS members.

D. Brief narrative description

1. **Project population:** The term "Members with Special Health Care Needs (SHCN)" refers to individuals who exhibit high healthcare requirements presenting with multiple chronic conditions, mental illness, or substance use disorders. This population encompasses individuals who either: Experience functional disabilities, reside in environments with health or social conditions which predispose them to functional disabilities (e.g., severe chronic illnesses, environmental risk factors like homelessness, or family issues necessitating foster care placement), or belong to prioritized populations as defined in OAR 410-141-3870. As delineated in OAR 410-141-3860, individuals receiving Medicaid-funded long-term care or long-term services and supports should undergo assessment and are often classified within SHCN populations due to associated risks and health conditions.
2. **Intervention (address each component attached):** Advanced Health has various interventions aimed at enhancing coordination of care and improving health outcomes for FBDE LTSS members.

   Activity 1.1 - The Mental Health First Aid (MHFA) training for care coordination staff enhances their ability to identify and respond to mental health and substance use challenges. This training enables Advanced Health to initiate targeted depression screenings, improving early detection and intervention. Additionally, it enhances care coordination by preparing staff to better address the comprehensive mental health needs of members.

   Activity 2.1 - An Increase in referrals received from APD. The increase in referrals to Advanced Health's CC Program ensured more members received personalized care planning, including thorough social needs assessments. This proactive approach addressing social determinants of health and disparities based on REALD and SOGI factors, contributed to more equitable and effective care. Also, in 2024, we

will establish a bidirectional referral process and begin Initiating referrals from our care coordinators to APD for services and potential assignment to an APD case manager. This intervention ensures members receive necessary follow-up care, assessments, and monitoring, thereby improving health outcomes.

Activities 2.2, 3.1, 3.2 have been retired from this project in favor of more effective strategies.

Activity 4 .1 - The collaboration with Aging and People with Disabilities (APD) and the Medicare Advantage plan, with monthly interdisciplinary team meetings, involves all entities in a member's care and ensures comprehensive coordination and shared accountability. By addressing social determinants of health and ensuring discharged individuals receive necessary follow-up care, these meetings help prevent and reduce hospital readmissions.

Activities 4.2, 5.1, 5.2 have also been retired from this project in favor of more effective strategies.

Activity 6 - This new initiative aims to establish a cohort within PointClickCare to monitor ED hospital utilization among FDBE LTSS members. The goal is to analyze the reasons for admissions, identify any disparities, and create a plan to reduce ED utilization by 10% compared to baseline data. By the end of 2024, 25% of LTSS members with past-year ED visits will have a documented care coordination plan in the system, including medication refills and follow-up appointments. This increases to 75% by 2025. This data-driven approach with improved care coordination aims to improve health outcomes, reduce unnecessary hospitalizations, and enhance quality of life for LTSS members.

Activity 7 – Another new initiative that focuses on the SDOH needs of our members by implementing a review process to assess members' needs for climate devices, additional food supports, housing supports, and other necessary supports by the end of 2024. Complete the review of members' needs and begin linking them with appropriate SDOH resources by the end of 2024. Document 90% of these supports in care plans by the end of 2025. by addressing basic needs and reducing immediate health risks, we can improve and track health outcomes for our LTSS members.

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

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

☑ Short term or ☐ Long term

Monitoring measure 1.1	Mental Health First Aid (MHFA) Training			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No staff are currently trained in MHFA	Document 50% of CC and Customer Service staff are MHFA trained.	12/2023	Document 100 % of CC and Customer Service staff are MHFA trained.	12/2024

Activity 2 description (revised): Increase rate of ~~depression screening and~~ referral for FBDE LTSS members. In 2024, begin Initiating referrals from our care coordinators to APD for services and potential assignment to an APD case manager.

☐ Short term or ☑ Long term

Monitoring measure 2.1	Track number of APD referrals to the CCO's CC Program.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Average of 2 referrals per month average for 2022.	Document 50 % percent increase in the number of LTSS members referred to the CCO for CC and CM services/supports. Track REALD and SOGI data to ensure equitable referral process.	12/2023	Document 100 % increase of LTSS member referred to the CCO for CC and CM services/supports. Begin initiating referrals from our care coordinators to APD for services Track REALD and SOGI data to ensure equitable referral process.	12/2024
Monitoring measure (retired) 2.2	Monitor rate of depression screening and referral for FBDE LTSS members			

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

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

☒ Short term or ☐ Long term

Monitoring activity 4 for improvement: By December 2024, track and report the number of monthly Interdisciplinary Team (IDT) meetings held for FBDE LTSS members, engaging all relevant entities (CC, APD, Medicare Advantage, and Mental Health) to ensure comprehensive and equitable participation in the coordination and care management process.

Monitoring measure 4.1	Track number of monthly IDT meetings for FBDE LTSS members			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Starting from a baseline of 12 meetings per year with no	Conduct a mid-year review in June 2024 to ensure at least 6 meetings have been conducted with all relevant entities in attendance (CC,	6/2024	Conduct an end-of-year review in December 2024 to ensure at least 6 meetings have been conducted with all	12/2024

missed meetings.	APD, Medicare Advantage, Mental Health) to ensure comprehensive and equitable participation in the coordination and care management process.		relevant entities in attendance (CC, APD, Medicare Advantage) to ensure comprehensive and equitable participation in the coordination and care management process.	
Monitoring measure (retired) 4.2	**Track number of individual FBDE LTSS members whose data is shared between CCO care coordinators and APD care coordinators**			

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

Activity 6 description: By 9/1/2024, Advanced Health aims to implement the use of member data on ED diagnoses and core health issues to initiate follow-ups and ensure comprehensive care coordination for LTSS members, enhancing health outcomes and reducing unnecessary ED visits. Additionally, we plan to establish a cohort within PointClick Care for LTSS members to monitor ED hospital utilization, starting from a baseline of no specific cohort, by December 2024. This cohort will be fully operational by August 2024, serving as a trigger for care coordination notifications.

Each member will undergo review and screening by a care coordinator, utilizing PRAPARE for social needs assessment, PHQ-9 for mental health evaluation, and HRA for physical health needs. All assessment results will be meticulously tracked and managed within Activate Care to ensure comprehensive and equitable care coordination. An end-of-year review will assess the cohort's establishment, data accuracy, and use the analysis to formulate a plan aimed at reducing admissions.

By the end of 2024, we aim to ensure that 25% of LTSS members who had ED visits in the past 12 months have a care coordination plan, including medication refills and follow-up provider visits, tracked and documented in PointClick Care. By the end of 2025, we plan to increase this to 75% of LTSS members with ED visits having a care coordination plan tracked in PointClick Care.

Additionally, by the end of 2025, we will implement the tracking of ongoing health monitoring and follow-up testing for members who have had ED visits, including A1C checks, blood pressure monitoring, cognitive assessments, depression screenings, medication reconciliation, home visits, and participation in fall prevention programs, as appropriate.

☐ Short term or ☑ Long term

Monitoring measure 6.1	Monthly progress reports leading up to August 2024 to ensure the cohort is being set up on schedule. Confirm by August 2024 that the cohort is fully operational and integrated into PointClick Care.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Establish a cohort within PointClick Care for LTSS members to monitor ED hospital utilization, starting from a baseline of no specific cohort.	Establishing the cohort PointClick and the data is refreshed on a regular basis.	08/2024	Perform an end-of-year review to assess the establishment of the cohort and the accuracy of the data. Use this data analysis to create a plan for reducing ED admissions.	12/2024
The current state is that no screening process exists. Baseline: By 9/1/2024, begin using member data on ED diagnoses and core health issues to conduct follow-ups and ensure care coordination.	Objective: Improve care coordination and follow-up for members. Action: Utilize member data on ED diagnoses and core health issues to conduct follow-ups and ensure care coordination.	8/1/2024 - 9/1/2024	By the end of 2024, ensure that 25% of LTSS members who had ED visits in the past 12 months have a care coordination plan, including medication refills and follow-up provider visits, tracked and documented in Point Click Care. By the end of 2025, increase this to 75% of LTSS members with ED visits in the past 12 months having a care coordination plan that includes medication refills and follow-up provider visits tracked in Point Click Care. Also by the end of 2025, ensure that members who have had ED visits receive ongoing health monitoring or follow-up testing, such as A1C, blood pressure checks, cognitive testing, depression screening, medication reconciliation, home visits, and participation in fall prevention programs, as applicable.	12/2024 & 12/2025

Activity 7 description: Specific: Establish a screening process to link LTSS members with Social Determinants of Health (SDOH) resources to support their health improvements by the end of 2024.

Measurable: Track the number of LTSS members who receive SDOH supports and the needs identified, including:

- The number of climate devices deployed
- The number of members receiving additional food supports
- The number of members receiving LTSS assessments for services
- The number of members receiving housing supports

Achievable: Implement a review process to assess members' needs for climate devices, additional food supports, housing supports, and other necessary supports by the end of 2024.

Relevant: Ensure 90% of LTSS members receiving these supports have this documented in their care plan, with the health outcome listed in the request, by the end of 2025.

Time-bound: Complete the review of members' needs and begin linking them with appropriate SDOH resources by the end of 2024. Document 90% of these supports in care plans by the end of 2025.

Innovative: Develop and utilize new strategies and technologies to accurately assess and document SDOH needs and interventions.

Equitable: Ensure the process addresses health disparities by providing tailored supports based on individual member needs.

☐ Short term or ☑ Long term

Monitoring measure 7.1	Verify that all assessment results are being accurately entered and tracked in Activate Care.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The current state is that no screening process exists.	Track the number of LTSS members who receive SDOH supports and the needs identified, including: The number of climate devices deployed The number of members receiving additional food supports The number of members receiving LTSS assessments for services The number of members receiving housing supports	12/2024	Complete the review of members' needs and begin linking them with appropriate SDOH resources by the end of 2024. Document 90% of these supports in care plans by the end of 2025.	12/2024 & 12/2025

Project # 410 – Medical Shelter Program

Section 1: Transformation and quality projects

A. Project title: Medical Shelter Program

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

If continued, insert unique project ID from OHA: 410

B. Components addressed

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):** To improve access for our Special Health Care Need (SHCN) members, Advanced Health has developed numerous referral pathways and community partnerships to better meet their complex health needs. Members are identified through various established Coordinated Care Organization (CCO) mechanisms and entry points into Care Coordination (CC) services.

   Upon enrollment, multiple attempts are made to screen all new Advanced Health members by our Customer Service department using a Health Risk Assessment (HRA). This assessment provides an opportunity for members to self-identify with special health care needs and be referred to CC services. Additional referral pathways to CC included:

   - Internal referrals from other Advanced Health departments, such as pharmacy, medical management, and claims.
   - Referrals from the local health care providers, medical clinics, and hospitals.
   - Referrals from out of area hospitals, including Sacred Heart Riverbend Hospital, Oregon Health & Science University, Legacy Emanuel Hospital, and Lower Umpqua Hospital.
   - Referrals from other medical sources, such as Home Health and Wound Care at Bay Area Hospital.
   - Referral from Community Based Organizations, such as the Oregon Coast Community Action (OCCA).
   - Referrals from Substance Use Disorder and Behavioral Health treatment providers.
   - Referrals from the Office of Developmental Disabilities Services, Aging and People with Disabilities Services, the Department of Health and Human Services, and the Oregon Health Authority.
   - Referrals from the Community Corrections of Coos County and the Curry County Parole & Probation Department.
   - Referrals from providers of homeless services.
   - Self-referral.

   These pathways ensure that members with complex health needs receive the coordinated care necessary to improve their health outcomes.

Advanced Health is currently serving about 29,000 Medicaid members, with approximately one-third having Special Health Care Needs (SHCN). Individuals with this designation typically exhibit elevated healthcare requirements, including multiple chronic conditions, mental illness, or substance use disorders. These individuals may experience functional disabilities, reside in environments with health or social factors predisposing them to functional disabilities, such as serious chronic illnesses, environmental risks (e.g., homelessness), or family circumstances necessitating foster care placement, or belong to a Prioritized Population as defined in OAR 410-141-3500. An unhoused status creates a complex web of challenges that can contribute to the development or worsening of health conditions, ultimately leading to individuals meeting the criteria for SHCN. Addressing homelessness requires a comprehensive approach that involves providing stable housing, access to healthcare, social services, and addressing underlying systemic issues contributing to homelessness and health inequities.

Being unhoused profoundly impacts an individual's health in various detrimental ways, spanning physical, mental, and social aspects. Homeless individuals have a higher rate of chronic diseases, such as hypertension, diabetes, and cardiovascular conditions, due to limited access to regular medical care. Living on the streets increases the risk of infectious diseases like syphilis, hepatitis, and respiratory infections. The unhoused are also more susceptible to weather-related health issues such as hypothermia, frostbite, heat stroke, and dehydration due to prolonged exposure to harsh environmental conditions. The risk of injuries from accidents, physical assaults, and sexual violence is significantly higher among the homeless, leading to both acute and long-term health problems.

Homeless individuals face significant barriers to accessing healthcare, such as lack of transportation, difficulty keeping appointments, and the absence of a permanent address. Access to nutritious food is often compromised, leading to malnutrition, weakened immune systems, and greater vulnerability to diseases. Wounds requiring surgical intervention are particularly problematic, as lack of healthcare access and environmental factors exacerbate complications and hinder recovery. Social isolation among the homeless magnifies mental health issues and reduces the chances of reintegration into society Mental health disorders, including depression, anxiety, schizophrenia, and PTSD, are highly prevalent and often worsened by the stress of unstable living conditions. Substance abuse is common as a coping mechanism, further complicating health issues and creating barriers to care and housing. Consequently, homeless individuals have a significantly lower life expectancy compared to the general population due to the cumulative effects of untreated medical conditions, chronic stress, and lack of healthcare.

Due to the effects homelessness has on a member’s mortality, Advanced Health continues its efforts to address the needs of the unhoused and underserved individuals with SHCN at the Coalbank Village. Located on the south side of Coos Bay, Coalbank Village offers 26 Pallet Shelters designed to provide temporary housing for homeless individuals seeking to resolve their unhoused status. There are 2 medical shelters and 2 mental health shelters for those with more specialized needs. Village residents have shared access to amenities including a full kitchen area, a restroom shelter with electricity and

shower facilities, and a covered recreation area.

By providing a safe environment and improved access to necessary resources, the residents of the village have better opportunities to secure permanent housing. The program has demonstrated both quantifiable and qualitative impacts on those served. The initiatives undertaken at the Coalbank Village in 2023 are outlined as follows.

The Coalbank Village project leverages a braided funding model, combining resources from Supporting Health for All through Reinvestment (SHARE) and Health-related Services (HRS). It also builds upon existing partnerships with Advanced Health, Bay Area Hospital nursing care coordinators, and the Devereaux Coal Bank Village case management staff. Through these collaborations, Advanced Health provided medically sheltered housing for 23 members in 2023. These individuals were either transitioning from hospital stays or experiencing frequent emergency department (ED) visits due to acute medical needs. The program offered stable housing for periods of one to ten weeks, allowing participants to focus on medical stabilization, recovery, and ultimately, a pathway to long-term housing solutions.

During the medical sheltering stay, staff, including Care Coordinators (CCs), Traditional Healthcare Workers (THWs), and Registered Nurses, support SHCN members by coordinating care to meet their individual healthcare goals. CCs collaborate with members to establish and review goals related to housing, clothing, food security, employment or education, finances, transportation, legal matters, and communication needs. Members engage with their CCs at least once weekly to track their progress and assess adherence to care coordinator guidance. The healthcare goals include medication access and adherence, primary care appointments, medical tests, Durable Medical Equipment (DME), specialty care (e.g., specialists, wound care, IV infusion), behavioral health, substance use disorder treatments, dental

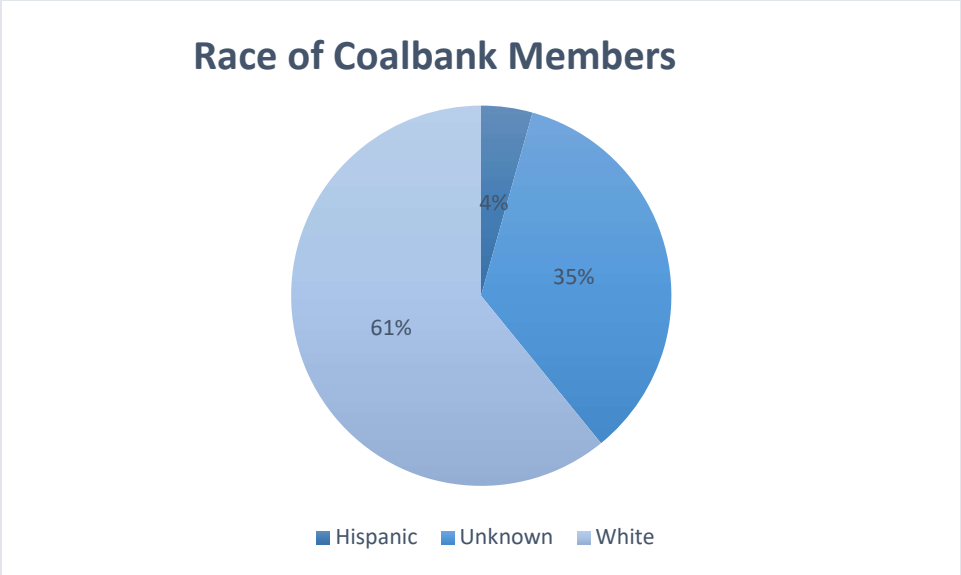
health, and Social Determinants of Health (SDOH). These goals, tailored to individual needs, are documented in care plans within Activate Care, the case management platform used by Advanced Health. The plans include specific objectives with timelines which are implemented through member-coordinator collaboration.

In addition to the care coordination facilitated by Advanced Health, the medical sheltering program ensures that members with complex medical needs post-discharge have access to a safe and hygienic environment conducive to healing. Access to electricity and kitchen facilities aids in meeting nutritional needs. Additionally, Village residents, including medical shelter occupants, have access to transportation services five days a week, facilitating travel to the Devereux Center, where they can access hot meals, computer facilities, and laundry services. The Village offers 24-hour site monitoring, providing a safety net for medically complex individuals. It maintains a clean and sober atmosphere, potentially supporting abstinence among those grappling with SUD concerns. Devereux care coordinators, in collaboration with care coordinators, closely monitor members to ensure medical follow-up. They also assist in medication adherence, a challenge often faced by homeless individuals. The community environment fosters social interactions and reduces stress levels, contributing to the healing process.

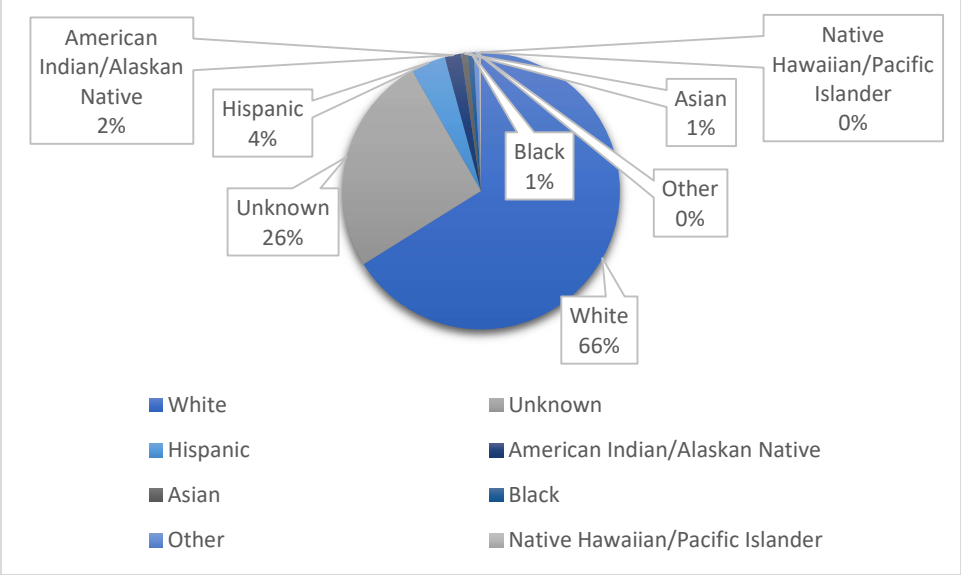
Johnson, a Deverux staff member reflects on what some of the interactions members have with care coordinators are like "They meet weekly with a case manager. The case manager helps them set goals and helps them achieve goals and wants to make sure that their goals are reasonable. 'I want to get into permanent housing.' That's most people's initial goal. Okay, do you have any income? 'No, I don't have any income.' Okay, well then maybe we should start there. Do you have I.D.? 'No, I don't have any identification.' Okay, do you have a birth certificate... so we break it down into bite-sized pieces"

When a member becomes a resident at Coalbank Village, the care coordinator monitors their care to improve their condition or facilitate a transition to alternative housing. Data collected includes entry and exit dates, total days housed, member name and Medicaid ID, referral source, medical needs, CC program status, outcomes, and post-sheltering housing status. Emergency Department and inpatient hospital utilization data is recorded pre- and post-sheltering, with post-sheltering data captured six months later to evaluate long-term health impacts.

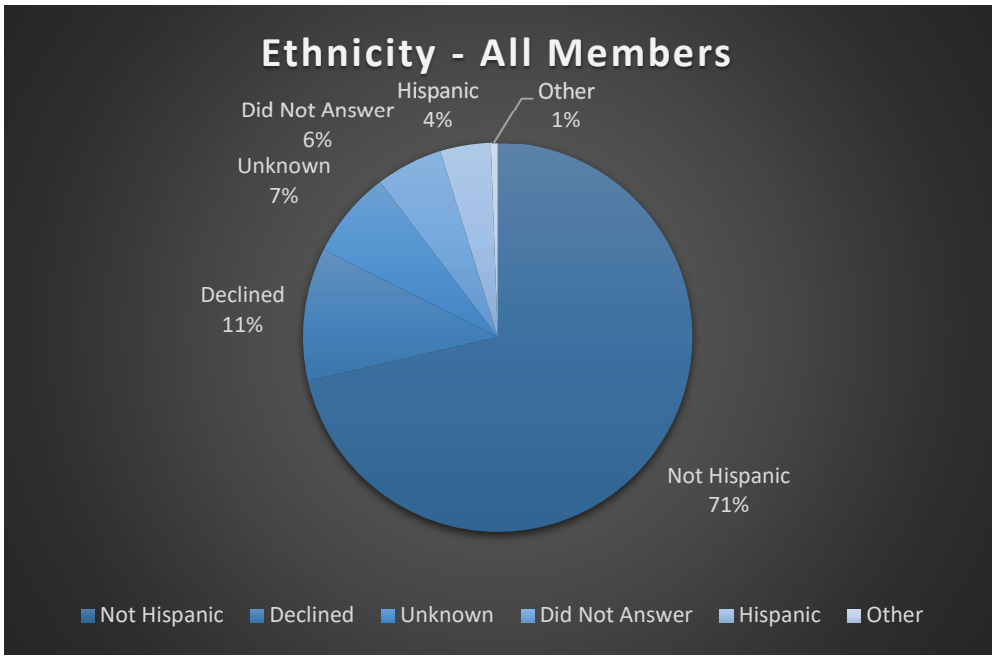
To ensure health equity, a REALD and SOGI analysis of the Coalbank Village population was conducted, using the entire eligible member population as a baseline for comparison. The results are outlined below. The examination of race data for the residents of Coalbank Village in 2023 revealed that the majority identified as White (61%), followed by an Unknown population (35%), and a small percentage identifying as Hispanic (4%).



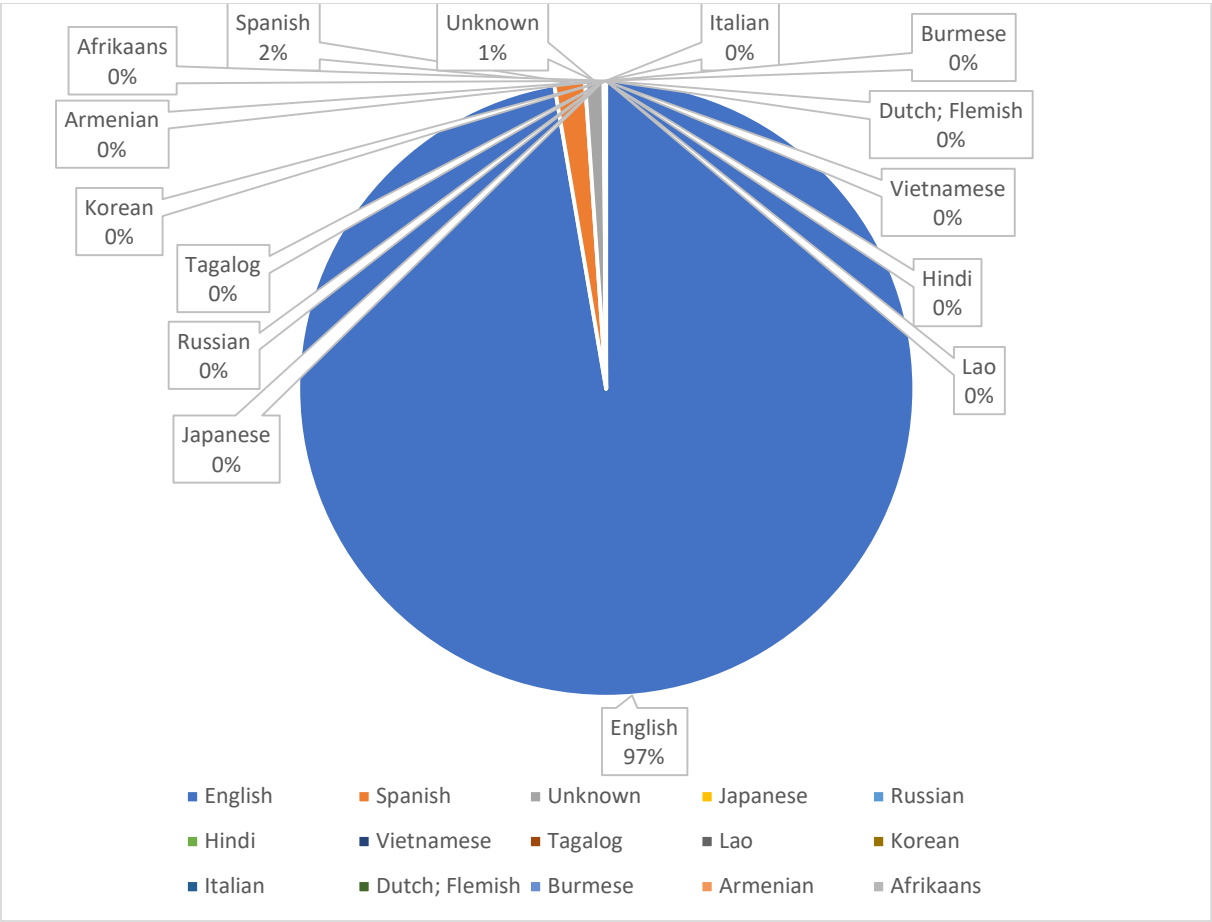
These racial demographics align with those of the overall Advanced Health membership, where White, Unknown, and Hispanic individuals represent the largest groups. Please refer to the graph below for precise numerical details. This analysis confirms that Coalbank Village provides shelter equitably to individuals of all races in need.



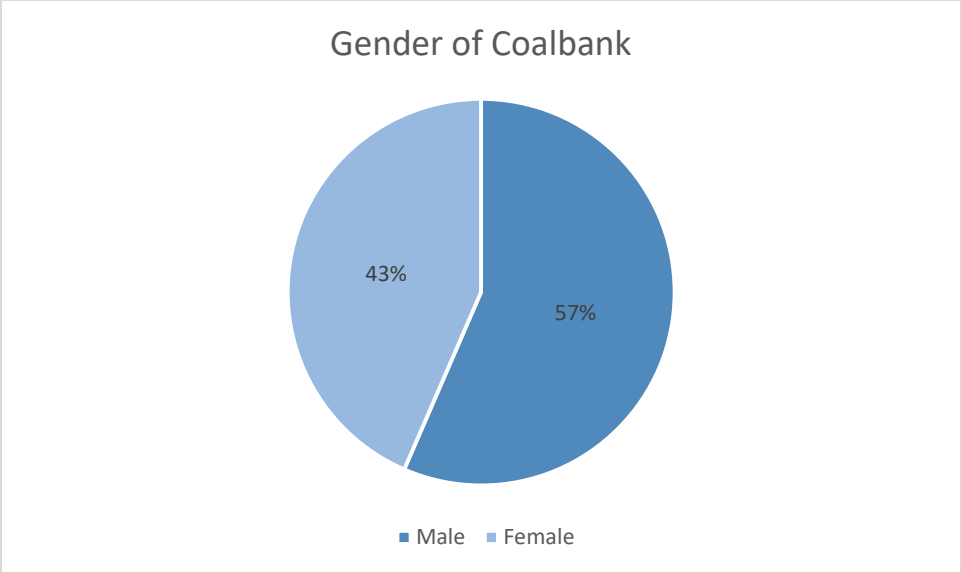
Ethnicity was examined, with specific attention paid to the demographics of Coalbank Village. The population of Coalbank Village was found to be 96% non-Hispanic, which mirrors a significant portion of Advanced Health's member base, where Non-Hispanic individuals constitute 71%. This aligns with the predominant ethnicity in the region, as indicated by Census data for Curry County (91.2% White, equivalent to Non-Hispanic) and Coos County (89.9% White, equivalent to Non-Hispanic)(https://www.census.gov/quickfacts/fact/table/currycountyoregon/PST045223 & https://www.census.gov/quickfacts/fact/table/cooscountyoregon/PST045223).



An analysis of language within the Coalbank Village population showed that all residents spoke English, aligning closely with a notable portion of Advanced Health's member base. This finding corresponds with member language statistics, where a substantial majority (97%) are English speakers. This linguistic uniformity within both the village and the health plan's membership suggests a shared cultural and communicative context, facilitating effective healthcare delivery and patient engagement at the Coalbank Village.



An analysis of gender within the Coalbank Village population revealed a majority identifying as male, constituting 57% of residents, while females comprised the remaining 43%.



This distribution contrasts with the gender makeup of Advanced Health member population, of which approximately 49% are male and 51% are female, see the Member Demographics Summary dashboard on page 86. To delve deeper into potential gender disparities, demographic data from the National

Alliance to End Homelessness was examined. In Oregon, the rate of unhoused females per 10,000 people stands at 23.4%, compared to 46.8% for males. Furthermore, the 2023 Annual Homelessness Assessment Report (AHAR) to Congress, released by the U.S. Department of Housing and Urban Development, highlights that 30.1% of the unhoused population is female, while 68.2% is male.

These findings suggest a notable deviation from national homelessness trends within the Coalbank Village population. While the gender distribution within the village is skewed towards males, it's important to note that this doesn't align precisely with broader state and national patterns of homelessness, where females are often disproportionately affected. This may indicate unique social or economic dynamics at play within the village, warranting further investigation to understand the underlying factors influencing gender disparities in housing security.

2. **Describe whether last year's targets and benchmarks were met (if not, why):** In 2023, significant accomplishments were realized alongside areas identified for further enhancement. The program successfully achieved Target and Benchmark 1.1, which aimed at reducing the utilization of emergency room visits (# of visits/member for 6 months). Post-sheltering, there was a notable decrease in the number of ED visits per member, dropping from 65 visits in 2022 to 26 visits by the end of 2023. While this reduction demonstrates progress, the figure has stabilized at 1.36 visits per member within a six-month period. Consequently, Advanced Health will continue tracking performance in this area and also direct its efforts towards improving performance in other targeted areas.

   Furthermore, notable success was achieved in reaching Target 1.2 to reduce the utilization of hospital inpatient days (number of days per member over 6 months). Initially, in 2022, inpatient utilization stood at 215 days. By the conclusion of 2023, it decreased to 57 days, equating to a rate of 8.9 days per member in a six-month period. However, it is essential to acknowledge that the benchmark of 6 inpatient days per member over 6 months was not met. This highlights the ongoing opportunity for improvement and the need to fulfill the initial goal. Consequently, the threshold date will be extended to 2025 to ensure continued interventions and care planning with the care coordinators. These interventions will address behavioral health needs, substance use disorder treatment, transportation requirements, access to prescriptions, employment assistance, and provisions for clothing and necessities. These efforts are anticipated to further reduce hospitalizations and advance towards meeting the established objectives.

   The targets for activities 2.1 and 2.2 aimed at improving health outcomes through weekly care coordinator check-ins and securing housing were met. By December 2023, 100% of members were engaged in care coordination and 57% of sheltered members were placed in long-term or transitional housing. Efforts continue to increase the number of members who secure housing to meet the benchmark set for December 2024.

   The target for activity 3 with the goal of monitoring the Coalbank residence for Durable Medical Equipment (DME) needs and tracking the provision of DME to those residents was successfully met. In 2023, 11 members required DME, and we exceeded our target by providing DME to 100% of them. Increasing access to DME improves health outcomes by enhancing mobility, managing chronic conditions, and reducing the risk of injuries and complications. Care coordinators continue to ensure that all residents receive the necessary DME.

   Activity 4 is a new initiative aimed at completing a Health Risk Assessment (HRA) survey for 90% of newly admitted Coalbank residents within ten days of their arrival. Completing the survey will identify

various risk factors contributing to adverse health outcomes and gather comprehensive REALD and SOGI data, ensuring inclusivity and equity in the health assessment process. Also, this will help with early interventions, personalized care, effective management of health conditions, better communication, informed resource allocation, and data-driven decision making —all contributing to improved health outcomes for residents.

- **Lessons learned over the last year:** A key lesson learned in 2023 was the importance of starting discharge planning before patients arrive at Coalbank Village. Effective planning is essential for successful health outcomes. Identifying special care needs, such as wound care, feeding tubes, catheters, ventilator procedures, or transferring from bed to chair, ensures a safe transition. It also involves assessing home health care needs, medications, follow-up appointments, and DME. Discharge planning is a crucial part of the care plan process and is vital for successful medical sheltering.

  Additionally, it is crucial to start the referral process to find housing within the first week. Quickly submitting the referral significantly increases the likelihood of a member finding housing. For transitional housing, where there is often a long waiting list, being added as soon as possible reduces the waiting time. Prompt referrals are essential for securing stable housing, which is a key initiative of this project.

  The provision of basic items to increase the comfort and health of residents is vital for achieving positive health outcomes. For example, giving a diabetic member a pillbox and an alarm for reminders increases the likelihood of medication adherence. Providing a reclining chair for someone who needs to keep their feet elevated makes them more comfortable and makes it more likely they will follow their care plan. Supplying pillows to reduce headaches and migraines by providing proper support for the head, neck, and spine is another essential measure. Ensuring these basic items are available to residents at Coalbank Village is a priority for Advanced Health and will significantly improve the health and well-being of these individuals.

  Another important lesson is how crucial it is to properly screen potential residents to ensure they are willing to meet the expectations and follow the rules of Coalbank Village. The program's resources are valuable and can be wasted if a member is not committed to:

  - An agreement to attend recommended medical care.
  - An agreement to participate in substance use disorder and behavioral health treatment, when needed.
  - Actively participation in seeking out and accessing resources.
  - Actively participation in their own care plan.

  These commitments are essential for achieving the goal of finding transitional or stable housing, which is necessary for positive health outcomes. Therefore, careful screening to assess the willingness of the member is vital to ensure that Coalbank Village is a good fit.

  Additionally, great care is taken to ensure a respectful and equitable screening process based on members' needs and social determinants of health (SDOH). The CC Program Prioritization Process uses a detailed scoring system to prioritize referrals and medical shelter admissions based on members' risk

level. This ensures that individuals with the most urgent needs receive prompt attention and support. The scoring system categorizes members into three priority risk levels:

- Priority 1 (High Risk) – 10 Points: Includes individuals with complex discharge needs, high-risk pregnancies, severe substance use, impending homelessness, multiple ED visits, LTSS and other high-risk conditions.
- Priority 2 (Moderate Risk) – 8 Points: Covers members with moderate needs such as hospitalization without complex discharge, behavioral health concerns, and basic needs within 1-2 weeks.
- Priority 3 (Low Risk) – 5 Points: Involves those with less urgent needs like new pregnancies, assistance with appointments, and support with resource access.

Risk Stratification and Complicating Factors:

- Complex Medical Needs: Members with two or more serious health conditions.
- High Needs Medical: Additional points for severe medical conditions and essential DME need.
- Social Determinants of Health (SDOH): Points added for issues like housing, food access, and transportation barriers.
- Other Complicating Factors: Extra points for urgent needs such as behavioral health discharge, domestic violence, and caregiving needs.

The total priority score is calculated by adding together points from the priority risk level and risk stratification and complicating factors. This comprehensive approach also ensures that care plans are tailored to meet the specific needs of each member, enhancing the effectiveness of interventions and improving overall health outcomes.

D. Brief narrative description

1. **Project population:** Members with Special Health Care Needs (SHCN) who are accepted for medical respite at Coal Bank Village. To be accepted, the member must be unhoused and referred for medical sheltering from acute care settings. Additional priority is given to those who also have diabetes, mental illness, asthma, dementia, and a history of falls.
2. **Intervention (address each component attached):** Intervention 1: To demonstrate the success of the Coalbank Village and the care management received by those who reside there, Advanced Health is tracking hospital admissions, both inpatient and ER. The results of this tracking show a reduction in readmissions and avoidable emergency department utilization. Although the benchmark set has been met, this data is still collected for the monitoring of successful health outcomes.

   Intervention 2: Health outcomes are further improved through weekly care coordinator check-ins and the provision of stable or transitional housing. Securing housing significantly enhances residents' overall health by providing a stable environment, improving access to healthcare, and reducing the stress and health risks associated with homelessness. By December 2024, we aim to meet the benchmark of engaging 89% of Coalbank Village residents in weekly care coordinator check-ins and facilitate finding housing for 85% of them.

   Intervention 3: The care coordination program at Coalbank Village is tracking the provision of Durable Medical Equipment (DME) to its residents. Identifying members who need DME and increasing access to it will improve health outcomes by enhancing mobility, managing chronic conditions, and reducing the risk of injuries and complications.

Intervention 4: To further address the health impacts of homelessness of the members at the Coalbank Village, a Health Risk Assessment (HRA) survey is conducted. The goal is to survey 90% of newly admitted residents within ten days of arrival. This survey identifies risk factors contributing to adverse health outcomes and gathers REALD and SOGI data. Residents needing medication assistance (e.g., those with diabetes, mental illness, asthma, dementia, and falls) are referred to medication management to reduce side effects and prevent hospitalizations.

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

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

☐ Short term or ☒ Long term

Monitoring measure 1.1	Reduction in utilization of emergency room visits (# of visits/member for 6 months)			
# of ED visits per Member 6 months prior to Sheltering	# of ED Visits per Member 6 months post Sheltering	Target met by (MM/YYYY)	Benchmark/future goal	Benchmark met by (MM/YYYY)
65 visits/12 Members (5.4 visits/Member)	34 visits/12 Members (2.8 visits/Member)	12/2022	2 visit/member	12/2023
Monitoring measure 1.2	Reduction in utilization of hospital inpatient days (# of days/member for 6 months)			
# of inpatient days per Member 6 months prior to Sheltering	# of inpatient days per Member 6 months post Sheltering	Target met by (MM/YYYY)	Benchmark/future goal	Benchmark met by (MM/YYYY)
215 days/12 Members (18 days/Member)	71 days/12 Members (5.9 days/Member)	12/2022	5 inpatient days	12/2023

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

☒ Short term or ☐ Long term

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

Monitoring measure 2.1	Number of members placed in housing or transitional housing after emergency shelter program			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
73% of members sheltered were placed in long term or transitional housing	80% of members sheltered were placed in long term or transitional housing	12/2023	85% of members sheltered were placed in long term or transitional housing	12/2024

Monitoring measure 2.1	Members engaged in weekly care coordination during medical Sheltering period, to work on member centered care plan goals			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
85% of members engaged with care coordination during the medical sheltering process	87% of members engaged with care coordination during the medical sheltering process	12/2023	89% of members engaged with care coordination during the medical sheltering process	12/2024

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

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement:

Monitoring measure 3.1	Number of Members with identified DME needs successfully receiving DME during medical sheltering period.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
14 members with identified DME needs prior to medical sheltering (2022)	Monitor number of members in medical sheltering program with identified DME needs	12/2023	Monitor number of members in medical sheltering program with identified DME needs	12/2024
86% of those members successfully receiving DME while medically sheltered	90% of members successfully receiving DME while medially sheltered	12/2023	95% of members successfully receiving DME while medically sheltered	12/2024

Activity 4 description: Complete a Health Risk Assessment (HRA) survey for 90% of newly admitted residents within ten days of their arrival. This survey aims to identify various risk factors contributing to adverse health outcomes and to gather comprehensive REALD and SOGI data, ensuring inclusivity and equity in the health assessment process.

☐ Short term or ☑ Long term

Monitoring measure 4.1	Number of completed HRA's completed within ten days of admission.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
It is unknow how many members have completed an HRA and unlikely as the unhoused population is difficult to contact via traditional means (mail/phone call).	Update Activate Care criteria to require an HRA in the care plan.	12/2024	By the end of 2025, ensure that 90% of newly admitted residents complete the Health Risk Assessment (HRA) survey within ten days of their arrival. This will facilitate the identification of diverse risk factors contributing to adverse	12/2025

			health outcomes and the collection of REALD and SOGI data.	
Monitoring measure 4.2	The percentage of data collected on the completed HRA's.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No HRA data is currently being reviewed or analyzed.	Utilize the HRA data to analyze and identify diverse risk factors contributing to adverse health outcomes and the collect of REALD and SOGI data. Create a plan to address the findings.	12/2024	Using the information collected, refer members who need medication assistance (those with Diabetes, Mental illness, Asthma, Dementia, and Falls) to medication management to reduce side effects and prevent hospital utilization.	12/2025

Section 2: Supporting information (optional)

See Appendix A: Care Coordination and Health Outcome Data

Coalbank Tracking Sheet 2021 - 20222

Coalbank Tracking Sheet 2023

Project # – Increasing Pediatric Dental Access within Coos and Curry Counties

Section 1: Transformation and quality projects

A. Project title: Increasing Pediatric Dental Access within Coos and Curry Counties

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

If continued, insert unique project ID from OHA:

B. Components addressed

1. Component 1: 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.

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.

Advanced Health serves about 29,000 Medicaid members and has partnered with Advantage Dental to provide oral health services. Advantage Dental offers a network of dental providers and Primary Care Dentists who deliver dental care at locations where community members already receive other social services, enhancing access and improving the community's oral health. Their services include preventive and stabilization care, education, and tele-dentistry.

Advanced Health and Advantage Dental collaborate to ensure members are referred to oral health care by their Primary Care Provider (PCP) or behavioral health provider. PCP clinics and behavioral health providers work directly with Advantage Dental Care Coordinators, who can be reached through a single phone number, to schedule patients in real-time during their visits. With more comprehensive dental visit information available to PCP offices, they can better coordinate appointments for diabetic oral health exams, annual checkups and cleanings, urgent dental needs, and pediatric sealants. This collaboration facilitates better health information sharing, care coordination, and integration for shared patients.

Advanced Health aims to expand the delivery modalities for preventive oral health services for members aged 0 to 5 through strategies such as co-location and cross-training of medical professionals. Preventive oral health services are an essential component of comprehensive primary care. Delivering these services aligns with the principles of whole-person care and should be standard practice within a patient-centered medical home or advanced primary care practice. Integrating oral healthcare into primary care is not intended to replace dental care, but rather to broaden the workforce addressing preventive oral health and improve patient health outcomes.

Tooth decay, despite being preventable, remains a very common chronic disease in childhood in the U.S. According to the Centers for Disease Control and Prevention (CDC), over half (52%) of children aged 6 to 8 have had a cavity in their primary (baby) teeth. Additionally, children from low-income families are twice as likely to have untreated cavities compared to those from higher-income families. Dental caries not only cause pain and tooth loss but also contribute to weight loss, decreased growth rates, poor learning outcomes, and reduced quality of life. By integrating preventive oral health services into primary care and other settings, Advanced Health aims to combat these issues. This approach ensures that all children, regardless of socioeconomic status, receive the care they need for better overall health outcomes.

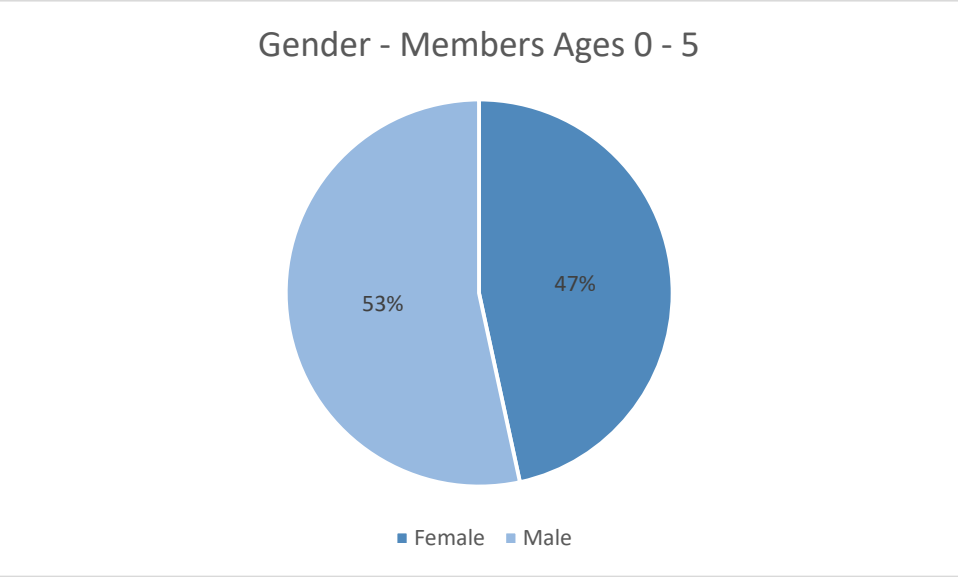
The data analyzed to support the adoption of this Performance Improvement Project (PIP) consists of dental utilization data used for the Coordinated Care Organization (CCO) Quality Metrics. As of the January 2024 OHA CCO Metrics Dashboard, the Preventive Dental or Oral Service Utilization measure for ages 1 to 5 years was at 53.7%. Although we are meeting our 2023 improvement target and the 2023 benchmark of 47.2%, we recognize that 46.3% of our members within this age category had not yet received a preventive dental or oral service in 2023. This data demonstrates that many of our youngest members could receive preventive dental or oral services during well-child visits by their assigned pediatricians and primary care providers if their providers were certified in children’s oral health.

We are currently awaiting the final OHA CCO Metrics Dashboard results for 2023, which will be used to establish our benchmark for this PIP and set our 2024 improvement targets.

Approximately 2,551 members, or 9% of Advanced Health’s total member population of approximately 29,000, fall within the 0 to 5 years age group. Within this age group, we have identified various race/ethnicity categories and languages (see table below). This data will be utilized to develop future interventions aimed at reaching our minority populations in an equitable and culturally appropriate manner.

Race Category:	Language:
82.24% White	97.02% English
3.99% Hispanic	0.09% Hindi
1.92% American Indian/Alaskan Native	0.78% Russian
0.90% Black	1.09% Spanish
0.47% Asian	1.76% Unknown
0.27% Native Hawaiian/Pacific Islands	2.97% Total of Non-English & Unknown Language
0.11% Other	
10.07% Unknown	

Additionally, the gender distribution of this population is primarily female at 53% and male at 47%. Since this project focuses on a pediatric population of members aged 0 to 5, the gender data is included for monitoring and reporting purposes only. For detailed demographics of Advanced Health's entire member population, please refer to the Member Demographics Summary dashboard on page 86.



Recommendations from the American Academy of Pediatrics recommends the initiation of fluoride varnish application starting at 6 months of age, coinciding with the eruption of the first teeth, and continuing through age 5. By integrating fluoride varnish application into pediatrician visits during the first year of life, when children typically receive regular check-ups and immunizations, multiple opportunities for application are created, along with guidance to establish a dental home for ongoing care before the child's first birthday.

The Quality Department conducted an environmental scan to evaluate the presence of medical practices with staff certified in to provide oral health care for children in Coos and Curry counties. The scan revealed that there are no locations with staff holding the First Tooth or Smiles for Life Certification in these counties. Given that Coos and Curry counties are situated in a particularly rural region of the state, the lack of awareness of the First Tooth Certification or the Smiles for Life programs and the absence of available Child Oral Health Certification training were identified as the root causes behind the scarcity of clinicians with this certification.

Rationale/Project Aim Statement: By the end of 2026, achieve a 40% increase in the number of clinicians trained and certified in Child Oral Health within each county (Coos and Curry), resulting in a minimum of 10 certified clinicians serving members aged 0 to 5 years. Also, target bilingual providers for this training. The overarching goal is to increase routine dental utilization to help increase kindergarten readiness. This will be measured through regular progress assessments, tracking of clinicians who receive their Child Oral Health Certification, and performance on the CCO metric for Preventive Dental or Oral Service Utilization for ages 1 to 5 years.

This project addresses significant gaps in preventive dental care for young children, particularly in underserved rural areas. By increasing the number of certified providers, the project aims to enhance early dental interventions, ultimately improving long-term health outcomes and school readiness for children. The collaboration with the dental care organization and targeted marketing efforts are essential to ensuring the program's success and sustainability

D. Brief narrative description

1. **Project population:** Members aged 0 months to 5 years.
   Population size: This is a sub-set of members aged 0 months to 5 years of age which is currently at 2,551 members.
   Population description: Members between the ages of 0 months and 5 years who lack access to dental care, particularly focusing on those who do not receive primary care. This analysis will include examining utilization based on REALD and SOGI factors, although for this age category we do not anticipate SOGI data to be an area of focus but will monitor once we have the data available to us.
2. **Intervention (address each component attached):**
   Activity 1: Increase the Number of Certified Clinicians
   Objective: Achieve a 40% increase in the number of Child Oral Health certified clinicians, resulting in a minimum of 10 certified clinicians in each county (Coos and Curry) by the end of 2026. Focus recruitment efforts on minority clinicians to improve cultural responsiveness and accessibility.
      - Long-term Activity
      - Monitoring Measure 1.1: The percentage of certified clinicians.
      - Baseline: As of 2024, there are no independent clinicians certified to provide Children's Oral Health in Coos and Curry counties, aside from those employed by Advantage Dental.
      - Target: Certify at least 5 clinicians by the end of 2025, with 20% of these clinicians being bilingual.
      - Benchmark: Certify at least 10 clinicians by the end of 2026, with 20% of these clinicians being bilingual.

   Activity 2: Enhance School Readiness through Oral Health
   Objective: Enhance school readiness for children aged 0 to 5 years through increased routine dental check-ups and oral health education.
      - Long-term Activity
      - Monitoring Measure 2.1: Track the utilization of routine dental check-ups for children aged 0 to 5.
      - Baseline: As of 2024, only 47.2% of children aged 0 to 5 years receive annual dental check-ups.
      - Target: Achieve a 5% point increase in the percentage of children receiving annual dental check-ups by the end of 2025, reaching 52.2%.
      - Benchmark: Achieve a 10% point increase in the percentage of children receiving annual dental check-ups by the end of 2026, reaching 57.2%.

   Activity 3: Expand Delivery Modalities for Child Oral Health Services

Objective: Increase performance in the Preventive Dental or Oral Service Utilization Age 1 to 5 metric by 5% and expand the delivery modalities/locations offering Children's Oral Health services by adding 4 new locations by the end of 2025. This will be accomplished through partnerships with local pediatricians, community health centers, and mobile dental units, ensuring services are accessible and equitable for all families.

- Short-term Activity
- Monitoring Measure 3.1: Track the number of new locations/modalities offering Children's Oral Health services quarterly.
- Baseline: Currently, Advantage Dental is the only provider performing children's oral health services in Coos and Curry counties.
- Target: Schedule children's oral health certification training for at least two local pediatricians, community health centers, and mobile dental units to expand service delivery by the end of 2024.
- Benchmark: Partner with at least four local pediatricians, community health centers, and mobile dental units to expand service delivery by the end of 2025.
- Monitoring Measure 3.2: Monitor and report the number of children aged 1 to 5 receiving preventive dental or oral services each month to assess progress towards the 5%-point increase in the Preventive Dental or Oral Service Utilization metric.
- Baseline: Per the 2023 preliminary OHA CCO Metrics Dashboard, the Preventive Dental or Oral Service Utilization Age 1 to 5 was 59.6%.
- Target: Reach the target or benchmark set by OHA for the Preventive Dental or Oral Service Utilization Age 1 to 5 metric for 2024.
- Benchmark: Exceed the target or benchmark set by OHA by 5% for the Preventive Dental or Oral Service Utilization Age 1 to 5 metric for 2025.

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

Activity 1 description: Achieve a 40% increase in the number of clinicians certified to provide children's oral health services, resulting in a minimum of 10 certified clinicians in each county by the end of 2026. Focus recruitment efforts on minority clinicians to improve cultural competence and accessibility.

☐ Short term or ☑ Long term

Monitoring measure 1.1	The percentage of certified clinicians			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
As of 2024, there are no independent clinicians certified in the First Tooth or Smiles for Life programs in Coos and Curry counties, aside from those employed by Advantage Dental.	Certify at least 5 clinicians by the end of 2025, with 20% of these clinicians being bilingual.	12/2025	Certify at least 5 clinicians by the end of 2026, with 20% of these clinicians being bilingual.	12/2026

Activity 2 description: Enhance school readiness for children aged 0 to 5 years through increased routine dental check-ups and oral health education.

☐ Short term or ☑ Long term

Monitoring measure 2.1	Track the utilization of routine dental for children 0 – 5.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
As of 2024, only 47.2% of children aged 0 to 5 years receive annual dental check-ups.	Achieve a 5% point increase in the percentage of children receiving annual dental check-ups by the end of 2025, reaching 52.2%.	12/2025	Achieve a 5% point increase in the percentage of children receiving annual dental check-ups by the end of 2026, reaching 57.2%.	12/2026

Activity 3 description: Increase performance in the Preventive Dental or Oral Service Utilization Age 1 to 5 metric by 5% point and expand the delivery modalities/locations offering children's oral health services in a primary care or non-traditional setting, by adding 4 new locations by the end of 2025. This will be accomplished through partnerships with local pediatricians, community health centers, and mobile dental units, ensuring services are accessible and equitable for all families.

☑ Short term or ☐ Long term

Monitoring measure 3.1	Track the number of new locations/modalities offering children's oral health services quarterly. This will measure progress towards adding 4 new locations by the end of 2025.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current state: Advantage Dental is currently the only provider performing children's oral health services in Coos and Curry counties	Schedule child oral health certification training for at least two local pediatricians, community health centers, and mobile dental units to expand service delivery.	12/2024	Partner with at least four local pediatricians, community health centers, and mobile dental units to expand service delivery.	12/2025
Monitoring measure 3.2	Monitor and report the number of children aged 1 to 5 receiving preventive dental or oral services each month. This will help assess progress towards the 3% increase in the Preventive Dental or Oral Service Utilization metric.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Per the 2023 preliminary the OHA CCO Metrics Dashboard, the Preventive Dental or Oral Service Utilization Age 1 to 5 was 59.6%.	Reach the target or benchmark set by OHA for the Preventive Dental or Oral Service Utilization Age 1 to 5 metric for 2024.	12/2024	Exceed the target or benchmark set by OHA by 5% points for the Preventive Dental or Oral Service Utilization	12/2025

			Age 1 to 5 metric for 2025.	

Section 2: Supporting information (optional)

See Appendix A: Root Cause Analysis

Project # 93 - Roadmap to Improved Behavioral Health Access and Integration

Section 1: Transformation and quality projects

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

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

If continued, insert unique project ID from OHA: 46

B. Components addressed

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

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

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**
   To improve the integration of behavioral health, Advanced Health actively engages in networking and collaboration with multiple community partners and providers. These efforts aim to meet the diverse needs of our membership, enhance access to services, and elevate member satisfaction within the behavioral health care system. Our collaborative efforts focus on several key areas, including fostering a robust provider network, promoting integration across healthcare settings, investing in workforce development, providing member education, supporting community projects, facilitating effective care coordination, and ensuring seamless referrals and data sharing. Through these integrated approaches, Advanced Health is committed to delivering comprehensive, member-centered behavioral health care services that address the unique needs of our members and contribute to their overall health and well-being.

   In 2023, Advanced Health witnessed significant growth in its behavioral health system, driven by additional funding allocated by the Oregon Health Authority (OHA) through the Behavioral Health Directed Payments (BHDP) initiative, which became effective on January 1, 2023. This initiative infused crucial resources into the behavioral health sector, resulting in a notable 15-30% increase in funding, with a particular emphasis on Co-Occurring Disorders and Culturally & Linguistically Specific Services.

The impact of these directed payments was profound, leading to a more resilient and adaptable behavioral health system within Coos and Curry counties.

The number of contracted behavioral health providers increased from 240 to 451 by December 31, 2023, representing an 88% increase. These additional providers are practicing in various care settings throughout Coos and Curry counties, significantly improving the timeliness of access to services. The expansion of telehealth options has further enhanced access to behavioral health services. In 2023, Advanced Health covered telehealth visits for 453 members at home, a significant increase from 284 members in December 2022. By the end of 2023, 3% of members were utilizing behavioral health services at home via telehealth.

In addition to contracting with more behavioral health providers, our four largest primary care clinics, which are PCPCHs (Patient-Centered Primary Care Homes), have integrated behavioral health clinicians. These integrated behavioral health teams serve approximately 80% of Advanced Health's membership, facilitating access to mental health consultations and seamless transitions to care within the same visit. Moreover, integrated behavioral specialists are adept at referring members to specialty programs once additional behavioral health or substance abuse services are identified as needed. The role of four and five-star PCPCHs has been pivotal in strengthening the integration of physical well-being with mental health in our community.

To enhance the quality of care for our members, the Director of Behavioral Health at Advanced Health encourages the recruitment of qualified behavioral health professionals from beyond Coos and Curry counties. Hiring out-of-area professionals strengthens our network without depleting local resources, promotes growth, and cultivates a culture of teamwork and support. This strategic approach expands our provider network by including professionals with diverse backgrounds and expertise, fostering a collaborative environment where they can learn from one another. This leads to a more comprehensive approach to member care. Additionally, by attracting experts in specific areas like psychotherapy, we increase our ability to deliver trauma-informed services. This collaborative and diverse network ensures our members have access to the highest quality behavioral health care available.

Advanced Health’s network includes Coos Health and Wellness (CHW) and ADAPT as the County Mental Health Provider’s (CMHP) in our service area. CHW offers a successful Intensive In-Home Behavioral Treatment (IIBHT) program. IBHT services are customized to address the specific needs of both the child and their family. These services encompass 4-6 hours of intensive support per week, strategically scheduled at times and locations that accommodate the family's preferences and routines. Additionally, IIBHT offers comprehensive training and round-the-clock support, empowering families to acquire the skills necessary for effectively managing and preventing mental health crises.

CHW also offers many other services in Coos County which include a comprehensive range of mental health services. These services are primarily for adults and include, but are not limited to:

- Therapy Services
    - Individual and family therapy
    - Psychiatric services for adults and children
    - Evidence-based treatments for children, adults, families, and groups
- Support Services
    - Case management and skills training

    - Specialized services for adults and youth with significant needs, including housing, employment, peer and family supports
- Older Adult Program
    - Therapy, case management, and skills training
    - Enhanced Care Outreach Services (ECOS)
    - Pre-Admission Screening and Resident Review (PASRR)
    - Collaboration with Aging and People with Disabilities and local assisted living/nursing facilities
- Supported Housing
    - Available to eligible CHW clients with more severe mental illnesses
- Employment Services
    - Supported Employment Services (SE) through a contract with the Mental Health Association of Oregon
- Mental Health Court
    - An alternative to traditional courts for defendants with mental illness
    - Collaboration with the County Court system, local law enforcement, District Attorney, and Public Defenders Office
- Protective Services
    - In collaboration with the Office of Investigators, Training, and Safety (OTIS)

CHW also has outpatient services specifically for children and youth that include traditional therapy, skills training, and psychiatric care. They also utilize the Early Assessment & Support Alliance (EASA) to support their younger patients. The evidence-based therapeutic models include:

- Parent-Child Interaction Therapy (PCIT)
- Cognitive Behavioral Therapy (CBT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)
- Parent-Child Psychotherapy/Attachment Therapy
- Wraparound
- Collaborative Problem Solving
- Trauma-Informed Care
- EMDR (Eye Movement Desensitization and Reprocessing)
- Filial Therapy
- Motivational Interviewing
- Solution-Focused Therapy

When traditional outpatient services are insufficient, CHW provides Care Coordination (CC). CC ensures that necessary services are in place, well-coordinated, and effectively delivered. These services help manage youth at risk of placement disruption, school failure, criminal involvement, homelessness, or other undesirable outcomes. CC also recruits and directs natural and additional supports through the Wraparound planning process.

CHW actively participates in behavioral health collaborations with the local hospital, providing immediate support to youth inpatients. CHW also staffs the Coos County Assertive Community Treatment (ACT) team. ACT is an evidence-based practice recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) for aiding adults with serious mental illness, helping them avoid unnecessary psychiatric hospitalizations while ensuring their safety in the community.

CHW collaborates with Advanced Health's CC to ensure members with Severe and Persistent Mental Illness (SPMI) receive appropriate care. Individuals with SPMI and other high-risk populations often need intensive support to maintain community tenure and may require hospitalization or step-down care following hospitalization. The involvement of a member from the ACT team ensures smooth care transitions, reduces over-utilization and trauma, and ultimately leads to better outcomes and cost savings.

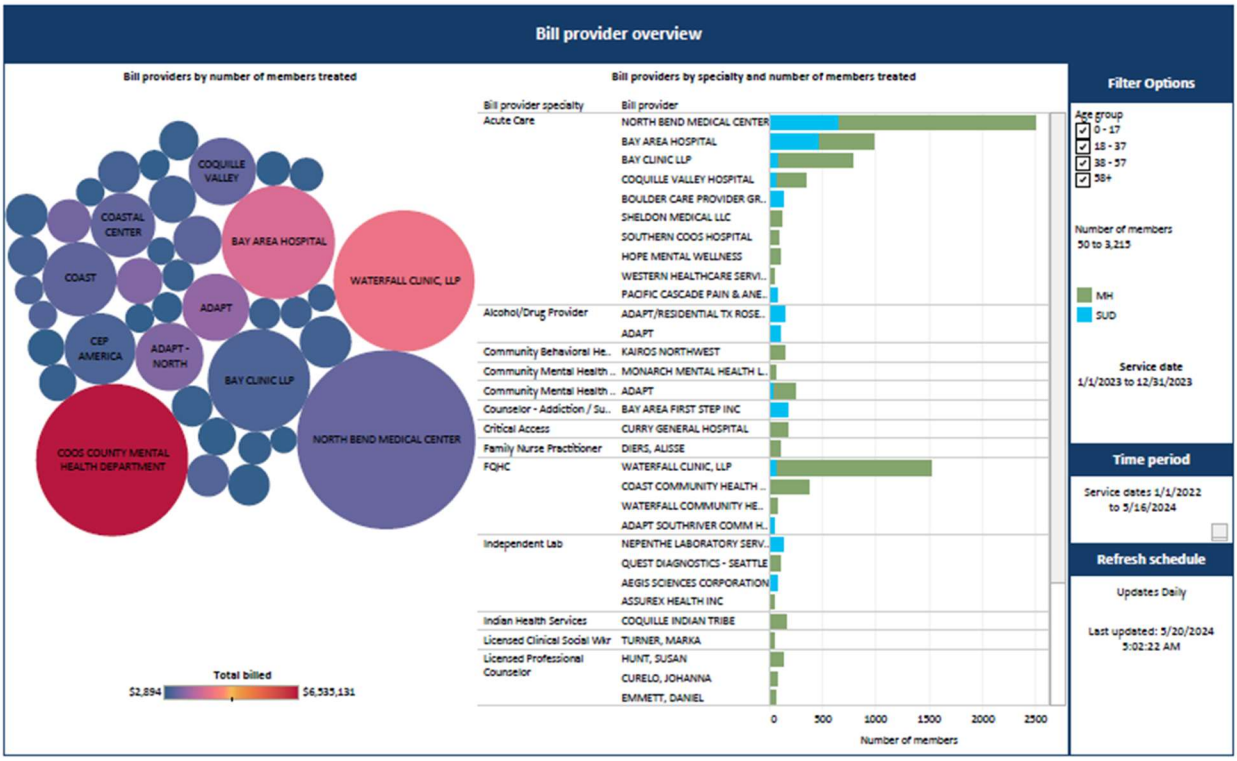
Serving Curry County as the CMHP, ADAPT has grown its capacity to provide a comprehensive range of mental health services, complementing its existing Substance Use Disorder (SUD) treatment programs. ADAPT's behavioral health services include, but are not limited to:

- Mobile Crisis Team and Crisis Intervention Services
  - Rapid response team for immediate mental health crises
  - Crisis intervention services to stabilize individuals in acute situations
- Adult Outpatient Behavioral Health:
  - Comprehensive outpatient psychiatric and behavioral health care for adults
  - Psychiatric assessment and diagnosis
  - Medication services
  - Individual, group and family services
  - Rehabilitation services
  - Clinical case management
  - Open Access (same day) walk-in access to mental health care
  - Skill-building training
  - Community Support Programs to assist clients in obtaining employment, medical care, supportive housing, and other social services to support recovery and independence
- Youth and Family Services
  - Comprehensive assessment and treatment planning
  - Individual, group and family services
  - Supportive Mental Health therapy
  - Skills-training to support and sustain stability
  - Parent Child Interactive Therapy (PCIT)
  - Healthy Transitions Initiative
- Care coordination, referrals, and transition planning with:
  - Community services
  - Residential care
  - Psychiatric Nurse Practitioners
  - Wraparound Program
- Community Supportive Services:
  - Assertive Community Treatment (ACT)
  - Clinical Case Management
  - Early Assessment & Support Alliance (EASA)
  - IPS Supported Employment
  - Peer Support Services
  - Forensic services
  - Jail Diversion Program (JDP)
    - .370 Project (also known as Aid and Assist)
    - Psychiatric Security Review Board (PSRB)
    - Mental Health Court

    - Choice Model Partnership to ensure the availability and quality of treatment services and supports
- Substance Use Treatment (also available in Coos County):
    - Confidential assessment and treatment planning
    - Individual and group counseling
    - Intensive outpatient treatment
    - Case management and continuing care to support treatment and recovery needs
    - DUII assessment and treatment
    - Corrections treatment services
    - Addiction Recovery Team for families involved with Child Welfare
    - Peer mentor and community support
    - Problem gambling treatment
    - Nicotine dependence treatment
    - IPS Supported Employment (SEP)
    - Medication-assisted treatment
    - Referral to detox, residential care, or medication-assisted treatment

ADAPT has several locations throughout Coos County that include Coos Bay, North Bend, and Reedsport and offer SUD treatment. Addressing SUD is closely linked with achieving good mental health, as substance use and mental health disorders often co-occur. The availability of ADAPT's SUD services helps enhance behavioral health across our service area.

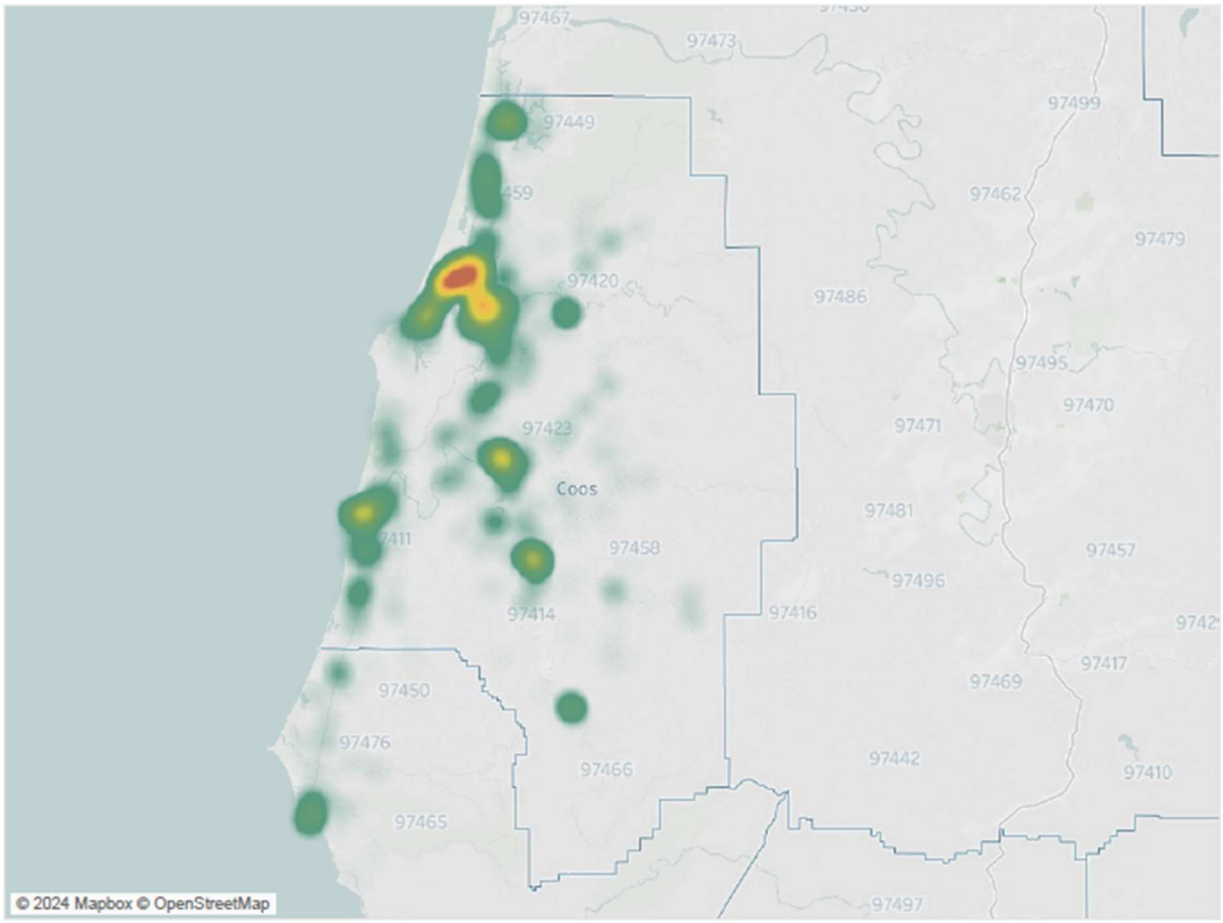
Advanced Health prioritizes access to behavioral health services for members with SPMI. We use claims data to identify members with SPMI diagnoses (details in Bill Provider Overview Dashboard below). This data visualization helps us understand access patterns and treatment locations across our 2023 service area. Recognizing the key role of primary care in behavioral health, we continuously monitor this data to ensure a sufficient network and equitable access for all members, ultimately promoting health equity.



Advanced Health also uses geographical data to analyze claims, enhancing our understanding of how to improve access to care. The graph below shows a heat map of individuals with behavioral health diagnoses based on zip code, helping us identify areas where care delivery options can be enhanced to better serve our members.

Members by Age Cohort

	2-5	6-11	12-17	18-24	25-64	65+	Grand Total
Num	168	627	1,206	690	3,202	309	6,202
Den	294	841	1,569	1,070	5,758	882	10,414
Measure Ra..	57.1%	74.6%	76.9%	64.5%	55.6%	35.0%	59.6%



To provide accessible care to students, Advanced Health partners with local schools to station behavioral health professionals on-site. Various behavioral health providers are stationed at several schools to address the diverse needs of students. The following schools have integrated behavioral health support:

- Marshfield High School Staff: Patient Navigator, QMHP-C/Behavioral Health Consultant, LPC/Registered Associate Mental Health Therapist, Medical Doctor from Coos Bay Clinic, Social Worker from CHW.
- North Bay Elementary School Staff: QMHP-C/Mental Health Therapist and a Family Nurse Practitioner.
- Harbor Lights Middle School Staff: Mental Health Therapist from CHW.
- Ocean Crest Elementary School Staff: Mental Health Therapist from CHW.
- Bandon High School Staff: Mental Health Therapist from CHW.
- North Bend High School Staff: Mental Health Counselor
- North Bend Middle School Staff: Mental Health Counselor.

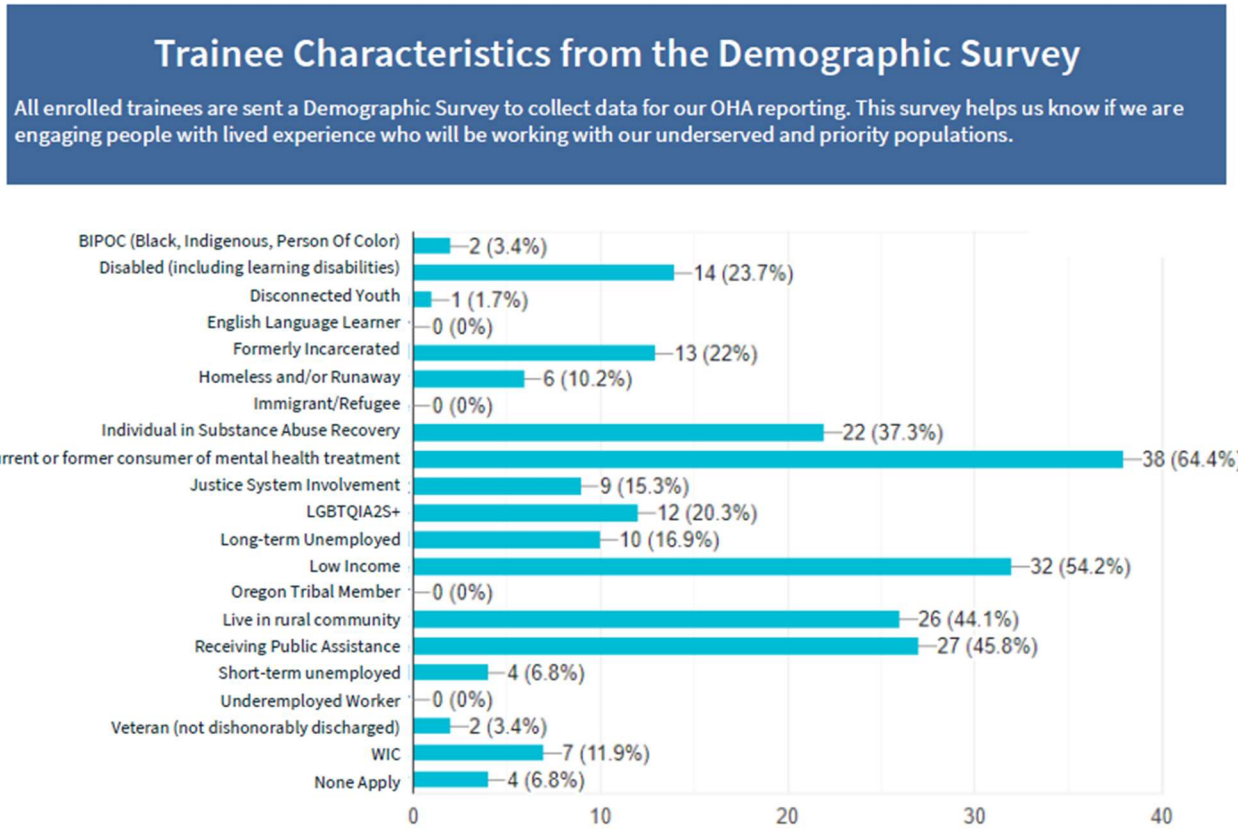
However, there are currently vacant positions at North Bend Hillcrest Elementary School, Sunset Middle School, and Millicoma Middle School in Coos Bay. Filling these vacancies is crucial to ensuring comprehensive behavioral health support for students across the region. To address this issue, plans are in place for Kairos Coastline Services to provide therapists at both Sunset and Millicoma Middle Schools in 2025.

In Fall 2023, Southwestern Oregon Community College (SOCC), with campus locations in Coos and Curry Counties, launched a program modeled after its nursing program to address the local demand for social workers and therapists. The Human Services Associate of Applied Science degree prepares students for state certification in addiction counseling through the Mental Health and Addiction Certification Board (MHACBO). The program focuses on workforce development for the behavioral health sector and Advanced Health actively supports and collaborates with SOCC to ensure its success.

During a recent meeting with Human Services/Psychology Instructor Jennifer Lewis, PhD, it was highlighted that additional marketing is necessary to clarify that the program is a pathway to becoming a Certified Alcohol and Drug Abuse Counselor (CADC), which could increase enrollment. Currently, the program has 3 students from Curry County and 10 from Coos County, with a goal to enroll more students within three years to sustain the program.

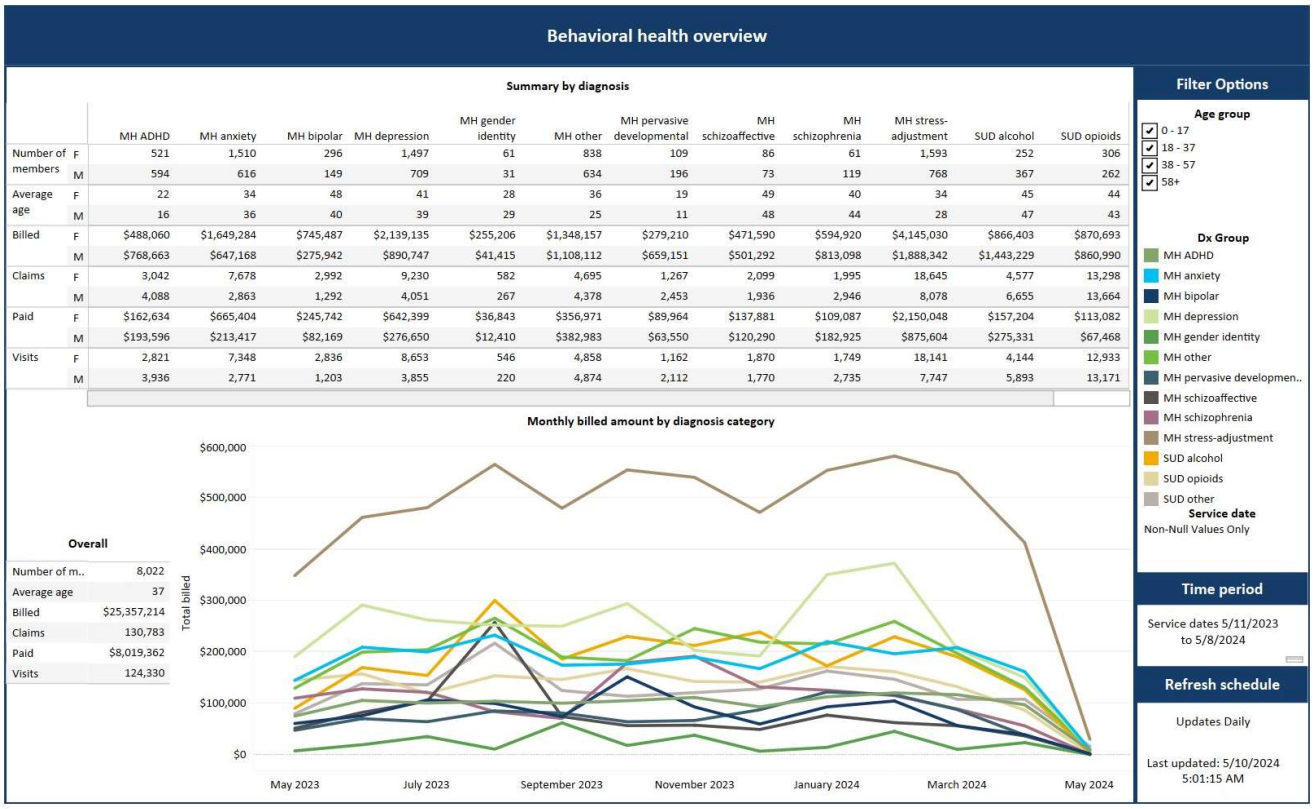
Additionally, the program requires behavioral health providers to supervise students during their practicum after completing one year of the program. To address this need, the Director of Behavioral Health at Advanced Health invited Jennifer Lewis to present at the Coos and Curry Community Mental Health monthly meeting where over 30 local providers and networks learned of the program, it's needs for agencies to serve as internship locations, as well as the need for mental health leaders to join the programs necessary board of directors. The interest was great with several agencies and MH/SUD providers agreeing to board participation. Jennifer Lewis also requested that Nirmala Diar from OHA, Advanced Health's Behavioral Health Program Manager, and the Director of Behavioral Health join the Advisory Board for the Human Services program. They agreed to contribute their expertise by attending bi-annual Advisory Board meetings. Nirmala shared that she has trainings that would augment the colleges curriculum thus a wonderful partnership was developed.

The Southwestern Oregon Workforce Investment Board (SOWIB) offers a free Traditions Health Workers (THW) Training Program, which includes Peer Support Specialist (PSS) training. These specialists can specialize in supporting families or youth. PSSs play a crucial role by leveraging their personal experiences with mental health challenges to foster empathy and strengthen relationships. By sharing their journeys, PSSs effectively connect with individuals, helping them set personal goals, develop strategies for self-empowerment, and take concrete steps toward building fulfilling and self-determined lives. In 2023, a total of 44 individuals completed training in Coos and Curry County. These trained THWs are now integrated into the workforce within Advanced Health's service area, providing culturally attuned care that respects diverse health beliefs, preferred languages, health literacy levels, and other communication needs of the community, see chart below for demographic information.



*data courtesy of SOWIB

Advanced Health currently serves approximately 29,000 Medicaid members, including about 8,000 individuals with a behavioral health diagnosis and an additional 1,448 members identified as SPMI. The graph below provides an overview of mental health utilization and encounter data for 2023, including gender breakdowns for those with behavioral health diagnoses. According to the data, females constitute the majority (58%) of individuals with behavioral health diagnoses and tend to utilize services more frequently compared to males (42%). This contrasts with the gender distribution of the entire membership, which is approximately 51% female and 49% male. These findings highlight a potential underutilization of behavioral health services among male members, suggesting a need for targeted educational efforts to encourage greater engagement.



		MH ADHD	MH anxiety	MH bipolar	MH depression	MH gender identity	MH other	MH pervasive developmental	MH schizoaffective	MH schizophrenia	MH stress-adjustment	SUD alcohol	SUD opioids
Number of members	F	521	1,510	296	1,497	61	838	109	86	61	1,593	252	306
	M	594	616	149	709	31	634	196	73	119	768	367	262
Average age	F	22	34	48	41	28	36	19	49	40	34	45	44
	M	16	36	40	39	29	25	11	48	44	28	47	43
Billed	F	$488,060	$1,649,284	$745,487	$2,139,135	$255,206	$1,348,157	$279,210	$471,590	$594,920	$4,145,030	$866,403	$870,693
	M	$768,663	$647,168	$275,942	$890,747	$41,415	$1,108,112	$659,151	$501,292	$813,098	$1,888,342	$1,443,229	$860,990
Claims	F	3,042	7,678	2,992	9,230	582	4,695	1,267	2,099	1,995	18,645	4,577	13,298
	M	4,088	2,863	1,292	4,051	267	4,378	2,453	1,936	2,946	8,078	6,655	13,664
Paid	F	$162,634	$665,404	$245,742	$642,399	$36,843	$356,971	$89,964	$137,881	$109,087	$2,150,048	$157,204	$113,082
	M	$193,596	$213,417	$82,169	$276,650	$12,410	$382,983	$63,550	$120,290	$182,925	$875,604	$275,331	$67,468
Visits	F	2,821	7,348	2,836	8,653	546	4,858	1,162	1,870	1,749	18,141	4,144	12,933
	M	3,936	2,771	1,203	3,855	220	4,874	2,112	1,770	2,735	7,747	5,893	13,171

Advanced Health is dedicated to ensuring equitable access to behavioral health services for all members, with particular attention to minority and unreported groups. Addressing potential inequities involves ongoing monitoring and targeted interventions to provide appropriate and effective care to underserved populations.

As illustrated by the Member Demographics Summary on page 86, the majority of Advanced Health's membership is White (66%) or categorized as Unknown (26%). Hispanic members represent the largest minority group, comprising 4% of the membership, followed by American Indian/Alaskan Native members at less than 2%. In terms of ethnicity, 71% of members are Not Hispanic, while 24% either decline to answer or are categorized as Unknown. This underscores the critical need for oversight to ensure equitable access to behavioral health services for all members.

Oversight is an integral part of the statewide Process Improvement Project (PIP) on Mental Health Access Monitoring. Among identified members with a behavioral health diagnosis, 4% are Hispanic, 23% are declining/not answering or Unknown, 73% are Not Hispanic, and a handful (too small to list for privacy reasons) are categorized as Other. These figures align with the overall population demographics.

English is the primary language for 97% of Advanced Health's membership, with a small but notable number of members who speak Spanish (less than 2%). However, when reviewing members diagnosed with a behavioral health condition, all are English-speaking, indicating a potential disparity for Spanish-speaking members. Despite having Spanish-speaking behavioral health providers in the network and on the Coos/Curry Behavioral Health Hub, this disparity suggests that Spanish-speaking members may face barriers to accessing behavioral health services. Addressing these barriers is crucial to ensure equitable care for all members and Advanced Health is in the process of contracting with OYEN Emotional Wellness Center and has one provider credentialed and another in the process of being credentialed.

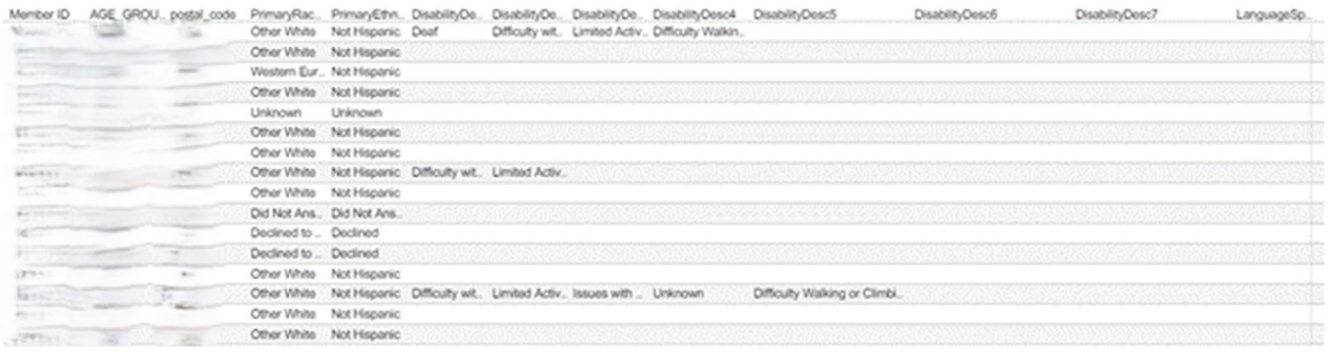
OYEN Emotional Wellness Center is a bilingual and bicultural clinic offering a range of mental health support services. The clinic provides highly qualified English and Spanish-speaking professionals who deliver individual and family therapy, drug and alcohol assessments, couples therapy, psychoeducation, and telehealth in a culturally-specific, trauma-informed manner. OYEN also partners with community-based organizations and members to increase awareness of mental health wellness and available resources, helping to break down barriers that the Latino community faces when accessing mental health services.

An analysis of disabilities and their effect on behavioral health shows a strong correlation between the two. Among the general population, 84% do not have a disability, while 15% have one or more disabilities. However, among members with a behavioral health condition, 21% have a disability. This indicates a higher prevalence of disabilities in individuals with behavioral health conditions, highlighting the need for integrated care strategies. To address the complex needs of these members, we're actively monitoring this group to form a cohort. This will enable us to develop targeted interventions for members with disabilities who also face behavioral health challenges.

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

The dashboard view shown below enables Advanced Health to identify specific members with an SPMI diagnosis and assess the services they are accessing. This helps evaluate the need for additional services such as Assertive Community Treatment (ACT), Early Assessment and Support Alliance (EASA), or Intensive In-home Behavioral Health Treatment (IIBHT). Individual cases are reviewed by the CC director and CC teams to evaluate high-needs members for care coordination and possible linkages to other specialized services. The goal is to prevent crises and relapses by providing a robust, member-centered treatment plan and collaborating with members to achieve their health care goals.

BH PIP Denominators with REALD and Location Data



Member ID	AGE_GROU..	postal_code	PrimaryRac..	PrimaryEthn..	DisabilityDe..	DisabilityDe..	DisabilityDe..	DisabilityDesc4	DisabilityDesc5	DisabilityDesc6	DisabilityDesc7	LanguageSp..
			Other White	Not Hispanic	Deaf	Difficulty wit..	Limited Activ..	Difficulty Walkin..				
			Other White	Not Hispanic								
			Western Eur..	Not Hispanic								
			Other White	Not Hispanic								
			Unknown	Unknown								
			Other White	Not Hispanic								
			Other White	Not Hispanic								
			Other White	Not Hispanic	Difficulty wit..	Limited Activ..						
			Other White	Not Hispanic								
			Did Not Ans..	Did Not Ans..								
			Declined to ..	Declined								
			Declined to ..	Declined								
			Other White	Not Hispanic								
			Other White	Not Hispanic	Difficulty wit..	Limited Activ..	Issues with ..	Unknown	Difficulty Walking or Climbi..			
			Other White	Not Hispanic								
			Other White	Not Hispanic								

Advanced Health uses a combination of utilization data (claims) and member self-determination through the Health Risk Assessment (HRA) screening tool. The HRA screenings are administered upon initial enrollment and annually thereafter. Members who do not respond to mailed surveys are contacted by phone by customer service to ensure that all members needing additional services are identified. Additional referral pathways to CC included:

- Internal referrals from other Advanced Health departments such as pharmacy, medical management, and claims.
- Referrals from all local area medical clinics and hospitals.
- Referrals from other hospitals, including Sacred Heart Riverbend Hospital, Oregon Health & Science University, Legacy Emanuel Hospital, and Lower Umpqua Hospital.
- Referrals from other medical sources, such as Home Health and Wound Care at Bay Area Hospital.
- Referral from Community Based Organizations, such as the Oregon Coast Community Action (OCCA).
- Referrals from Substance Use Disorder and Behavioral Health treatment providers.
- Referrals from the Office of Developmental Disabilities Services, Aging and People with Disabilities Services, the Department of Health and Human Services, and the Oregon Health Authority.
- Referrals from the Community Corrections of Coos County and the Curry County Parole & Probation Department
- Referrals from providers of homeless services
- Self-referral

These pathways ensure that members with complex health needs receive the coordinated care necessary to improve their health outcomes.

Additionally, members with SPMI often require lifelong management and a combination of psychiatric and social interventions to optimize daily functioning and improve quality of life. Most individuals diagnosed with SPMI experience significant impairments and disabilities in daily functioning. They may exhibit psychotic features, neglect personal hygiene, display cognitive deficiencies, and demonstrate erratic or unusual behaviors. These symptoms can pose challenges for coordinating care, necessitating a well-planned course of treatment and regular monitoring.

Advanced Health utilizes various data visualizations to comprehend the extensive landscape of behavioral health services utilized in our community. The graph below, developed by the Systems of Care Committees throughout Oregon, harnesses statewide claims data, stratified by REALD, to capture the utilization of behavioral health services by CCO and service region. This data undergoes review and analysis by our local Systems of Care (SOC) groups, aiming to monitor access to behavioral health care and identify disparities and gaps in services.

SOC grant funds also support behavioral health through various activities facilitated by the South Coast Early Learning Center, including training sessions, peer support groups, parent cafes, and a parent advisory council. Waterfall Clinic's Starfish Youth Therapy Center, an Autism Treatment Program, received funds to build a playground. The playground equipment is used therapeutically to develop sensory input, encourage fun social interactions, and promote exercise among the children. The playground is fully adaptable and accessible for children of all abilities. Furthermore, SOC grant funds contribute to the South Coast Equity Coalition Scholarship Fund, which supports financial literacy, vocational training programs/fees, and further education for BIPOC (Black, Indigenous, and People of Color), including those who identify as BIPOC-LGBTQIA2S+.

Member education on benefits and conditions is also pivotal in increasing behavioral health utilization. In late 2022, Advanced Health contracted with KRAMES, a patient education platform offering a comprehensive range of educational resources. This platform includes printable materials, brochures,

workbooks, and videos covering various physical, mental health, and substance use disorders and illnesses. These resources are designed with health literacy in mind to ensure they are easily understood by members. KRAMES provides clinically reviewed, evidence-based health content, empowering members to take an active role in their healthcare and ultimately improving outcomes. Access to the KRAMES platform is available to the entire Advanced Health provider network at no cost.

Both the Advanced Health Custom Service and CC staff actively utilize the materials in KRAMES for member education. In 2023, our contracted Primary Care Case Management Teams began training to become proficient KRAMES users. This expansion will extend utilization to four of our largest clinics, serving approximately 20,000 Advanced Health members.

2. **Describe whether last year's targets and benchmarks were met (if not, why):** Advanced Health has made significant strides in improving Behavioral Health Access and Integration, with notable accomplishments in 2023 and identified areas for further improvement.

   The program successfully met Target and Benchmark 1.1, which aimed to enhance access to Behavioral Health services by expanding the provider network. Over the past two years, the number of contracted providers has grown from 240 to 451 by December 31st, 2023. Contracting endeavors persist as we identify Behavioral Health providers serving our members.

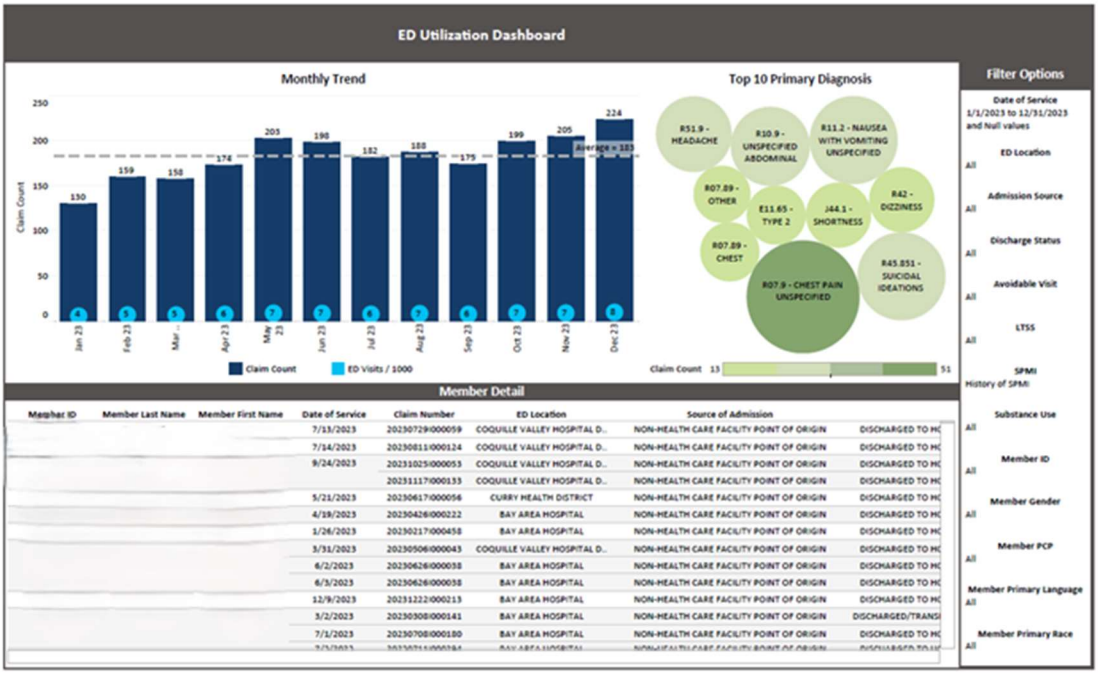
   In addition to the significant increase in new providers in Coos and Curry counties, efforts in collaboration with Southwestern Oregon Community College (SOCC) are also focused on augmenting the pool of contracted Behavioral Health providers. SOWIB has also contributed by increasing the number of CADC's in both Coos and Curry by a total of five in 2023.

   Significant progress was achieved in refining the Tableau data dashboards, originally developed in 2020, to monitor encounter data from the expanded Behavioral Health network. These dashboards analyze results to identify opportunities to enhance member access and service utilization, particularly for those with a behavioral health diagnosis. This Tableau data dashboard has undergone numerous upgrades in 2023, transforming it into a comprehensive data source. Encounter data is continuously updated and analyzed monthly, aggregated by diagnosis, number of members, age group, average age, number of claims, billed charges, paid amount, and number of visits. This allows for ongoing oversight and monitoring of access, facilitating the identification of service gaps, with a focus on our most vulnerable populations.

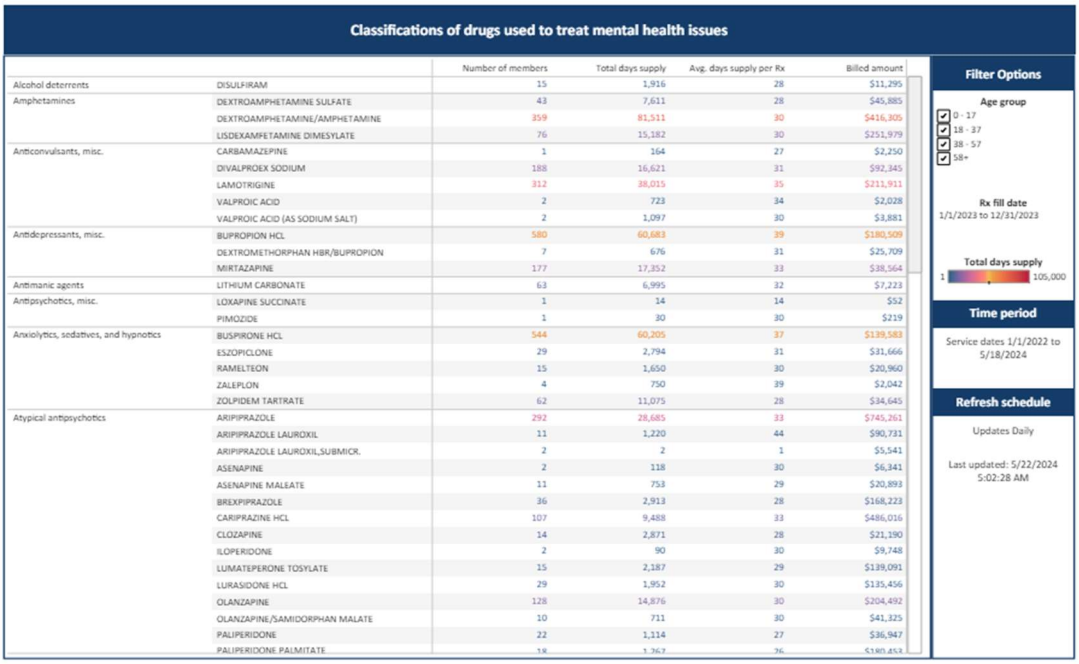
   The Behavioral Health Overview dashboard identifies the members and the number of mental health diagnoses, aiding in tracking high utilizers and ensuring their enrollment in intensive care coordination or case management services. To monitor the distribution of plan resources, the dashboard features a tab listing diagnoses billed in order of prevalence for the population, sortable by age groups (0-17, 18-37, 38-57, 58+). This Behavioral Health Overview dashboard is on page 53.

Analysis of members with a behavioral health diagnosis visit by Place of Service (POS) enables examination of the location of behavioral health service provided, encompassing various service settings. This is particularly useful in identifying members utilizing services via telehealth. Additionally, this Place of Service by Billed Amount dashboard provides insight into billing trends and frequency of member visits.

The ED Utilization Dashboard provides detailed information on behavioral health members, including ID, name, date of service (DOS), claim number, facility, discharge status, admission source, and primary care provider. This data can be further filtered by age, gender, race, language, SPMI, LTSS, and substance use. These filters enable targeted interventions for high-utilizers of emergency room services, allowing for more effective and personalized care strategies.

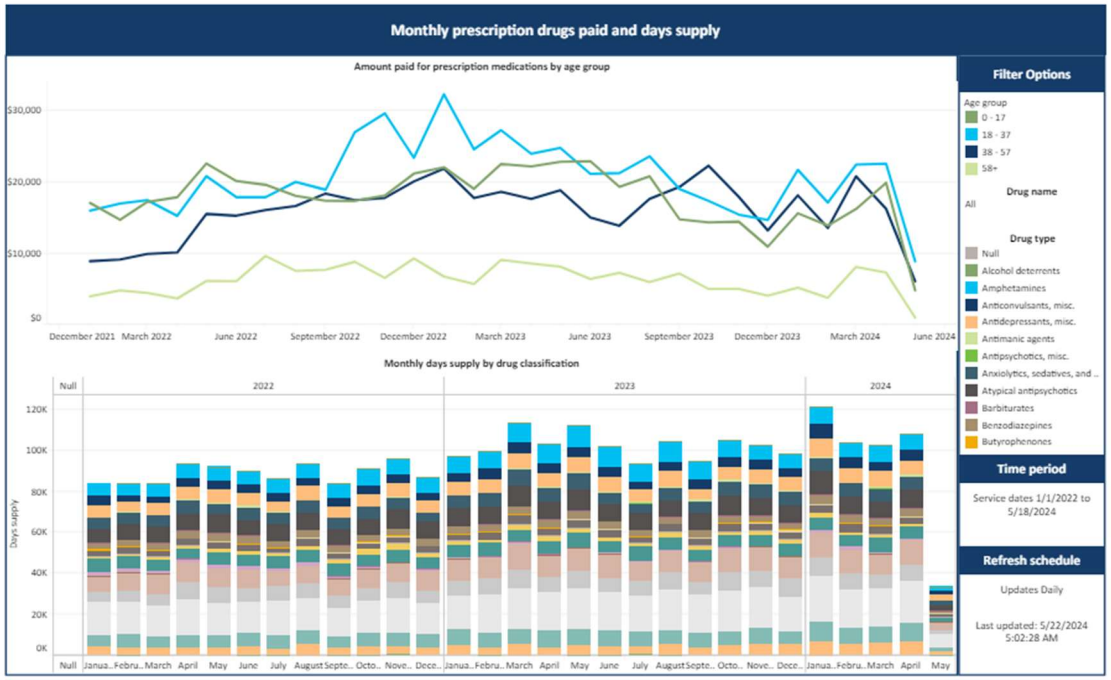


The Classification of Drugs Used to Treat Mental Health Issues dashboard provides an overview of behavioral health prescription utilization by drug type. It tracks the number of members, total days supplied, average days supplied, and billed charges, allowing us to pinpoint areas for targeted interventions.

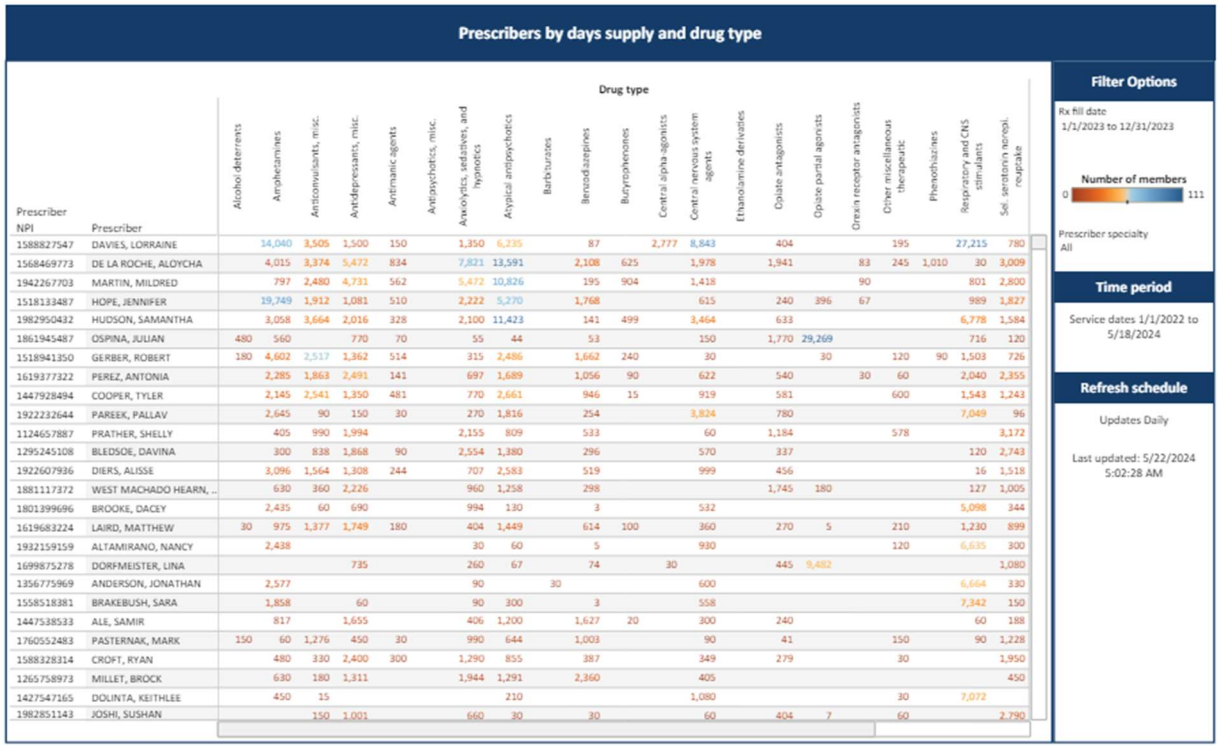


		Number of members	Total days supply	Avg. days supply per Rx	Billed amount
Alcohol deterrents	DISULFIRAM	15	1,916	28	$11,295
Amphetamines	DEXTROAMPHETAMINE SULFATE	43	7,611	28	$45,885
	DEXTROAMPHETAMINE/AMPHETAMINE	359	81,511	30	$416,305
	LISDEXAMFETAMINE DIMESYLATE	76	15,182	30	$251,979
Anticonvulsants, misc.	CARBAMAZEPINE	1	164	27	$2,250
	DIVALPROEX SODIUM	188	16,621	31	$92,345
	LAMOTRIGINE	312	38,015	35	$211,911
	VALPROIC ACID	2	723	34	$2,028
	VALPROIC ACID (AS SODIUM SALT)	2	1,097	30	$3,881
Antidepressants, misc.	BUPROPION HCL	580	60,683	39	$180,509
	DEXTROMETHORPHAN HBR/BUPROPION	7	676	31	$25,709
	MIRTAZAPINE	177	17,352	33	$38,564
Antimanic agents	LITHIUM CARBONATE	63	6,995	32	$7,223
Antipsychotics, misc.	LOXAPINE SUCCINATE	1	14	14	$52
	PIMOZIDE	1	30	30	$219
Anxiolytics, sedatives, and hypnotics	BUSPIRONE HCL	544	60,205	37	$139,583
	ESZOPICLONE	29	2,794	31	$31,666
	RAMELTEON	15	1,650	30	$20,960
	ZALEPLON	4	750	39	$2,042
	ZOLPIDEM TARTRATE	62	11,075	28	$34,645
Atypical antipsychotics	ARIPIPRAZOLE	292	28,685	33	$745,261
	ARIPIPRAZOLE LAUROXIL	11	1,220	44	$90,731
	ARIPIPRAZOLE LAUROXIL,SUBMICR.	2	2	1	$5,541
	ASENAPINE	2	118	30	$6,341
	ASENAPINE MALEATE	11	753	29	$20,893
	BREXPIPRAZOLE	36	2,913	28	$168,223
	CARIPRAZINE HCL	107	9,488	33	$486,016
	CLOZAPINE	14	2,871	28	$21,190
	ILOPERIDONE	2	90	30	$9,748
	LUMATEPERONE TOSYLATE	15	2,187	29	$139,091
	LURASIDONE HCL	29	1,952	30	$135,456
	OLANZAPINE	128	14,876	30	$204,492
	OLANZAPINE/SAMIDORPHAN MALATE	10	711	30	$41,325
	PALIPERIDONE	22	1,114	27	$36,947
	PALIPERIDONE PALMITATE	18	1,267	36	$180,453

The Monthly Prescription Drugs Paid and Days Supply dashboard graphs the number of members filling prescriptions each month. This data can be filtered by age groups and drug types to identify and analyze trends in behavioral health prescriptions over time.



The final dashboard Prescribers by Days and Drug Type lists prescribers of alcohol and drug and behavioral health drugs by prescriber National Provider Identifier, name, specialty, drug type, total day supply, and number of members, aiding in oversight of prescribing practices.



Prescribers by days supply and drug type

Drug type

Prescriber NPI	Prescriber	Alcohol deterrents	Amphetamines	Anticonvulsants, misc.	Antidepressants, misc.	Antimanic agents	Antipsychotics, misc.	Anxiolytics, sedatives, and hypnotics	Atypical antipsychotics	Barbiturates	Benzodiazepines	Butyrophenones	Central alpha-agonists	Central nervous system agents	Ethanolamine derivates	Opiate antagonists	Opiate partial agonists	Orexin receptor antagonists	Other miscellaneous therapeutic	Phenothiazines	Respiratory and CNS stimulants	Sel. serotonin norepi. reuptake
1588827547	DAVIES, LORRAINE		14,040	3,505	1,500	150		1,350	6,235		87		2,777	8,843		404			195		27,215	780
1568469773	DE LA ROCHE, ALOYCHA		4,015	3,374	5,472	834		7,821	13,591		2,108	625		1,978		1,941		83	245	1,010	30	3,009
1942267703	MARTIN, MILDRED		797	2,480	4,731	562		5,472	10,826		195	904		1,418				90			801	2,800
1518133487	HOPE, JENNIFER		19,749	1,912	1,081	510		2,222	5,270		1,768			615		240	396	67			989	1,827
1982950432	HUDSON, SAMANTHA		3,058	3,664	2,016	328		2,100	11,423		141	499		3,464		633					6,778	1,584
1861945487	OSPINA, JULIAN	480	560		770	70		55	44		53			150		1,770	29,269				716	120
1518941350	GERBER, ROBERT	180	4,602	2,517	1,362	514		315	2,486		1,662	240		30			30		120	90	1,503	726
1619377322	PEREZ, ANTONIA		2,285	1,863	2,491	141		697	1,689		1,056	90		622		540		30	60		2,040	2,355
1447928494	COOPER, TYLER		2,145	2,541	1,350	481		770	2,661		946	15		919		581			600		1,543	1,243
1922232644	PAREEK, PALLAV		2,645	90	150	30		270	1,816		254			3,824		780					7,049	96
1124657887	PRATHER, SHELLY		405	990	1,994			2,155	809		533			60		1,184			578			3,172
1295245108	BLEDSOE, DAVINA		300	838	1,868	90		2,554	1,380		296			570		337					120	2,743
1922607936	DIERS, ALISSE		3,096	1,564	1,308	244		707	2,583		519			999		456					16	1,518
1881117372	WEST MACHADO HEARN, ..		630	360	2,226			960	1,258		298					1,745	180				127	1,005
1801399696	BROOKE, DACEY		2,435	60	690			994	130		3			532							5,098	344
1619683224	LAIRD, MATTHEW	30	975	1,377	1,749	180		404	1,449		614	100		360		270	5		210		1,230	899
1932159159	ALTAMIRANO, NANCY		2,438					30	60		5			930					120		6,635	300
1699875278	DORFMEISTER, LINA				735			260	67		74		30			445	9,482					1,080
1356775969	ANDERSON, JONATHAN		2,577					90		30				600							6,664	330
1558518381	BRAKEBUSH, SARA		1,858		60			90	300		3			558							7,342	150
1447538533	ALE, SAMIR		817		1,655			406	1,200		1,627	20		300		240					60	188
1760552483	PASTERNAK, MARK	150	60	1,276	450	30		990	644		1,003			90		41			150		90	1,228
1588328314	CROFT, RYAN		480	330	2,400	300		1,290	855		387			349		279			30			1,950
1265758973	MILLET, BROCK		630	180	1,311			1,944	1,291		2,360			405								450
1427547165	DOLINTA, KEITHLEE		450	15					210					1,080					30		7,072	
1982851143	JOSHI, SUSHAN			150	1,001			660	30		30			60		404	7		60			2,790

Filter Options

Rx fill date
1/1/2023 to 12/31/2023

Number of members
0 — 111

Prescriber specialty
All

Time period

Service dates 1/1/2022 to 5/18/2024

Refresh schedule

Updates Daily

Last updated: 5/22/2024 5:02:28 AM

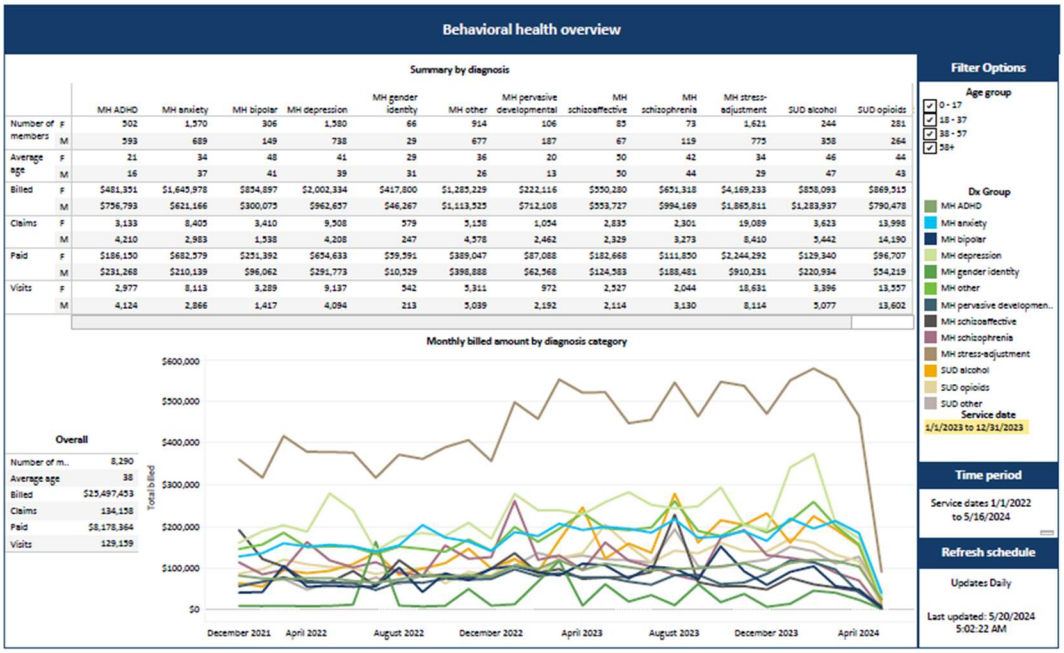
The Director of Behavioral Health regularly reviews and analyzes all of these dashboards, reporting identified trends to the Systems of Care committee to ensure services are provided in the most integrated settings. With the updates to the dashboards, the previous activity of refining the Tableau dashboard is considered complete. Moving forward, new activities will include the addition of REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) data.

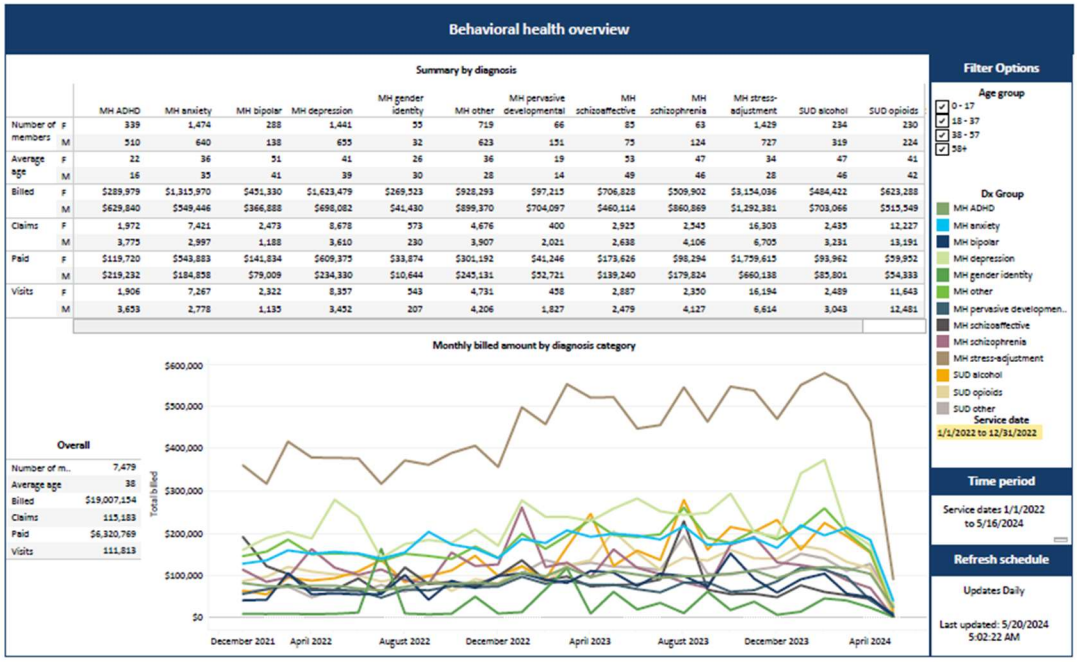
The targets for delivering a Tableau Dashboard via a provider portal to community behavioral health providers were not achieved, prompting a reassessment of thresholds and benchmarks. Advanced Health acknowledges the advantages of having a provider portal and has prepared a business case document detailing its benefits and functionalities. This document has been presented to Executive leadership to secure project funding as part of the budgeting process.

In 2023, the targets for enrolling 50 members with the ACT team at Coos Health and Wellness was not achieved. Despite serving a substantial number of individuals, with 33 members in Coos County and 2 members in Curry County, the benchmarks fell short. While the ACT team can accommodate a maximum of 50 members, it seems prudent to shift our focus from increasing member numbers utilizing ACT to directing resources and improvement efforts toward the increasing the number of THW's available to support families who are experiencing crisis.

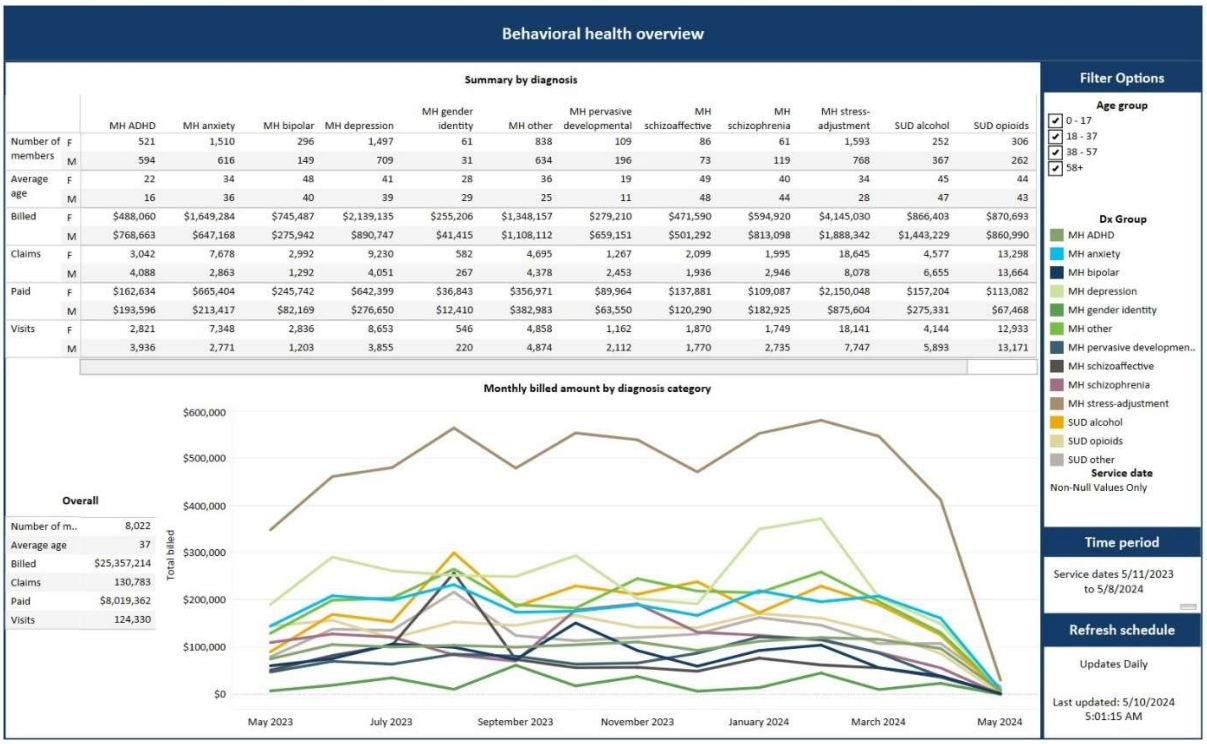
Additionally, we have observed that Mobile Response and Stabilization Service (MRSS) and CC are intervening and providing enough support to members which keeps them from reaching ACT levels of care. Advanced Health will research to identify best practice for these programs to effectively work together in tandem. We will also educate our providers on the criteria for determining which program best meets the needs of our members.

3. **Lessons learned over the last year:** An assessment of behavioral health utilization reveals a remarkable improvement from 2022 to 2023. Utilization increased from 111,813 visits in 2022 to 129,159 in 2023. This increase is a direct result of efforts to expand the number of contracted behavioral health providers. We will continue to monitor utilization to ensure that growth remains steady and will also focus on adding THWs to our provider network.





The highest behavioral health concern across all ages for Advanced Health members is Stress Adjustment Disorder. Which is a condition characterized by an individual's exaggerated emotional and behavioral responses to stressful events, such as illness, job loss, or divorce, resulting in difficulties both at work and at home. This maladaptive reaction to psychosocial stressors significantly disrupts social and occupational functioning. The prevalence of Stress Adjustment Disorder is demonstrated in the graph below which demonstrates the majority of Advanced Health members with a Behavioral Health diagnosis are not severe in nature and caused by Severe and Persistent Mental Illness (SPMI).



		MH ADHD	MH anxiety	MH bipolar	MH depression	MH gender identity	MH other	MH pervasive developmental	MH schizoaffective	MH schizophrenia	MH stress-adjustment	SUD alcohol	SUD opioids
Number of members	F	521	1,510	296	1,497	61	838	109	86	61	1,593	252	306
	M	594	616	149	709	31	634	196	73	119	768	367	262
Average age	F	22	34	48	41	28	36	19	49	40	34	45	44
	M	16	36	40	39	29	25	11	48	44	28	47	43
Billed	F	$488,060	$1,649,284	$745,487	$2,139,135	$255,206	$1,348,157	$279,210	$471,590	$594,920	$4,145,030	$866,403	$870,693
	M	$768,663	$647,168	$275,942	$890,747	$41,415	$1,108,112	$659,151	$501,292	$813,098	$1,888,342	$1,443,229	$860,990
Claims	F	3,042	7,678	2,992	9,230	582	4,695	1,267	2,099	1,995	18,645	4,577	13,298
	M	4,088	2,863	1,292	4,051	267	4,378	2,453	1,936	2,946	8,078	6,655	13,664
Paid	F	$162,634	$665,404	$245,742	$642,399	$36,843	$356,971	$89,964	$137,881	$109,087	$2,150,048	$157,204	$113,082
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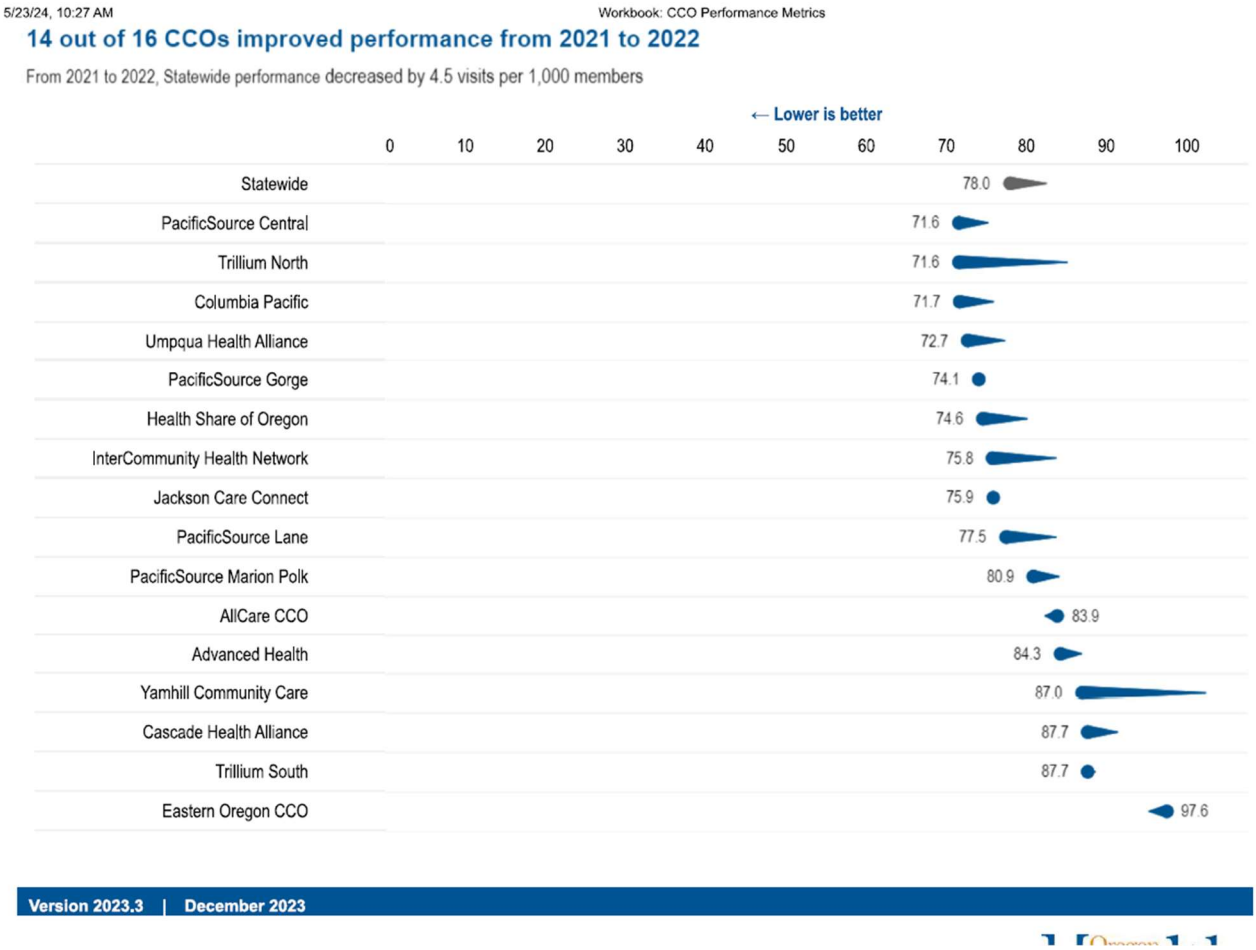
Visits	F	2,821	7,348	2,836	8,653	546	4,858	1,162	1,870	1,749	18,141	4,144	12,933
	M	3,936	2,771	1,203	3,855	220	4,874	2,112	1,770	2,735	7,747	5,893	13,171

MH stress-adjustment		
1,591	Number of members	F
766		M
34	Average age	F
28		M
$4,115,573	Billed	F
$1,876,255		M
18,524	Claims	F
8,015		M
$2,131,468	Paid	F
$868,298		M
18,034	Visits	F
7,690		M

The prevalence of anxiety and depression is high among Advanced Health's membership. Efforts to reduce these conditions, along with Stress Adjustment Disorder, can help prevent members from

escalating to SPMI. Individuals with SPMI have higher rates of drug and alcohol dependence and increased ER utilization. Improvement efforts will focus on reducing the number of ED visits for Stress Adjustment Disorder, Anxiety, and Depression. These efforts will also aim to increase peer support by adding more Traditional Health Workers who can provide care in various settings and locations.

Data from the OHA dashboard for 2022 shows that Advanced Health has slightly improved but is still performing below the 2019 pre-pandemic rate. The ED utilization rate for members with a history of mental illness decreased from 86.9% in 2021 to 84.3% in 2022. This downward trend is attributed to Advanced Health's efforts in communicating the availability of behavioral health benefits to members and increasing access to care.



In conclusion, Advanced Health remains dedicated to continually improving the integration of behavioral health by engaging in networking and collaboration with multiple community partners and providers. Our efforts remain focused on meeting the diverse needs of our membership, enhancing access to services, and elevating member satisfaction within the behavioral health care system. We will continue to cultivate a robust provider network, promote integration across healthcare settings, invest in workforce development, provide member education, support community projects, facilitate effective care coordination, and ensure seamless referrals and data sharing. Through these integrated approaches, Advanced Health is dedicated to delivering comprehensive, member-centered behavioral health care services that address the unique needs of our members and contribute to their overall health and well-being.

D. Brief narrative description

1. **Project population:** Every Advanced Health member should have access to comprehensive mental and emotional health services in addition to physical health care. There is a particular need for intensified attention to members coping with Severe and Persistent Mental Illness (SPMI).
2. **Intervention (address each component attached):** Collaboration lies at the core of Advanced Health's interventions, driven by the goal of enhancing the utilization of community services for our members. Ensuring equitable access to comprehensive mental and emotional health services alongside physical healthcare is imperative for every Advanced Health member. Given the heightened significance, there's a particular emphasis on providing intensified support to members grappling with Severe and Persistent Mental Illness (SPMI).

   Activity 1 - The intervention to identify and add more behavioral health providers to Advanced Health's network was successful. Although this benchmark was met, any additional identified behavioral health providers will be contracted with to increase access. This goal aligns with Advanced Health's objective to expand the provider network and improve access to behavioral health services.

   Activity 2 - The intervention of refining the Tableau dashboards for both uses of behavioral health and SPMI monitoring and creating interventions was met. An example of the function of a dashboard is monitoring the ER admissions for SPMI members. This goal supports the objective of improving service delivery and outcomes for members with behavioral health needs.

   Activity 3 – Although still in process, the intervention of reviewing and sharing the behavioral health Tableau dashboards with contracted providers is crucial. Having this available will help increase collaboration between the CCO and providers in the community bolstering performance in meeting the CCO Quality Measure, especially the Depression Screening and Follow-up measure or Screening, Brief Intervention and Referral to Treatment (SBIRT) for drug and alcohol use. This goal aligns with Advanced Health's objective to improve data-driven decision-making and enhance behavioral health service delivery.

   Activity 4 - This intervention involves boosting the capacity of Assertive Community Treatment (ACT) teams. By closely monitoring utilization of services, we aim to provide stronger support for individuals with severe and persistent mental illness (SPMI) and ultimately improve their health outcomes.

   Activity 5 – Our goal is to decrease ED admissions for Stress Adjustment Disorder, Anxiety, and Depression by 5% by December 2026. We plan to leverage our extensive behavioral health provider network to utilize and offer peer support services through Traditional Health Workers. This approach can provide valuable assistance to individuals experiencing mental health crises by decreasing day to day stressors while utilizing all practitioners to the top of their licensure to reduce unnecessary ED visits.

   Activity 6 – This intervention aims to reduce ED visits for SPMI members by implementing a referral program to connect top SPMI ED utilizers with Assertive Community Treatment (ACT) services. This aligns with our objective to improve health outcomes and reduce healthcare costs for SPMI members. Additionally, we are committed to ensuring that all SPMI members, regardless of their background, have access to ACT services

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

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

☐ Short term or ☒ Long term

Monitoring measure 1.1	Identify Behavioral Health providers not contracted with Advanced Health and practicing in Coos and/or Curry County and work to contract with them to bring them into the Advanced Health provider network.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
240 contracted providers in 2021	252 contracted providers by the end of 2022 (5% increase from 2021)	12/2022	277 contracted providers by the end of 2023 (10% increase from 2022)	12/2023

Activity 2 description: Refine the Tableau data dashboards developed in 2020 to monitor encounter data from the expanded Behavioral Health network. Analyze dashboard results for opportunities to improve Member access and utilization of services, especially for members with an SPMI diagnosis.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement:

Monitoring measure 2.1	Review 2020 Tableau data dashboards for potential revisions or additional data sources prior to rolling out dashboard results to providers.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2021 encounter data collected	2021 encounter data processed after adequate time for claims runout	06/2022	Continue to feed data and analyze for process improvement	12/2022
Identified data sources for claims and encounter data as well as member demographic data to be included in dashboards	Ongoing meetings with analytics to review additional and best sources of data	07/2022	Complete revisions to data dashboard, if deemed necessary	08/2022

Activity 3 description: Rollout Tableau dashboards to community providers.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement:

Monitoring measure 3.1	Train and implement Tableau Dashboard for community providers. Monitor percentage of providers actively using software and number of Members actively enrolled in behavioral health services. Due to Covid restrictions and pandemic-related strains on the local health care system, these targets and benchmarks are still in the development phase. Advanced Health will continue to engage with providers to educate on access and provide community-based solutions.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No documented procedure	Develop written procedure to monitor dashboards and reach out to providers	05/2025	Roll out dashboards and procedure to community providers	08/2026
No improvement targets set	15% of providers actively engaging with data	06/2025	25% of providers actively engaging with data dashboard	12/2026

Activity 4 description: Increase ACT team capacity and monitor utilization of services.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement:

Monitoring measure 4.1	Increase in ACT services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
34 clients served (CY 2021)	50 clients served	12/2022	Maintain capacity to serve 50 clients per year	12/2023

Activity 5 description: To decrease the number ER admissions for Stress Adjustment Disorder, Anxiety, and Depression by 5% by December 2026, by leveraging our extensive behavioral health provider network to offer additional peer support through Traditional Health Workers (THWs). This entails aiding families in meeting their fundamental physical and emotional needs during crises and over the long term. The threshold for success is set by increasing the number of contracted THW's by a target of 2% by December 2025, with a benchmark of an additional 2% by December 2025

☐ Short term or ☑ Long term

Monitoring measure 5.1	The number of members who have a Stress Adjustment Disorder, Anxiety, and Depression diagnosis.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In Q1, 2024: 13,022 visits with Stress Adjustment Disorder, Anxiety, or Depression diagnosed.	Reduce the number of visits with a Stress Adjustment Disorder, Anxiety, and Depression diagnosis by 2%.	12/2025	Reduce the number of visits with a Stress Adjustment Disorder, Anxiety, and Depression diagnosis by 3%.	12/2026
Monitoring measure 1.2	Improving access to Traditional Health Worker (THW) peer support and services through home visits tailored to the needs of families to enhance the achievability of the goal by addressing barriers to access.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
112 contracted THW's as of Q2, 2024.	An increase in the number of contracted THW's by 2%.	12/2025	An increase in the number of contracted THW's by 2%.	12/2026

Activity 6 description: Reduce the number of ED visits by SPMI members by implementing a referral program to ACT for the top SPMI ED utilizers. Achieve a 15% reduction in ED visits by SPMI members by December 31st, 2026

☐ Short term or ☑ Long term

Monitoring measure 6.1	Track the number of ED visits by SPMI members.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In 2023, the number of ED visits for SPMI members totaled 2,195, averaging 183 visits per month.	A 5% reduction in ED visits by SPMI members.	12/2025	A 10% reduction in ED visits by SPMI members.	12/2026
Monitoring measure 6.2	Track the number of referrals made to ACT.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
There is currently no process in place to refer SPMI members to ACT when they over-utilize the ED.	Collaborate with ACT teams to establish a referral process and ensure capacity for additional patients.	12/2024	Ensure 20% of SMPI ED utilizers receive a referral to ACT, focusing on top utilizers.	12/2025

Project # 361 - Patient-Centered Primary Care Home Advancement and Enrollment

Section 1: Transformation and quality projects

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

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

If continued, insert unique project ID from OHA: 361

B. Components addressed

1. Component 1: PCPCH: Member enrollment
2. Component 2 (if applicable): PCPCH: Tier advancement
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, Advanced Health demonstrated significant progress in expanding its network of contracted behavioral health providers and PCPCH-recognized clinics. Utilization of behavioral health services increased from 111,813 visits in 2022 to 129,159 in 2023, indicating improved access. The number of members assigned to PCPCH-recognized clinics is as follows:

PCPCH Recognition Level	Number of Members Assigned	% of Total Advanced Health Members
5 Star	14,074	51%
Tier 4	7,294	26%
Tier 3	2,592	9%
Tier 2	0	0%
Tier 1	0	0%
Not Recognized	3,571	13%

By the end of 2023, key providers such as North Bend Medical Center and Bay Clinic maintained their 5-star status, ensuring that 51% of Advanced Health members were empaneled at top-tier clinics

2. **Describe whether last year's targets and benchmarks were met (if not, why):** Activity 1, which aimed to establish an IQAC sub-committee led by CCO quality staff and peer clinic subject matter experts by the end of 2023, was not met. This was due to a lack of interest among PCPCH facility staff in participating in another committee. In response, feedback was solicited from PCPCH staff at an Inter-Agency Quality Committee meeting. During this meeting, it was revealed that a PCPCH Learning Collaborative would better address current needs. This collaborative would allow staff to attend as they can and would focus on supporting clinics attesting under the new 2025 PCPCH Standards, rather than functioning as a formal committee. Due to this feedback and the unanimous agreement from PCPCH staff on the benefits of forming a Learning Collaborative, Activity 1 has been revised accordingly. Advanced Health is now in the process of identifying an appropriate venue to accommodate these meetings.

   Activity 2 which requires the monitoring of both the PCPCH tier levels of primary care providers in the Advanced Health network and the proportion of Advanced Health's membership assigned to PCPCH recognized clinics was not met. As of December 31, 2023, 86% of Advanced Health members had a source of primary care with a PCPCH recognized clinic, which falls short of the target of 95%. With the new PCPCH requirements for 2025 and the reduction in membership due to redetermination, this activity has been revised with a more achievable target of 90% of Advanced Health members receive primary care from a PCPCH by December 2024.

   Activity 3, which aims to improve Advanced Health's performance on the Patient Centered Primary Care Home (PCPCH) weighted enrollment metric to exceed the statewide average, was met and represents a significant improvement in quality. By December 2023, Advanced Health achieved an 82% weighted enrollment, surpassing the target of 77%. This success highlights the effectiveness of our initiatives and the commitment of our network to enhancing patient-centered care.

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

   OHA's final calculation of CCO performance rate for 2023 was 80.6% which was a reduction from 2022. However, this is not concerning due to the ongoing redetermination process. The details on Advanced Health's year-end 2023 PCPCH member assignment at all tier levels is given below.

PCPCH Recognition Level	Number of Members Assigned	% of Total Advanced Health Members
5 Star	14074	51%
Tier 4	7294	26%
Tier 3	2592	9%
Tier 2	0	0
Tier 1	0	0
Not recognized	3571	13%

At the end of 2023, the largest provider in Advanced Health's network; North Bend Medical Center retained their PCPCH 5-star status at its main Coos Bay location. With Bay Clinic also retaining their PCPCH 5-star status in 2023, 51% (14,074) of our members were empaneled at a 5-star recognized clinic. Advanced Health currently has 13% of its members empaneled at non-PCPCH recognized clinics, this is a byproduct of the multiple single provider or small mulit-provider clinics in our rural area.

Throughout 2023, most of our community PCPCH clinics maintained their Tier status. Waterfall Community Health Center successfully obtained Tier 4 status at their main clinic and their School Based health center. Curry Medical Center went from Tier 4 to Tier 3 due to a lapse in PCPCH recognition and Dr. Mike and Friends Pediatrics' PCPCH attestation expired in late 2023 which created a shift in the percentage of members empaneled based on tier. The satellite locations of North Bend Medical Center in Coquille, Bandon, Myrtle Point, and Gold Beach have historically obtained tier 3; each obtained Tier 4 in 2023. Southern Coos Hospital and Health Center, who has historically not been PCPCH recognized successfully obtained Tier 3 in 2023.

The planned Interagency Quality and Accountability Committee (IQAC) sub-committee was unable to form due to demands on our provider network. However, individualized, on demand technical assistance was offered and utilized throughout 2023. After discussion with the IQAC, a Learning Collaborative specific to preparing for attestation under new 2025 standards was deemed more valuable and therefore the monitoring measure below has been updated to reflect the goal of establishing a PCPCH learning collaborative.

D. Brief narrative description

1. **Project population:** The project population consists of all Advanced Health members, with a particular focus on those enrolled at clinics recognized under the Patient-Centered Primary Care Home (PCPCH) program.
2. **Intervention (address each component attached):**

As of December 31, 2023, 86% of Advanced Health members had a source of primary care with a PCPCH recognized clinic. This is due in part to the number of clinics who maintained tier status and our largest clinics who hold a large majority of our member population retaining their 5-Star recognition status. Advanced Health is committed to offering technical assistance in learning collaboratives, general PCPCH education and one-on-one sessions with clinics who aim to increase their tier status or attest for the first time. Throughout 2023 Advanced Health held discussions with clinics to better understand their PCPCH goals and barriers to tier advancement. Goals set by clinics through the year were met by obtaining or maintaining PCPCH recognition and Tier status. The PCPCH recognition process and resources are reviewed at least annually via the Interagency

Quality and Accountability Committee (IQAC), and on demand between clinic partners and the Advanced Health Quality team. These approaches allow clinics to leverage their peers' combined experience and knowledge and other resources available through the CCO.

In 2024, Advanced Health plans to continue to offer education and resources for PCPCH tier advancement and recognition with a focus on assisting PCPCH clinics as they navigate updated PCPCH standards and Tier structure taking effect in 2025. Advanced Health will work with individual clinics to understand how the new PCPCH standards impacts Tier status, understand new must pass standards and creating interventions for increasing points to maintain current Tier status under new standards. With many current PCPCH clinics re-attesting in 2025, Technical Assistance will be offered both one on one and in group settings to support the need. The Interagency Quality and Accountability Committee (IQAC) was polled to gauge interest in a learning collaborative model during 2024-2025 with the goal to prepare clinics for attestation under the new standards. The response was overwhelmingly positive, and work will begin in early 2024 to engage clinics.

Advanced Health plans to investigate the loss of PCPCH recognition by one of our pediatric offices to better understand the barriers, gauge the interest in re-obtaining recognition and offer one on one technical assistance if appropriate.

Coquille Valley Hospital's primary care clinic plans to attest to Tier 4 in Q2 of 2024 with hopes of attesting to 5-Star by the end of 2024. Coquille Valley Hospital plans to open a new Myrtle Point location in early 2024, housing three primary care providers and Integrated Behavioral Health to serve members in Coquille, Myrtle Point, Powers and other rural surrounding areas. This clinic plans to attest 5-Star in Q4 of 2024. The extra location and tier advancement for Coquille Valley Hospital's Primary Care Clinic should positively impact Advanced Health's overall weighted average enrollment performance rate.

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

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

Activity 1 description (revised): Establish PCPCH Learning Collaborative to support clinics attesting under the new 2025 PCPCH Standards.

X Short term or ☐ Long term

Monitoring measure 1.1	Establish learning Collaborative and monitor attendance by clinic representatives			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No Learning Collaborative established	Learning Collaborative established lead by	7/2024	Quarterly Meetings established	7/2024

	CCO quality staff and peer clinic subject matter experts			
No utilization of Learning Collaborative	7 clinic staff present at each meeting	12/2024	10 clinic staff present at each meeting	6/2025

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

☐ Short term or ☒ Long term

Monitoring measure 2.1	Monitor progress quarterly as part of the DSN capacity reporting process.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
86% of Advanced Health members receive primary care from a PCPCH (Q4 2023 reporting)	90% of Advanced Health members receive primary care from a PCPCH	12/2024	95% of Advanced Health members receive primary care from a PCPCH	12/2025

Activity 3 description: Improve CCO performance on Patient Centered Primary Care Home (PCPCH) weighted enrollment metric. Return to performance over the statewide average.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Monitor progress annually for PCPCH weighted enrollment metric			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
82.0% weighted enrollment (MY 2022)	79% weighted enrollment	12/2024	80% weighted enrollment	12/2025

Project # 45 - Improve Language Services Access

Section 1: Transformation and quality projects

A. Project title: Improve Language Services Access

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

If continued, insert unique project ID from OHA: 45

B. Components addressed

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

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

Continued projects

Progress to date (include CCO- or region-specific data and REALD & GI data for the project population): Advanced Health aims to ensure all 29,000 Medicaid members, regardless of their language proficiency or cultural background, can fully understand their healthcare options and actively participate in decisions about their health. By 2026, we aim to enhance the accessibility and quality of our language interpreter services and cultural competency programs. This includes implementing a Value-Based Payment (VBP) model to incentivize providers who use Certified and Qualified interpreters, thereby increasing the utilization of interpretation services among Limited English Proficiency (LEP) members. Our commitment is to ensure all members receive equitable, respectful, and culturally responsive care, aligning with our overarching goal of promoting health equity and improving health outcomes for all members.

To better align with the goal of providing culturally responsive services Advanced Health addresses the equitable distribution of resources, enhances cultural competency, and improves language access services. This initiative is outlined in the Health Equity Plan, which aims to:

a. Initiate Organizational Changes: Build equity, inclusion, and diversity into service planning and delivery.
b. Establish Accountability: Incorporate health equity into accountability, resource allocation, and performance management with the Oregon Health Authority (OHA).
c. Foster Community Discussion: Provide a context for discussions on health equity within the organization and the broader community.
d. Operationalize Health Equity: Align with OHA's definition of health equity, ensuring all individuals can reach their full health potential without disadvantage due to social determinants.

The focus areas, strategies, and goals from the 2023 and 2024 Health Equity Plan cover the years 2022, 2023, and early 2024:

1. REALD/SOGI Data Integration: Incorporate REALD data into internal reports and explore data collection through community partnerships. Ensure all internal reports include REALD data to identify trends and improve equity.
    a. Strategy: The Advanced Health Analytics Department is integrating REALD data into all reports and has partnered with Reliance HIE and UniteUs for enhanced data exchange and coordination of social health needs. Reliance is a widely used Health Information Exchange platform, while UniteUs, available since February 2023, serves as the Connect Oregon platform for Community Information Exchange, facilitating closed-loop referrals and data collection from community screenings. The Analytics department is assessing data gathered by community partners through

UniteUs and has paused the integration of non-OHA data until data sources can be accurately identified, ensuring a reliable internal data source. Plans for a larger data warehouse are underway to manage data from multiple sources. In 2023, the strategy was slightly modified to account for the SOGI data that Advanced Health would receive from OHA.

b. Goal: Ensure all internal reporting dashboards include REALD data. By including REALD data in all reports, trends can be identified to improve equity. This is an ongoing goal, and Advanced Health has undergone an internal Analytics restructuring, which includes reviewing each reporting dashboard for data accuracy and data addition.

2. CLAS Standards: Implement culturally and linguistically appropriate services, including governance, leadership, workforce training, communication, and language assistance. Enhance language access services and provide training for staff and the provider network.
    a. Strategies: Advanced Health created a CLAS Champions Workgroup, which emerged from the Health Equity Steering Committee. The champions, who meet monthly, include staff from several departments, such as Compliance, Intensive Care Coordination, Customer Member Services, Health Policy, and Grievances and Appeals. As of 2024, the workgroup is developing a CLAS 5-year guide. The guide's goal is to standardize the process of renewing policies, procedures, manuals, announcements, and publications on Advanced Health's website and member-facing resources to ensure they align with CLAS standards.
    b. Collaboration: Advanced Health continues to partner with its Regional Health Equity Coalition, the South Coast Equity Coalition (SCEC), to sponsor its annual South Coast Diversity Conference. This effort supports the SCEC's goal of understanding community perspectives on Diversity, Equity, Inclusion, Justice, Accessibility, and Belonging (DEIJAB) principles. By doing so, it prioritizes topics identified by the community's priority populations which address the root causes of inequities.
    c. Goal: Increase staff attendance at the South Coast Diversity Conference. In 2023, 22% of staff attended, and in 2024, attendance decreased to 16%.
3. People with Disabilities and LGBTQIA2S+ Inclusion: Enhance services and support for these groups.
    a. Strategy: Advanced Health shall collaborate with the National Association of Developmental Disabilities and Mental Health Needs (NADD) for training and consultation. Additionally, select CCO staff will attend monthly Community Living Case Management (CLCM) meetings to identify additional barriers and gaps in the intellectual and developmental disabilities (I/DD) population. In 2023-2024, the monthly NADD meetings conflicted with other required meetings. However, staff attended other relevant training courses, including those sponsored by the System of Care (SOC) and OHA. CLCM meetings shifted from monthly to quarterly. The Behavioral Health Manager coordinated with the CLCM Manager to address employment challenges for I/DD youth and adults. A CLCM placement criteria presentation was provided to SOC members in both Coos and Curry Counties. Additionally, the SOC provided grant funds for an independent provider in Curry County to develop a childcare center for children with Autism, including outdoor sensory equipment.
        i. Goal: Increase participation in NADD training and CLCM meetings. The Behavioral Health Manager was unable to attend NADD training due to scheduling conflicts but attended 2 of the 4 CLCM meetings.
    b. Strategy: To improve the member experience, Advanced Health has sponsored Mental Health First Aid and Safe Zone training for CC and Customer Service staff who coordinate member healthcare. Mental Health First Aid is a national program that teaches how to identify, understand, and respond to signs of mental illnesses and substance use disorders. This training equips attendees with the skills needed to provide initial help and support to individuals experiencing mental health or substance use issues. All Advanced Health staff who

communicate directly with members, either verbally or in-person, will complete Safe Zone and Mental Health First Aid (MHFA) training.

i. Goal: All Advanced Health staff who communicate directly with members, either by phone or in-person, will complete Safe Zone and Mental Health First Aid (MHFA) training. From June 2023 until now, three Customer Service Representatives and one CC staff member completed Safe Zone training, with another training session planned for later this year.

c. Strategy: After a listening session with the Queer community in November 2023, Advanced Health gained a better understanding of barriers and areas for improvement. It was evident that additional information was needed. Concerns included a lack of providers, particularly Primary Care Providers, who understand and are educated about the Queer community's needs and resources. The listening sessions also revealed that some members have experienced inconsistent gathering of their SOGI data including what information was gathered and at how or at what point it was gathered.

i. Goal: To assure consistency of the gathering of SOGI data by the Advanced Health Provider Network.

d. Strategy: Gather feedback from Advanced Health members who identify as having sexual orientation diversity on the CCO's current efforts to be inclusive.

i. Goal: Survey people with sexual orientation diversity on their experiences with Advanced Health.

4. Community Engagement: Strengthen community collaboration and engagement through various projects and initiatives.

a. Strategy: Increase member participation in the Community Advisory Council (CAC) meetings by providing alternative methods to access resources discussed during meetings. This will foster greater community involvement in addressing health equity gaps.

i. Goal: Increase the amount of information and updates provided during monthly CAC meetings available to meet the needs of all individuals, including 3 new ways for CAC members to access information by 2024. This goal was met in 2023 and continues to be achieved by offering hard copy versions of the agenda and other meeting materials.

b. Strategy: Developed in 2024, this strategy aims to increase community members' access to healthy fruits and vegetables and to raise awareness and education about available food resources. Additionally, it aims to enhance food nutrition education opportunities for community members.

i. Goal: Increase access to healthy fruits and vegetables by investing in the expansion of existing successful programs to other cities within the counties they serve. Currently there are 11 distribution sites for fruits and vegetables in Coos and Curry Counties.

5. Continued development of organizational health equity infrastructure

a. Strategy: Continue collecting REAL-D and Employee Equity Assessment Survey data to evaluate these areas. Maintain the annual Employee Benefits Evaluation to ensure equitable distribution and access for employees. Additionally, rollout HRIS data insights in 2024. Advanced Health collects REAL-D data annually from employees, committee, and board members. The completion rate has increased yearly since 2021. This data collection follows Advanced Health's REAL-D Data Collection Policy and Procedure using the Oregon Health Authority's REAL-D Data Collection Form, ensuring a secure, consistent process. Data collection results are confidential and viewable only by the HR department.

i. Goal: To increase the number of responses for REAL-D and Employee Equity Assessment data collection, and to consider an employee benefits survey. To utilize

the HRIS's data insights to further evaluate diversity and equity amongst staff, positions, and departments.

	2022	2023	2024 (1st cycle)
Board- and Committee-Members	15%	16%	16%
Employees	22%	36%	32%

Community Projects:

- Mobile Shower Project In partnership with a local non-profit organization, this project provides mobile showers for the unhoused community in Curry County. Originating from the Health Equity Steering Committee, this project addresses community needs as identified by deeply embedded staff members.
- Member Support: The Member Engagement and Education Committee (MEEC) committee holds presentations to address barriers members face when contacting Advanced Health and actively participates in community meetings. This committee welcomes both staff members and community members.
- Health Equity Fair: Organized events that provide health services, educational materials, and community engagement, with notable participation and collaboration from various community organizations.

Annual Training and Education:

- Cultural Competence Training: Advanced Health promotes cultural responsiveness, addresses implicit bias, and fosters inclusive communication through comprehensive training modules, Lunch and Learn sessions, and sponsoring diversity events. These efforts ensure that healthcare professionals in our community are equipped to deliver culturally appropriate care.
- Board Training: Conduct training sessions for the Board of Directors on CLAS Standards.
- Provider Learning Opportunities: Offer CEU-accredited modules for the provider network focusing on cultural responsiveness and cross-cultural care.

The 2023 and 2024 Health Equity Plan's focus areas, strategies, and goals have significantly advanced health equity across the community. By integrating REALD/SOGI data, implementing CLAS standards, supporting people with disabilities and LGBTQIA2S+ individuals, and fostering community engagement, Advanced Health has taken crucial steps to address and reduce health disparities. The ongoing development of organizational health equity infrastructure further underscores their commitment to creating an inclusive and equitable healthcare environment. Through these concerted efforts, Advanced Health continues to make meaningful progress towards a more just and accessible healthcare system for all members.

The progress to date in improving language interpreter services and cultural competency at Advanced Health has been notable, but not as successful as hoped and marked by various initiatives and collaborations. While commendable, these efforts have presented challenges primarily due to the small population size for this project, prompting a reevaluation of strategies to better align with our goal of promoting health equity. Advanced Health remains steadfast in its commitment to this endeavor and will proceed with revisions aimed at optimizing outcomes. The activities undertaken in 2023 are outlined below.

As a Coordinated Care Organization (CCO), Advanced Health provides a variety of language access services, including but not limited to in-person, interpreters, bilingual staff, or remote interpreting systems such as telephone or video interpreting, as well the translation of written materials or signage, sign language, or braille materials. The Customer Service department provides these services upon request or once a member has been identified as needing assistance.

The expansion of the Health Care Interpreter Program with Language Line Solutions has significantly increased members' access to healthcare interpreters, offering 24/7 availability. This program benefits both members and providers by offering flexibility in the mode of interpretation, including over-the-phone, video remote, and on-site services. This flexibility allows healthcare providers to choose the most suitable option based on the members' specific needs and preferences.

However, while Language Line Solutions have improved access to interpretation services, they have not directly contributed to increasing the number of OHA Certified or Qualified interpreters. Despite this limitation, ongoing efforts such as staff training, development of informational materials, and utilization monitoring continue to maximize the benefits of Language Line Solutions. Until a better alternative is available, these activities demonstrate our commitment to optimizing the current services and ensuring members receive effective language support.

Advanced Health is committed to providing high-quality interpretation services and has maintained staffing that includes two Spanish-speaking Customer Service Representatives (CSRs). One of our CSRs holds a qualification as a Health Care Interpreter, ensuring proficient and accurate communication in healthcare settings. They are readily available within our Customer Service Department to assist Spanish-speaking members both over the phone and in person at our CCO office. Beyond interpretation services, our staff actively contribute to the development and verification of translated member materials and health education information. This ensures all content is culturally and linguistically appropriate, further enhancing the member experience.

The ongoing participation of Advanced Health's Qualified Health Care Interpreter in community events underscores our organization's dedication to accommodating diverse cultural and linguistic preferences. However, the tangible effects of these initiatives on enhancing healthcare access for underserved populations in the community have yet to be quantified. Community engagement is also facilitated through the Inter-Agency and Accountability Quality Group, which includes Advanced Health's leadership, provider network, and community partners. This committee oversees the delivery of language access services through quarterly reports, ensuring continuous improvement and accountability.

Efforts aimed at expanding the pool of certified Health Care Interpreters within our provider network via the Health Care Interpreter Scholarship Program exemplify proactive steps taken to meet workforce demands. Consistent promotion of this financial incentive underscores our commitment to increasing participation in the scholarship opportunity. In 2023, the Health Care Interpreter Scholarship Program supported the training costs for two clinic employees, out of the initial six awardees, who successfully completed the program and are now certified OHA Qualified Interpreters. This scholarship initiative remains accessible and continues to be actively promoted.

The contract with Krames, a technology-driven intervention, was successfully implemented in 2023. This intervention aims to enhance member education, improve patient safety, and reduce medical errors

related to miscommunication by providing easy-to-understand patient education in members preferred or identified languages and by improving access to quality interpreter services. This underscores Advanced Health's commitment to dismantling language barriers by offering educational resources in multiple languages, including English, Spanish, and video formats tailored for individuals who are deaf or hard of hearing. These health education materials are distributed either through mail or electronically by Advanced Health or its contracted providers, who have undergone training and have been granted access to the Krames platform, primarily in primary care settings. Comprehensive training for both staff and providers on the Krames platform was completed in 2023, with ongoing efforts to ensure proficiency.

To strengthen health equity in Coos and Curry counties, we plan to incorporate Native American health education materials from the Indian Health Service, The Federal Health Program for American Indians and Alaska Natives, into the Krames platform. These materials will be available for use by the community and by our Customer Service and Care Coordination staff at Advanced Health.

Since adopting the Performance Improvement Project to Improve Language Access in 2021, Advanced Health has conducted an environmental scan of clinics, healthcare providers, and community-based organizations within the community, aiming to:

1. Gain a better understanding of the process by which they identify members with Limited English Proficiency (LEP).
2. Identifying the tools they utilize for providing in-person and electronic interpreter services.

While the environmental scan is ongoing, Advanced Health has gained insights into how many of its contracted providers can identify members who are LEP. However, as of 2023, the utilization rate for the provision of an OHA Certified or Qualified interpreter for LEP members was less than 7%. Advanced Health faces significant challenges due to limited resources in its rural setting, including a shortage of experienced and trained staff and a scarcity of Certified and Qualified interpreters within the community. These factors are believed to contribute to the low utilization rate.

To ensure a full understanding of the cause of low utilization of interpretation services and identify any gaps, a thorough analysis was done which considered the characteristics and needs of the LEP population. This included a detailed examination of data, incorporating available REALD and SOGI data, as well as assessments of hearing impairments and other communication needs to the fullest extent possible.

With the additional REALD Lens, Advanced Health has undertaken the following actions to better understand the causes of low utilization of interpretation services and identify any gaps:

- Conducted an analysis of 2020 census data from LEP.gov.
- Evaluated the number of local interpreters registered in the area per OHA's Health Care Interpreter (HCI) Registry.
- Analyzed both member and provider REALD data.
- Outlined plans for utilizing SOGI data once it becomes available.

These initiatives are aimed at improving insights and informing strategic decisions to enhance language access services and better meet the diverse needs of our members.

Findings from Analysis:

Census Data: The analysis findings reveal the combined Limited English Proficiency (LEP) population in both Coos and Curry County is 915. In contrast, Advanced Health boasts a total membership of 1,282 LEP individuals which constitutes roughly 29% more LEP identified individuals than reported in the entire LEP census population data for Coos and Curry County combined. This suggests interpreters' services are not being excessively utilized by non-Advanced Health members within the LEP community, or the entire LEP population identified in the Coos and Curry County census data are all Advanced Health member and/or they are not self-identifying on the census.

County	Total Number of Advanced Health Members	Number of LEP Advanced Health Members	Total population of LEP per Census Data
Coos	26,192	915	722
Curry	4,182	367	193

Based on this analysis, there is a need to ensure equitable access to interpretation services for all LEP individuals in the community, not just those affiliated with Advanced Health. We will ensure there are outreach and education efforts to raise awareness about available language support services, collaborate with community organizations to enhance service provision, and addressing systemic barriers which hinder access to healthcare for LEP populations

Local Interpreters: An analysis of the local Qualified and Certified interpreters enlisted on the OHA HCI registry highlighted a prevalent trend of registrations marked as "statewide," predominantly concentrated in Portland, Oregon, or situated out of state. Notably, only 40 interpreters were categorized by county, and upon closer analysis, a mere 2 Qualified or Certified interpreters were identified in Coos County, with none in Curry County. This minimal representation of interpreters poses a significant challenge, contributing to low utilization rates and indicating a considerable disparity between the percentage of enrolled Advanced Health members with Limited English Proficiency (LEP) and the limited availability of interpreters within our two counties.

To address this equity concern, efforts will be focused on recruiting and training more local interpreters, incentivizing providers to use interpreters, and leveraging technology for remote interpretation services.

Member Data: To ensure this project is transformative and is advancing the provision of effective, equitable, understandable and respectful quality care and services which are responsive to diverse cultural health beliefs and practices, multiple languages, health literacy and other communication needs, a comprehensive analysis of member data by REALD and SOGI was performed. However, Advanced Health acknowledges the limitations of gender data sourced from OHA, as it may not equally represent all populations.

Based on Advanced Health’s Tableau report for language access and interpreter services, which flagged only 216 members from OHA as requiring interpreters for medical and dental services, there is a significant discrepancy between our LEP member count of 1,282 and those utilizing services, amounting to approximately 16.84%. This suggests potential disparities within our LEP member population.

To gain a comprehensive understanding of interpretation requirements, assessments were conducted on the primary languages spoken by all members and those identified as needing interpreters. The data revealed that the predominant language needs among members requiring interpretation services are primarily Spanish. Despite the availability of Spanish-speaking interpreters are available, this indicates the lack of utilization stems elsewhere and highlights the necessity for greater emphasis on cultural responsiveness.

Primary Language for all Advanced Health Members, in order of prevalence.

Language	Prevalence	Total Members
English	High	29,068
Spanish	Low	476
Unknown	Variable	301
Russian	Very Low	~
Japanese	Very Low	~
Hindi	Very Low	~
Vietnamese	Very Low	~
Tagalog	Very Low	~
Lao	Very Low	~
Korean	Very Low	~
Italian	Very Low	~
Dutch; Flemish	Very Low	~
Burmese	Very Low	~
Armenian	Very Low	~
Afrikaans	Very Low	~

~ Statistically Insignificant - Data Removed to Protect Member Confidentiality

To gain insights into the cultural and linguistic requirements of our membership, an analysis focused on racial demographics was conducted. Among the approximately 29,000 total members, the breakdown is as follows: 66% White, 26% Unknown, 4% Hispanic, 2% American Indian/Alaskan Native, 1% Asian, 1% Black, and 1% Other. The Native Hawaiian/Pacific Islander demographic was excluded due to privacy considerations.

Comparing this data with regional demographics reveals disparities, with Hispanic, Asian, Black, and other minoritized groups significantly underrepresented within the health plan compared to their proportions in the general population. This disparity suggests potential barriers to access, discrimination, or systemic inequities within the healthcare system.

Further analysis indicates that these underrepresented populations constitute the majority among those flagged for interpreter needs, with the breakdown as follows: 56% Hispanic, 27% Unknown, 13% White, 4% Asian, and 1% Black.

These findings underscore the critical need for high-quality interpretive services, with Spanish emerging as the most requested language. Addressing these disparities requires targeted interventions aimed at improving access, enhancing cultural competency, and dismantling systemic barriers to ensure equitable healthcare delivery.

Primary Race of Total Membership	Percentage of Members
White	66
Unknown	26
Hispanic	4
American Indian/Alaskan Native	2
Asian	1
Black	1
Other	1
Native Hawaiian/Pacific Islander	~

To assess the cultural responsiveness of our services, we analyzed the ethnicity of all Advanced Health members. Among the approximately 29,000 members covered by our health plan, the breakdown is as follows: 71% are Not Hispanic, 11% have declined to specify, 7% are listed as Unknown, 5% are categorized as Did Not Answer, 4% identify as Hispanic, and 1% are classified as Other.

This review of the ethnicity highlights concern with the "Declined" category comprising 11% and the "Unknown" category comprising 7% of the membership and suggests challenges in collecting or reporting accurate demographic information. This discrepancy may mask the true diversity within the membership and hinder efforts to tailor services to meet the cultural and linguistic needs of all members. Addressing these inequities may require improved data collection methods, enhanced cultural competency training for healthcare providers, and targeted outreach efforts to underrepresented communities.

Ethnicity	Percentage of Total Members
Not Hispanic	71
Declined	11
Unknown	7
Did Not Answer	5
Hispanic	4
Other	1

The different modalities of language assistance have been assessed, including braille, oral interpretation spoken and sign language needs along with written communication needs (see Interpreter Type table below

for a comprehensive list). These language assistance services ensure care and services are understandable to those who have limited English proficiency, those who are deaf or hard of hearing, or may have difficulty comprehending the health care system and its terminology.

The data reported for members flagged for interpreter needs is as follows: 91% SPI, 3% ASL, 2% Null, 1% ALD, and 1% CAP. This indicates the majority require a Spoken Language Interpreter. Notably, the PSE demographic was excluded from reporting due to privacy considerations as their population size was deemed statistically too small to disclose safely.

The specification of interpretation modality is not mandated as part of the Quarterly Language Access reporting by OHA. Consequently, Advanced Health does not currently gather this data or reconcile it with the members documented need for interpreter service modality. Following the contracting of new language vendors, the feasibility of collecting data on interpreter modality will be reassessed.

Code	Interpreter Type
ALD	Assistive Listening Device
ASL	American Sign Language
CAP	CART/Captioning
DSI	Deaf Interpreter for Additional Barriers
MEX	Mexican Sign Language
Null	No information
OTH	Other
PSE	Contact Sign Language Interpreter
SEE	Signing Exact English
SLI	Sign Language Interpreter for Another Language
SPI	Spoken Language Interpreter
TAC	Tactile (for Deaf-Blind people)

To further explore disparities among members requiring language assistance services, we conducted a review of disability data. The analysis revealed among those accessing language assistance, 17% have a disability, with many experiencing disabilities related to language access. Specifically, among individuals with language-related disabilities, the breakdown is as follows: 16% are blind, 2% are both blind and deaf, 13% are deaf, and 13% have a communication impairment. These findings suggest these members may encounter challenges related to language access. Further data collection is necessary to better understand the potential barriers faced by these groups in accessing necessary language support services.

To further explore the low utilization of qualified health care interpreters, we conducted an analysis of overall utilization among members flagged as needing interpretation services. We reviewed medical, dental, and behavioral health visits over the past two years. The analysis revealed 56% of these members were Hispanic, 27% were categorized as Unknown, 13% were White, 4% were Asian, and 1% were Black.

Most members (88%) accessed services, while 12% never sought or accessed services except in the emergency room (ER). The breakdown of non-utilization or ER utilization by race was 73% Hispanic, 20% Unknown, and 2% White.

While the analysis suggests varying utilization rates across racial categories, indicating potential barriers or inequities in access to interpretation services, it is noteworthy that Hispanic individuals requiring interpreters exhibited a high utilization rate. This implies that the lack of interpreter utilization may not be solely attributed to overall health plan utilization, highlighting the need for targeted interventions to address specific barriers and enhance access to interpreter services for all members.

Provider Data: An analysis of provider data revealed that REALD data is still not fully integrated into the provider directory, although the infrastructure for collecting this data is established. Language data for providers is available, and among the 447 individual in-network providers, 30 providers (6.7%) speak a total of 19 languages other than English. Additionally, 17 providers (3.8%) can communicate with their patients using American Sign Language.

Provider Type	Number of Providers who Speak a Language Other Than English	Languages
Mental Health	19	Russian
		Spanish
Primary Care Provider	10	Hindi
		Korean
		Malalayam
		Nepali
		Portuguese
		Spanish
		Tamil
Specialist Provider	10	Czech
		French
		German
		Hidi
		Italian
		Punjabi
		Sinhalese
		Spanish
		Telugu
Vision Provider	1	Spanish
Grand Total	**30**	**19**

In 2023, Advanced Health did not receive any grievances related to timely access from Limited English Proficiency (LEP) members. To further ensure that members receive timely access and as part of ongoing process improvement efforts to uphold quality standards, specific questions addressing timely access data and appointment wait times were incorporated into the provider network survey. These supplementary questions were introduced in Q1 2024, and the outcomes will undergo scrutiny by the Inter-Agency Quality Committee. The objective is to ensure there are no disparities concerning timely access and to proactively address any potential issues that may arise.

SOGI Data: The sole Sexual Orientation and Gender Identity (SOGI) data accessible for Advanced Health's in-network providers pertains solely to gender. These gender ratios align with those of the member population and most likely do not directly impact interpreter utilization. However, the absence of comprehensive SOGI data beyond gender limits the ability to fully understand and address the specific needs of LGBTQIA2S+ members.

Gender	Male	Female
Contracted Provider	49%	51%
Member	49%	51%

Members who identify as LGBTQIA2S+ face unique linguistic and cultural challenges, which should be considered when providing effective language assistance services. Advanced Health recently added OHA's recommended SOGI question to its Health Risk Assessment (HRA) to allow members to self-identify. This change, along with the data files from OHA, will ensure that Advanced Health's language assistance services are tailored to address the specific linguistic and cultural needs of different subgroups within the community.

In addition to language assistance, Advanced Health contracts with the local tribe, ensuring a strong tribal presence for healthcare in Coos and Curry counties. This collaboration facilitates the provision of culturally responsive care to the community. The Coquille Tribe operates the KoKwel Wellness Center, which offers holistic healing for the Coquille Tribal family, other American Indians and Alaska Natives, tribal employees, and the general public. Services include a pharmacy offering mail-order and same-day medication pickups, primary care clinics in Coos Bay and Eugene, behavioral health support, dental care, and a secure MyChart Patient Portal for managing health information. Additionally, the Community Services team provides information on benefits and assistance programs to Coquille Tribal families through the MyTribe portal, ensuring comprehensive and inclusive care. This clinic serves over 400 of Advanced Health's members assigned for primary care.

To ensure adequate health equity infrastructure, we will enhance collaboration with local tribal governments to address historical and contemporary injustices. Advanced Health's Tribal Liaison meets with the Coquille Tribe on a quarterly basis to support the partnership between Advanced Health and the tribes. The frequency of these meetings will be increased to a monthly basis to ensure we are supporting their health priorities and addressing any barriers which they face in accessing quality healthcare. This increased collaboration will allow us to tailor our services and outreach to better meet the specific needs of the Coquille Tribe, ultimately contributing to a more equitable healthcare system for all.

In conclusion we are committed to continuing our work on improving the requirements of CLAS Standard Five to "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." Moreover, this language assistance endeavors to be culturally sensitive, respectful, and tailored to the beliefs, practices, culture, and linguistic requirements of the diverse member populations and communities that Advanced Health serves.

Describe whether last year's targets and benchmarks were met (if not, why): Despite considerable effort invested in each improvement area, two of last year's targets and benchmarks were not achieved. Specifically, for measure 1.1, the objective of awarding scholarships to five additional participants for the Health Care Interpreter Scholarship Program fell short. Only two more applicants came forward, and feedback indicated the reluctance of bilingual staff to participate stemmed from the lack of compensation for the time spent on the course and the absence of a guaranteed pay raise upon completion.

The benchmark for measure 2.1, which involved completing three listening sessions with various cultural organizations in the community, was successfully met. These sessions aimed to gain deeper insights into the challenges and needs these groups face in accessing healthcare, as well as exploring approaches to better serve members in alignment with their cultural health beliefs, practices, preferred language, and communication needs.

Listening sessions were held with local community groups, including the Queer community, members with mental and physical disabilities, and individuals with limited English proficiency. The outcome of these sessions highlighted several key issues:

Queer Community: Members felt that the provider network lacked sufficient education and understanding of their needs. This highlighted the need for increased cultural competence training for providers to better serve the Queer community.

Members with Disabilities: Individuals with mental and physical disabilities expressed that providers often lacked empathy and did not adequately accommodate their specific needs. This underscores the importance of training providers to be more empathetic and responsive to the unique requirements of disabled members.

Spanish-speaking Members: It was found that a significant portion of the Spanish-speaking population preferred to receive in-language visits from bilingual providers rather than relying on OHA Qualified or Certified interpreters. Members also noted a lack of Spanish-speaking providers and inconsistency in language access support across the network.

From these sessions, valuable lessons were learned, and specific actions can be taken to address the identified inequities:

- Cultural Competence Training: Implement targeted training programs to educate providers about the unique needs and challenges of the Queer community, ensuring they can offer more inclusive and understanding care.
- Empathy and Accommodation Training: Develop comprehensive training programs focused on enhancing empathy and accommodation for members with mental and physical disabilities, ensuring that their particular needs are met with sensitivity and respect.

- Increase Bilingual Providers: Prioritize the recruitment and retention of bilingual providers to ensure that Spanish-speaking members receive consistent and culturally appropriate care in their preferred language.

By addressing these inequities through targeted interventions, Advanced Health aims to create a more inclusive and equitable healthcare environment that respects and meets the diverse needs of all its members.

Additionally, Advanced Health operates in a rural area with constrained resources and workforce availability, further complicating efforts to meet this target. Furthermore, in measure 3.1, which aimed for a 2% increase in the number of members requiring interpreter services receiving such services from the previous year's rate of 19.1%, the utilization rate reported was 19.3%, according to OHA's report "2023.11.30 Contract report OHA feedback_AH_2023Q2_HEM". Although there was a slight increase of 0.2%, the benchmark was not met due to limitations in available resources for providing interpreter services, which was further exacerbated by the rural nature of both Coos and Curry counties. Essentially, all available interpreters were already engaged in providing services in 2022, leaving no room for further increase in utilization.

Activity 4 is a new endeavor which aims to collaborate with at least 12 healthcare providers and 6 community organizations to inform at least 150 members from culturally specific populations about free language assistance services. These services will be equitable, understandable, and respectful, available in multiple languages, and include accommodation for people with disabilities. This initiative aims to increase language access and health equity, improve health literacy, and enhance healthcare accessibility, emphasizing equity and inclusion throughout the process. Progress will be measured by tracking the number of collaborations, outreach events, and members informed. By increasing language access, we ensure that all members, regardless of their language or abilities, can fully understand and utilize healthcare services, thereby promoting greater health equity.

Activity 5 is another new initiative aimed to execute contracts with a minimum of two language vendors that offer in-person, phone, and IVR interpretation services. These contracts will clearly define compliance requirements for OHA’s Language Access reporting. By establishing these contracts, we will increase access to language services, ensuring that members receive the interpretation support they need to effectively communicate with healthcare providers. This initiative will enhance language access, thereby improving overall healthcare accessibility and equity for non-English speaking and limited-English proficiency members.

In response to the updates made to the Health Equity Measure, Activity 6 aims to improve the timely provision of interpreter services and increase the number of healthcare visits with in-language providers. To achieve this goal, Advanced Health will launch a provider education campaign to promote proficiency testing for bilingual healthcare providers. This educational initiative will emphasize the patient benefits of receiving interpretation from healthcare providers who have successfully passed a proficiency test.

Activity 7 involves implementing a Value-Based Payment (VBP) model to reward providers for using certified/qualified interpreters or for passing a language proficiency test if the provider is bilingual. We will ensure that training and resources are accessible to providers and their staff, with additional support for those serving diverse or underserved populations. Progress will be tracked and evaluated against benchmarks for VBP implementation and payments, aiming to increase utilization inclusively and equitably. These payments will also incentivize providers to hire certified or qualified interpreters or have their staff complete certification, thereby increasing the number of certified or qualified interpreters in the community.

As outlined in the Health Equity Plan, Activity 8 aims to increase Advanced Health staff attendance at the South Coast Diversity Conference to at least 22%. To achieve this, we will provide the necessary resources and support to ensure inclusivity and equitable access for all staff members.

Another goal from the Health Equity Plans is Activity 9, which involves conducting a survey of individuals who have self-identified on the HRA with sexual orientation diversity. This survey will be conducted using accessible and inclusive methods to gather their experiences with Advanced Health. The findings will then be used to enhance service inclusivity and quality.

The final goal from the Health Equity Plan is Activity 10, which seeks to obtain accurate SOGI data from at least 50% of providers in the Advanced Health Provider Network. This will be accomplished using a standardized and inclusive process to identify barriers and implement innovative programs that enhance healthcare services for individuals with diverse sexual orientations and gender identities.

Lessons learned over the last year: Advanced Health has made significant strides in enhancing language interpreter services and cultural competency. Despite challenges, a thorough analysis of member data—encompassing language, race, ethnicity, and disability—has identified disparities and guided targeted interventions to improve access and cultural responsiveness in 2024. Developing a robust health equity infrastructure, including annual assessments and employee engagement surveys, has proven crucial. Key lessons learned highlight the importance of organizational accountability, resource allocation, and fostering a culture of inclusion and diversity at every level.

Expanding the interpreter program with Language Line Solutions, providing 24/7 access to interpretation services to our members, while beneficial, has not substantially increased the number of certified interpreters. Recognizing the need for more OHA Qualified and Certified interpreters, Advanced Health is exploring additional vendor options. A contract for a new language vendor is currently in process and it is anticipated the CCO will transition to the new vendor by the end of 2024.

Efforts to increase the number of certified interpreters through a scholarship program have seen some success but fell short of our targets due to challenges such as lack of compensation and limited workforce availability. Advanced Health intends to keep this program but will focus more on enhancing member and provider awareness of the available Spanish-speaking customer service representatives (CSRs) and promote their services in Coos and Curry counties.

Contracting with Krames for educational resources in multiple languages and formats has been successful in dismantling language barriers. Continued promotion of the platform and exploration of new utilization avenues are planned. The user base has expanded to our contracted Primary Care Case Management Teams who are in the process of becoming trained users. This will expand utilization to four of our largest clinics, who provide care to approximately 20,000 Advanced Health members.

Provider language capabilities remain limited and ensuring timely access for Limited English Proficiency (LEP) members continues to be a priority for improvement. With the addition of new criteria to the quarterly Language Access and Interpreter Services Report, recognizing in-language providers who have passed a proficiency test equivalent to OHA Certified or Qualified interpreters, efforts to encourage providers to undergo proficiency testing will be intensified.

Data analysis and environmental scans revealed that although most providers could identify Limited English Proficiency (LEP) members, and less than 7% provided Qualified or Certified interpreters for LEP patients.

This highlighted significant barriers due to limited resources and a shortage of Certified and Qualified interpreters in the rural areas of Coos and Curry County.

To better understand the utilization of interpretation services, comprehensive analyses were conducted, including reviews of census data, local interpreter availability, and member and provider REALD data. The results identified discrepancies between the number of LEP members and those utilizing interpretation services, indicating potential underutilization and gaps in service provision.

Additionally, some of the key lessons learned from the initiatives outlined on the Health Equity Plan include the prioritizing of enhancing language access services and cultural competency training. Advanced Health is working on implementing CLAS standards, ensuring all members receive culturally and linguistically appropriate care. Lessons include the importance of ongoing training and collaboration across departments to integrate these standards effectively.

The Health Equity Plan also facilitates vital community engagement, which in turn strengthens community collaboration through initiatives like the South Coast Diversity Conference and Community Advisory Council meetings. Lessons emphasize the need for continuous outreach and alternative methods for community involvement to address health equity gaps effectively.

The Initiatives to support people with disabilities and LGBTQIA2S+ individuals have underscored the importance of tailored services and ongoing training. Challenges include provider education and accessibility barriers, highlighting the need for targeted support and advocacy.

In conclusion, Advanced Health has made significant strides towards health equity by prioritizing cultural responsiveness, data-driven decision-making, community engagement, and inclusive service delivery. While progress was notable in 2023, ongoing improvements in interpreter services, data collection, and provider engagement remain critical. Advanced Health remains committed to refining its strategies to align with its goal of promoting health equity and enhancing health outcomes for all members. These lessons learned will continue to shape their ongoing efforts.

D. Brief narrative description

1. **Project population:** Health plan members or potential members who need interpreters, including but not limited to the disabled who are Deaf or Hard-of-hearing, have Speech or Language Disorders, or are Blind. Those who are Limited English proficiency (LEP) which is a term used to describe individuals who, by reason of place of birth or culture: Communicate in a language other than English, Do not speak English as their primary language, Have a limited ability to read, speak, write, or understand English, or Prefer to communicate in a language other than English.
2. **Intervention (address each component attached):** By 2030, Advanced Health aims to demonstrate organizational commitment to CLAS standards, especially standard five, and eliminate disparities for non-English speakers and those with Limited English Proficiency. To achieve this, Advanced Health will implement the following steps to further health equity and cultural responsiveness:

    - Tracking and Analysis for Targeted Solutions: Advanced Health will monitor interpreter utilization through quarterly Language Access reports, analyzing data by Race, Ethnicity, Age, Language, Sexual Orientation, and Gender Identity (REALD and SOGI). This approach will identify specific populations facing language barriers and inform tailored interventions, enhancing health equity.

- Targeted Interventions for Equitable Access: Disparities in interpreter utilization will prompt targeted interventions, such as offering translated materials in needed languages, increasing interpreter availability, and implementing tele-interpretation services. Resources will be focused on underserved communities to ensure equitable access, fostering cultural responsiveness.

- Continuous Improvement: Findings from the analysis will guide efforts to enhance health service delivery, setting specific targets for addressing disparities by December 2024 and 2025. Continuous monitoring and improvement will ensure that Advanced Health remains responsive to the cultural and linguistic needs of its members.

Activity Summaries:

- Activity 4: By December 31, 2025, inform at least 150 culturally specific members about free language assistance services, collaborating with 12 healthcare providers and 6 community organizations. This effort will ensure services are equitable, understandable, respectful, and available in multiple languages, including accommodations for disabilities. Progress will be tracked by the number of collaborations, outreach events, and members informed.

- Activity 5: Starting in Q1 2024, execute contracts with at least two language vendors offering in-person, phone, and IVR interpretation services, with compliance requirements defined by OHA's Language Access reporting. This initiative aims to enhance access to language services, furthering health equity, with a target to finalize contracts by April 2025.

- Activity 6: Launch a provider education campaign in Q1 2024 to increase healthcare visits with in-language providers, promoting proficiency testing for bilingual providers. The campaign will emphasize the benefits of accurate interpretation, aiming for a 2% increase in in-language provider visits by December 2025, supporting cultural responsiveness.

- Activity 7: By January 1, 2025, implement a Value-Based Payment (VBP) model to incentivize providers achieving a utilization rate above 10% for certified/qualified interpreters or proficiency-tested providers. The current rate is 5.5%. Training and resources will be provided to all providers, especially those serving diverse populations. Progress will be tracked by VBP implementation and utilization rate increases, with the goal of a 2% increase by December 2025, promoting health equity.

- Activity 8: Increase staff attendance at the South Coast Diversity Conference to at least 22% by December 2025, ensuring inclusivity and equitable access for all staff members. This goal includes providing necessary resources and support to further cultural responsiveness.

- Activity 9: By December 2026, Advanced Health will review and consolidate SOGI (Sexual Orientation and Gender Identity) data for its providers to ensure accuracy and consistency. This standardized process will enhance the quality of healthcare services for individuals with diverse sexual orientations and gender identities, promoting inclusivity, equity and cultural responsiveness in healthcare

Through these comprehensive measures, Advanced Health aims to demonstrate its commitment to CLAS standards, actively eliminate language access disparities, and further health equity and cultural responsiveness for non-English speakers and individuals with Limited English Proficiency. Proficiency.

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

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

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

Activity 3 description (retired): Increase utilization of Health Care Interpreter Services via the Language Access Quarterly Reporting-

Activity 4 description: By December 31, 2025, collaborate with at least 12 healthcare providers and 6 community organizations to inform at least 150 members from culturally specific populations about free language assistance services. Ensure these services are equitable, understandable, respectful, and available in languages other than English, including accommodations for people with disabilities. This initiative aims to improve health literacy and healthcare accessibility, emphasizing equity and inclusion throughout the process. Progress will be measured by tracking the number of collaborations, outreach events, and members informed.

☐ Short term or ☑ Long term

Monitoring measure 4.1	Monitor and analyze the number of members informed and the methods used to ensure the outreach is culturally appropriate for the member			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
All members are currently informed about language assistance services primarily through the member handbook. However, it is unclear whether this method effectively addresses the cultural specifics of Advanced Health's diverse membership.	Inform at least 75 members from culturally specific populations about free language assistance services. Using methods that are equitable, understandable, respectful, including accommodations for people with disabilities.	12/2024	Inform at least 75 members from culturally specific populations about free language assistance services. Using methods that are equitable, understandable, respectful, including accommodations for people with disabilities.	12/2025

Monitoring measure 4.2	Progress will be measured by tracking the number of collaborations, outreach events.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently collaborating with 2 healthcare providers and 1 community organization.	Collaborate with at least 6 healthcare providers and 3 community organizations.	12/2024	Collaborate with at least 6 healthcare providers and 3 community organizations.	12/2025

Activity 5 description: Beginning in Q1 2024, steps will be taken to execute contracts with a minimum of two language vendors that offer in-person, phone, and IVR interpretation services. These contracts will be drafted to clearly define the requirements for compliance with OHA's Language Access reporting. These new contracts will help increase access to language services.

☑ Short term or ☐ Long term

Monitoring measure 5.1	Number of members reported by REALD & GI who received interpreter services.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
One language vendor contract. However, this vendor does not have OHA Certified or Qualified interpreters available.	Execute contracts with one additional language vendor that offers in-person, phone, and IVR interpretation services. These contracts will be drafted to clearly define the requirements for compliance with OHA's Language Access reporting. These new contracts will help increase access to language services.	12/2024	Execute contracts with a minimum of two language vendors that offer in-person, phone, and IVR interpretation services. These contracts will be drafted to clearly define the requirements for compliance with OHA's Language Access reporting. These new contracts will help increase access to language services.	4/2025

Activity 6 description: To improve the timely provision of interpreter services, Advanced Health will increase the number of healthcare visits with an in-language provider. To achieve this goal, a provider education campaign will be launched to promote proficiency testing for bilingual healthcare providers. This educational initiative will highlight the patient benefits of receiving interpretation from healthcare providers who have successfully passed a proficiency test.

☑ Short term or ☐ Long term

Monitoring measure 6.1	Number of bilingual providers who have passed a language proficiency test.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline Assessment of Healthcare Visits with In-Language Providers: Conduct an initial assessment to determine the current percentage of healthcare visits facilitated by in-language providers within Advanced Health's network.	Create the provider training materials to promote language proficiency testing.	12/2024	Increase the Percentage of Healthcare Visits with In-Language Providers by 2% within 12 months of launching the provider education campaign.	12/2025

Activity 7 description: By January 1, 2025, implement a Value-Based Payment (VBP) model to pay providers who achieve a utilization rate above 10% in 2025 for using certified/qualified interpreters or proficiency-tested providers. Currently, the utilization rate is 5.5% per OHA's calculation for the 2023 CCO Quality Metric. Ensure training and resources are accessible to all providers, with extra support for those serving diverse or underserved populations. Progress will be tracked and evaluated with the following benchmarks for the implementation of the VBP and the associated payments, aiming for an increase in utilization to ensure the goal is met inclusively and equitably.

☑ Short term or ☐ Long term

Monitoring measure 7.1	Progress will be evaluated by the implementation of the VBP and the associated payments.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No VBP for the utilization for using certified/qualified interpreters or proficiency-tested providers.	Implement a VBP for the utilization for using certified/qualified interpreters or proficiency-tested providers.	12/2024	Issue an incentive payment to the providers or vendors who achieved a utilization rate of 10% or more.	12/2025
Monitoring measure 7.2	Progress will be evaluated by tracking the utilization rate.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
As of April 2024, the utilization rate for certified/qualified interpreters or proficiency-tested providers among current providers is 5.5%.	An increase in certified/qualified interpreters or proficiency-tested providers of 2%.	6/2025	An increase in certified/qualified interpreters or proficiency-tested providers of 2%.	12/2025

Activity 8 description: By December 2025, increase staff attendance at the South Coast Diversity conference to at least 22%, providing necessary resources and support to ensure inclusivity and equitable access for all staff members.

☐ Short term or ☒ Long term

Monitoring measure 8.1	Track and report the percentage of staff who register for and attend the South Coast Diversity conference.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current State: In 2023, 22% of staff attended the South Coast Diversity conference, and attendance decreased to 16% in 2024.	To increase staff attendance, implement targeted communication, incentives, and support measures to encourage participation.	1/2025	Achieve a staff attendance rate of at least 22% by December 2025, ensuring that necessary resources and support are provided to promote inclusivity and equitable access for all staff members.	12/2025

Activity 10 description: By December 2026, Advanced Health will review and consolidate SOGI (Sexual Orientation and Gender Identity) data for its providers to ensure accuracy and consistency. This standardized process will enhance the quality of healthcare services for individuals with diverse sexual orientations and gender identities, promoting inclusivity and equity in healthcare.

☐ Short term or ☒ Long term

Monitoring measure 10.1	Data Accuracy and Consistency Audits: Conduct quarterly audits to ensure the accuracy and consistency of the consolidated SOGI data. Report findings and take corrective actions if necessary.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current State: Currently, SOGI data collection from providers in the Advanced Health Provider Network is inconsistent and incomplete, with approximately 0.1% of providers collecting this data accurately.	Achieve at least 50% completion in the review and consolidation of SOGI data. Make any necessary adjustments to the process based on feedback and findings.	6/2025	All SOGI data for providers will be reviewed, consolidated, and standardized, achieving 100% data accuracy and consistency.	12/2026

Section 2: Supporting information (optional)

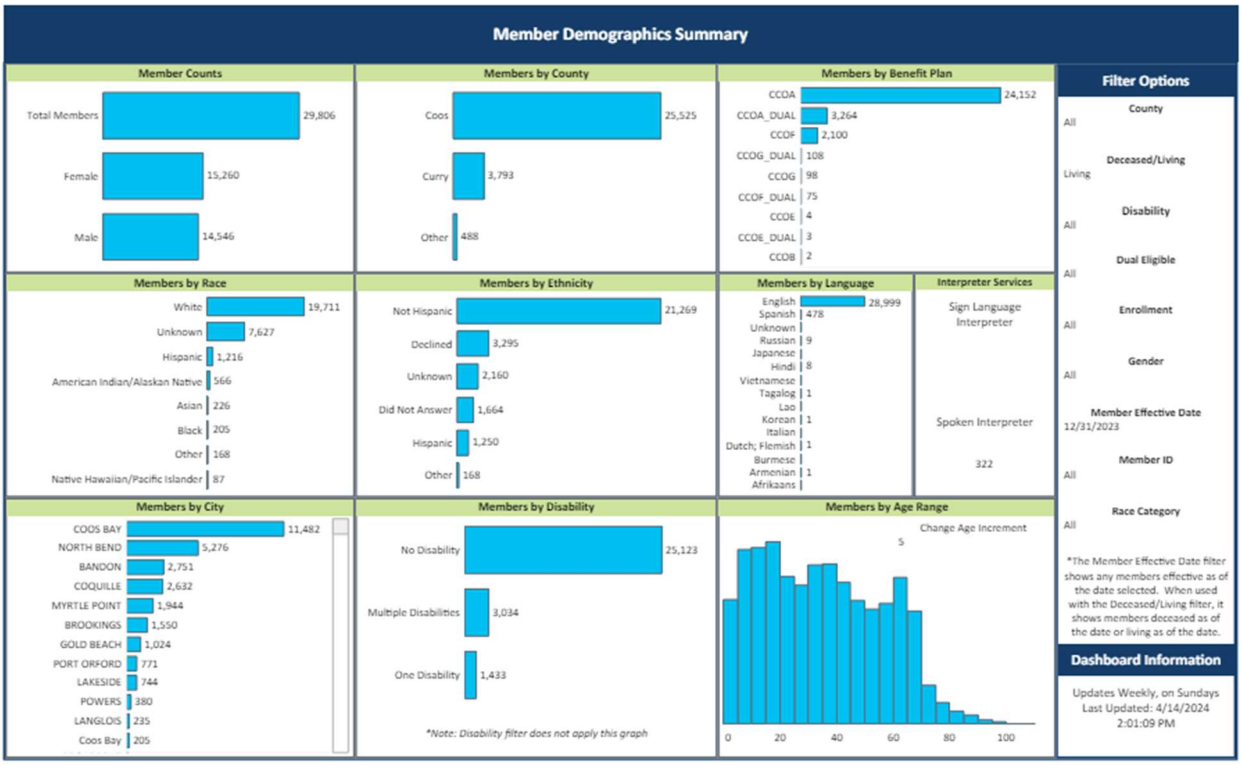
See Appendix A: Advanced Health 2023 Health Equity Plan Report

REALD and SOGI Data Use Plan

Advanced Health utilizes REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) data to achieve the Oregon Health Authority's definition of health equity by ensuring that "all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances." This commitment aligns with the mission statement of our Quality Improvement program, which strives "To advance and ensure quality healthcare is available for our communities, in a transformative manner that respects each individual's needs." Through collaboration with community stakeholders, including the Community Advisory Health Councils in each county, our goal is to enrich the lives of our members by recognizing and addressing their diverse backgrounds and individual needs.

At Advanced Health, several processes are in place to monitor and interpret members' cultural and linguistic requirements, utilizing available REALD data. For example, routine reporting includes Quarterly Demographic REALD reports to the Inter-Agency Quality Committee, alongside quarterly updates on interpreter service utilization. Additionally, staff have access to Health Equity reporting and an annual population health assessment, providing comprehensive insights into member demographics and health equity opportunities.

We extensively utilize demographic data encompassing race, ethnicity, language, and disability (REALD) provided by the Oregon Health Authority (OHA). This data is delivered in 834 enrollment files, which are ingested and stored in our records database. Furthermore, REALD data and demographic elements are collected directly from members through the Health Risk Assessment (HRA) survey and stored in a Tableau dashboard. This reporting includes members' self-reported races and ethnicities, preferred spoken and reading languages, disabilities, and SOGI information. In addition to these efforts, we have integrated member demographics into various reports and dashboards, enabling users to filter and analyze data effectively, facilitating the identification of potential disparities within specific populations. Please see the Member Demographics Summary report below as an example.



However, our current database of records cannot integrate with Tableau, or any other member demographic data not sourced from the 834 enrollment files. To enhance the collection and understanding of SOGI data, Advanced Health plans to utilize SOGI data provided in a flat file by OHA. This will necessitate the development of a new database capable of assimilating the SOGI flat file, the HRA data from Tableau, and the 834 enrollment files. Plans to create this database will be included in Advanced Health's 2025 QAPI Workplan, serving as a roadmap for a multi-year organizational effort toward improved data processes to create a master source for demographic data for integration throughout organizational reporting tools. Once complete, these different data sources will be used for both disaggregated and aggregated analysis to identify any marginalized populations requiring focused improvement efforts. The ultimate objective is to develop a member-level dashboard capable of displaying REALD and SOGI data alongside utilization and health outcome data. This identification of disparities will lead to programmatic recommendations for improvement efforts focused on marginalized populations.

Appendix A

Supporting information for: Increasing Pediatric Dental Access in Coos and Curry Counties

Root Cause Analysis:

1. Lack of Certified Clinicians in First Tooth or Smiles for Life Program

Root Causes:

Lack of Awareness:

Many healthcare providers in Coos and Curry counties are unaware of the First Tooth or Smiles for Life programs and the benefits of being certified.

Training Availability:

Limited availability of in-person First Tooth certification training sessions in the rural areas of Coos and Curry counties.

Resource Constraints:

Healthcare facilities may lack the resources or funding to send staff for training.

Potential Solutions:

Increase awareness of the Smiles for Life training through targeted marketing and outreach campaigns.

Schedule regular First Tooth certification training sessions locally or.

Provide financial incentives or support for training healthcare providers.

2. Limited Integration of Oral Health Services into Primary Care

Root Causes:

Coordination Issues:

Lack of streamlined processes for integrating dental services into routine pediatric visits.

Information Sharing:

Inadequate sharing of dental visit information between dental providers and primary care providers.

Workflow Challenges:

Primary care providers may not be adequately trained or have the necessary workflows in place to incorporate oral health services.

Potential Solutions:

Develop and implement standardized protocols for oral health screenings and fluoride varnish applications during pediatric visits.

Enhance communication channels and data sharing systems between dental and primary care providers.

Provide cross-training for primary care providers on the importance of oral health and the integration of dental services into routine care.

3. Barriers to Accessing Dental Care

Root Causes:

Geographical Barriers:

The rural nature of Coos and Curry counties leads to challenges in accessing dental care facilities.

Socioeconomic Factors:

Low-income families may face financial barriers to accessing dental care, even if services are technically available.

Transportation Issues:

Lack of reliable transportation can prevent families from attending dental appointments.

Potential Solutions:

- Increase the number of dental care access points, including mobile dental units and community health centers.
- Provide transportation assistance or mobile dental services to reach remote areas.
- Implement community outreach programs to educate families on the importance of preventive dental care and available resources.

4. Cultural and Language Barriers

Root Causes:

Cultural Differences:

Diverse populations may have different beliefs and practices regarding oral health, leading to variations in care-seeking behavior.

Language Barriers:

Non-English-speaking families may have difficulty navigating the healthcare system and understanding the importance of dental care.

Potential Solutions:

- Recruit and train bilingual clinicians to improve communication and cultural competence.
- Develop culturally appropriate educational materials and outreach programs.
- Partner with community organizations to build trust and awareness within diverse populations.

Summary:

Addressing these root causes requires a multifaceted approach, including increasing clinician training, enhancing care coordination, expanding access points, and overcoming cultural and language barriers. By implementing these solutions, Advanced Health aims to improve pediatric dental access, enhance school readiness, and achieve better oral health outcomes for children in Coos and Curry Counties.

Supporting information for: Medical Shelter Program

Care Coordination and Health Outcome Data

Coalbank Tracking Sheet 2021 – 20222

Coalbank Tracking Sheet 2023

ADVANCED HEALTH/DEVEREUX CENTER MEDICAL SHELTERS

Medical Shelter #1

Shelter entry date	Exit date	Total days	Member name	OHP #	Referring Source	Medical needs	Outcome	ICC - Y/N	Housing attained	Transitional housing	Check-in's weekly	Motel Diversion	# ED Visits 3 months prior	# ED 3 months post shelter	# Inpatient days 3 months prior	#Inpatient days 3 months post	#ED 6 months prior	#ED 6 months post	#inpatient days 6 mo prior	# inpatient days 6 mo post
10/14/2021	10/21/2021	7	[redacted]		ICC/BAH RN CM	Medication mgmt/liver disease	Stabilized/transitioned to Sheridan Place	Yes	Yes	yes	Yes	Yes	10	3	0	14	10	6	9	12
10/22/2021	11/9/2021	18	[redacted]		ICC/RN CM	MVA- multiple fractures/tissue/muscle injury	Transitioned to a standard Pallet Shelter	Yes		yes	Yes	Yes	n/a	deceased	n/a	deceased	deceased	deceased	deceased	deceased
11/12/2021	11/30/2021	18	[redacted]		BAH RN CM/ICC	COPD, hepatic encephalopathy	Discharged to THE/Shelter with BAFS	Yes		yes	Yes	Yes	3	0	6	0	6	0	6	0
12/2/2021	1/4/2022	34	[redacted]		TOC/Bandon Hospital	Cardiac respite	Connected with BAFS/THE House	Yes		yes	Yes	Yes	2	1	22	Moved out of area	Moved out of area	Moved out of area	Moved out of area	Moved out of area
1/6/2022	2/3/2022	29	[redacted]		BAH RN CM/ICC	New dx lung mass, MI, Adrenal abcess, Hep c	Deceased (Death w/ dignity, not homeless)	Yes			yes	Yes	n/a	deceased	n/a	deceased	deceased	deceased	deceased	deceased
2/16/2022	3/3/2022	15	[redacted]		PCP RN CM/ICC	Post covid recovery/COPD	2 weeks recovery time, as planned	Yes			Yes	No	1	0	0	0	1	0	0	0
3/16/2022	4/24/2022	39	[redacted]		DOJ/ICC	Wound care/ostomy/catheter/placement	Transitioned to a standard Pallet Shelter	Yes		yes	Yes	Yes	1	3	90	0	1	5	90	0
5/11/2022	7/23/2022	72	[redacted]		BAH RN CM/ICC	CVA x3, with increasing cognitive annd mobility limitations	Transitioned to a standard Pallet Shelter	Yes	Yes	yes	Yes	No	1	1	6	0	2	5	6	11
7/25/2022	9/9/2022	45	[redacted]		PCP/ICC	Recent MI, mobility/Fall, diabetes, TBI	Mission offered. Turned down >3 housing options	Yes	Yes	Yes	Yes	Yes	12	3	3	6	16	8	20	6
9/14/2022	9/19/2022	5	[redacted]		CHW	Peritoneal cancer (advanced), schizophrenia	Re-hospitalized for Hospice/deceased	No			n/a	No	deceased	deceased	deceased	deceased	deceased	deceased	deceased	deceased
10/3/2022	12/2/2022	60	[redacted]		BAH RN CM/ICC	Recent MI, Epilepsy, ETOH abuse, COPD, acidosis	Referred to the Mission - acute medical needs resolved	Yes		Yes	Yes	Yes	3	3	9	9	3	3	9	9
12/14/2022	12/21/2022	7	[redacted]		ICC	Epilepsy, TBI, waiting on APD placement	Did not occupy the shelter	Yes	NO	No	No	Yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Medical Shelter #2

12/14/2021	1/5/2022	22	[redacted]		BAH APU/ICC	Broken ankles (x2), wound care, wheelchair	CCRC - BH needs increasing	Yes			Yes	Yes	10	1	12	(Inpatient APU)	Moved out of area	Moved out of area	Moved out of area	Moved out of area
1/12/2022	2/5/2022	26	[redacted]		BAH RN CM/NDC	Oxygen, BiPap machine, Insulin	Connected with BAFS, transferred to THE	Yes	yes	yes	Yes	Yes	1	0	8	0	4	3	16	0
2/15/2022	3/25/2022	37	[redacted]		BAH RN CM/ED	Wound care, COPD/O2/wheelchair/placement	Motel/declined placement options	Yes		Yes	Yes	Yes	3	3	33	17	5	4	33	17
4/5/2022	4/17/2022	12	[redacted]		AH ICC	Liver failure	No longer has acute medical needs- tent.	Yes			Yes	Yes	5	1	8	0	6	4	10	23
4/21/2022	7/2/2022	72	[redacted]		ICC	CHF/COPD/Cellulitis/peripheral edema	Transitioned to standard shelter	Yes		yes	Yes	Yes	12	3	14	0 Deceased	Deceased	Deceased	Deceased	Deceased
7/4/2022	7/26/2022	22	[redacted]		BAH RN CM/PCP	CHF/COPD/Osteoarthritis/walker	Transferred to AFH in Myrtle Point	Yes	yes		Yes	Yes	7	2	14	0	11	3	14	3
7/27/2022	8/25/2022	30	[redacted]		Hospital- other/ICC	Hepatic failure/Hip fracture s/p surgery/ETOH	Mission offered. Continued heavy alcohol use	Yes			Yes	Yes	7	4	32	19 Not of AH	Not on AH	Not on AH	Not on AH	Not on AH
8/26/2022	9/30/2022	35	[redacted]		BAH RN CM/Devereux	Orthopedic/wheelchair/ sepsis/hepatic concerns	Moved to a motel paid for by ORCCA	Yes		Yes	Yes	No	Moved OOA	Moved OOA	Moved OOA	Moved OOA	Moved OOA	Moved OOA	Moved out of area	Moved out of area
10/14/2022	10/27/2022	13	[redacted]		BAH RN CM	Colon cancer, needing to remain C&S for surgery	Readmitted to BAH for surgery/RV site secured	Yes	Yes		Yes	Yes	2	1	3	9	6	1	8	9
10/28/2022	11/25/2022	28	[redacted]		BAH RN CM	Pulmonary HTN, CHF, Rheumatoid arthritis	No further medical needs/no progress on any goals	Yes			Yes	Yes	9	5	10	2 unk.	unk.	unk.	unk.	unk.
11/30/2022	1/3/2023	35	[redacted]		AH ICC	Diabetes type 1, recent DKA, nonadherent due to homelessness	Was abusing Substances; left to stay with friends	Yes		No	Yes	No	(see 2023 spreadsheet)							

ADVANCED HEALTH/DEVEREUX CENTER MEDICAL SHELTERS

Medical Shelter #1

Shelter entry date	Exit date	Total days	Member name	OHP #	Prioritization Score	Referring Source	Medical needs	Outcome	ICC - Y/N	HRA Completed	Housing attained	Transitional housin	Housing attained post exit (in 6 mo)	Motel Diversion	DME Obtained	PCP appts 6 mo prior	PCP appts 6 mo post	#ED visits 3 mo. Prior	#ED Visits 3 mo. Post	#Inpt days 3 mo prior	#Inpt days 3 mo. Post	#ED visits 6 mo prior	#ED visits 6 mo post	#Inpt days 6 mo prior	#Inpt days 6 mo post
																									0
1/2/2023	2/13/2023	43	[redacted]		68	Lower Umpqua Hosp.	Bilateral heel fractures, post-surgery; wheelchair	Transitioned to a Standard Shelter	Yes		No	Yes		Yes	Yes (crutches/walker)	No	Yes		1	2	29	7	1	3	29	7
1/30/2023	3/17/2023	46	[redacted]		72	BAH RN CM	Cardiac- EF 10%, needs heart transplant, cardiomyopathy, combined CHF, SUD	Moved into a house with caregiver	Yes		Yes	No		Yes	Yes (walker/shower chair)	No	Yes	Deceased	Deceased	deceased	deceased	deceased	deceased	deceased	deceased
3/23/2023	4/25/2023	33	[redacted]		50	BAH RN CM	MI, cardiac/low ejection fraction; ETOH dep.; Aortic thrombus- Lovenox BID	Declined the Mission; provided a tent bag	Yes		No	No		Yes	None needed	No	Yes		1	0	10	0	1	deceased	deceased	deceased
4/20/2023	6/15/2023	56	[redacted]		62	BAH RN CM	Post CVA x2- loss of most of vision, bilateral weakness; cardiac-monitor needs elec	Member using substances; offered Mission or THE- declined	Yes		No	No		Yes	None needed	No	Yes		5	1	7	0	5	1	7	0
6/20/2023	8/11/2023	51	[redacted]		63	ICC	Orthopedic/wound care- s/p MVA vs pedestrian/limited mobility	Transitioned to a Standard Shelter	Yes		No	Yes		Yes	Wound care supplies	Yes	Yes		16	1	13	0	16	1	13	0
8/11/2023	8/30/2023	19	[redacted]		55	PCP/ICC	Colorectal cancer, meatsized to liver. Surgery date pending	Assualted staff- Exited	Yes		No	No		No	None needed	Yes	Yes	Deceased	Deceased	deceased	deceased	deceased	deceased	deceased	deceased
8/11/2023	8/30/2023	19	[redacted]	n/a		PCP/ICC	(Shared shelter/partner/caregiver)	Left with partner	Yes		No	No		No	None needed	Yes	Yes		4	0	1	0	11	4	1	0
9/1/2023	10/18/2023	48	[redacted]		36	ICC	Austism	Exited with mother	Yes		No	No	Yes	No	None needed	Yes	Yes		1	0	0	0	1	0	0	0
9/1/2023	10/18/2023	48	[redacted]	n/a		ICC	Mother of Kinsley Clair	Exited due to substance abuse	Yes		No	No	Yes	No	None needed	No	Yes		0	0	0	0	0	0	0	0
10/19/2023	10/26/2023	7	[redacted]		68	P&P	MVA- Cervical spine fracture at C-1; Halo	Left with partner (who was exited for fighting)	Yes		No	No		Yes	Yes - Wedges	No	Yes		4	0	9	0	7	0	11	0
11/30/2022	1/3/2023	35	[redacted]		60	AH ICC	Diabetes type 1, recent DKA, nonadherent due to homelessness	Was abusing substances, left to stay with friends	Yes		Yes	No		No	Yes -Diabetic supplies				3	0	1	0	3	1	1	0
1/5/2023	1/23/2023	18	[redacted]		72	BAH RN CM	Liver failure, mural thrombus (cardiac), CHF, CKD, Diabetes	Admitted to BAH for CVA, passed away @ AFH	Yes		Yes	n/a		No	Yes- Commode, walker	No	Yes	Deceased	Deceased	Deceased	Deceased	Deceased	Deceased	Deceased	Deceased
1/24/2023	2/21/2023	29	[redacted]		42	BAH RN CM	Bilateral pneumonia; needs short term respite for recovery	Recovered from pneumonia- offered Mission	Yes		No	No		No	None needed	No	Yes		1	0	4	0	2	2	4	0
3/2/2023	3/21/2023	19	[redacted]		39	ICC/Homeless Coal.	Recovery- surgical repair of hernia	Transitioned to standard shelter	Yes		No	Yes		Yes	None needed	Yes	Yes		1	0	3	0	1	0	3	0
3/22/2023	5/19/2023	58	[redacted]		70	Riverbend/ICC	Orthopedic (multiple injuries), subdural hematoma, pulmonary-chest tube	Transitioned to THE house/BAFS	Yes		No	Yes	Yes	Yes	Yes - cane	No	Yes		3	2	50	0	5	6	52	28
5/22/2023	6/24/2023	32	[redacted]		62	BAH RN CM	Bradycardia, pacemaker needs, respiratory failure, poorly controlled DM	Member declined to participate; ongoing meth use	Yes		No	No		No	Yes - Diabetic supplies	Yes	Yes		3	0	6	0	3	2	6	6
6/30/2023	7/6/2023	7	[redacted]		45	DV services	Depression, ETOH dependence (Shared shelter)	Moved into temporary housing	Yes		No	Yes		No	None needed	No	No		0	0	0	0	0	0	0	0
6/30/2023	7/6/2023	7	[redacted]		45	DV Services	Mix2, CVA x2, mild dementia (Shared shelter)	Moved into temporary housing	Yes		No	Yes		No	None	Yes	Yes		1	0	0	0	2	0	6	0
7/7/2023	7/21/2023	14	[redacted]		70	BAH RN CM	S/P CVA/right-sided weakness, speech impaired, eye droop; SVT; CHF; SUD	Exited due to yelling at partner, active substance use in sh	Yes		No	No	Yes	No	Yes -walker, incontinence s	No	Yes		3	2	15	4	3	5	15	10
8/2/2023	10/6/2023	65	[redacted]		60	ICC/APO	Liver failure, kidbey failure, mobility limitations, PVD, CHF, LE wounds, SUD	Moved into Sheridan/BAFS	Yes		Yes	No		No	Yes - walker, wound care su	Yes	Yes		1	1	3	6	1	1	3	6
10/9/2023	11/7/2023	29	[redacted]		68	BAH RN CM	PVD, COPD, CHF, Wound care needs- LE, significant mobility limitations	Exited to HUD apartment	Yes		Yes	No		Yes	Yes- walker, wound care su	Yes	Yes		7	0	12	0	7	0	12	0
11/9/2023	11/15/2023	6	[redacted]		30	BAH RN CM	Displaced fracture of arm, post-op	Exited to housing- Boat	Yes		Yes	No		Yes	None needed	No	Yes		1	0	3	0	2	0	3	0
11/20/2023	12/22/2023	32	[redacted]		55	Devereux	DVT- legs; LE Edema- need for leg elevation	Returned to car- did not participate in anything	Yes		No	No		Yes	None	Unknown	Unknown		1	0	0	0	1	0	0	0

Supporting information for: Improving Language Access

Advanced Health 2023 Health Equity Plan Report

Health Equity Plan Report
June 2023

Table of Contents

CCO Workforce, CAC, and Service Area Demographic Information

CCO Name:	Advanced Health	
Health Equity Administrator (HEA) Name:	Anna Warner	
	Phone:	541-269-4560

HEA Contact information:	Email:	anna.warner@advancedhealth.com

1) Provide an update of **demographic information** about contractor's Service Area, contractor's workforce. There is a 3-page maximum for this question.
   a) CCO Service Area demographics

Advanced Health serves Oregon Health Plan Members in Coos and Curry Counties on the Southern Oregon Coast. According to the most recent US Census Bureau information available, Curry County is home to a population of about 23,600, 6.7% of whom speak a language other than English at home. And Coos County is home to about 65,000, 5.2% of whom speak a language other than English at home.

Race and Ethnicity	Coos County	Curry County
White alone	89.9%	91.2%
Black or African American alone (a)	0.7%	0.7%
American Indian and Alaskan Native alone (a)	3.0%	2.7%
Asian alone (a)	1.4%	1.0%
Native Hawaiian and Other Pacific Islander alone (a)	0.3%	0.2%
Two or More Races	4.8%	4.2%
Hispanic or Latino (b)	7.5%	8.0%
White alone, not Hispanic or Latino	83.9%	84.8%

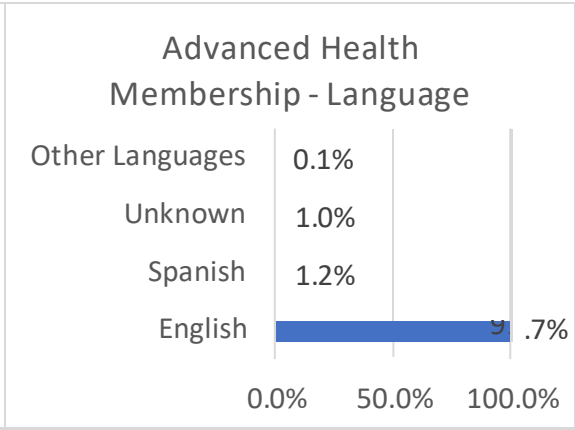
(a) Includes persons reporting only one race
(b) Hispanics may be of any race, so also are included in applicable race categories

Source: https://www.census.gov/quickfacts/cooscountyoregon, https://www.census.gov/quickfacts/currycountyoregon

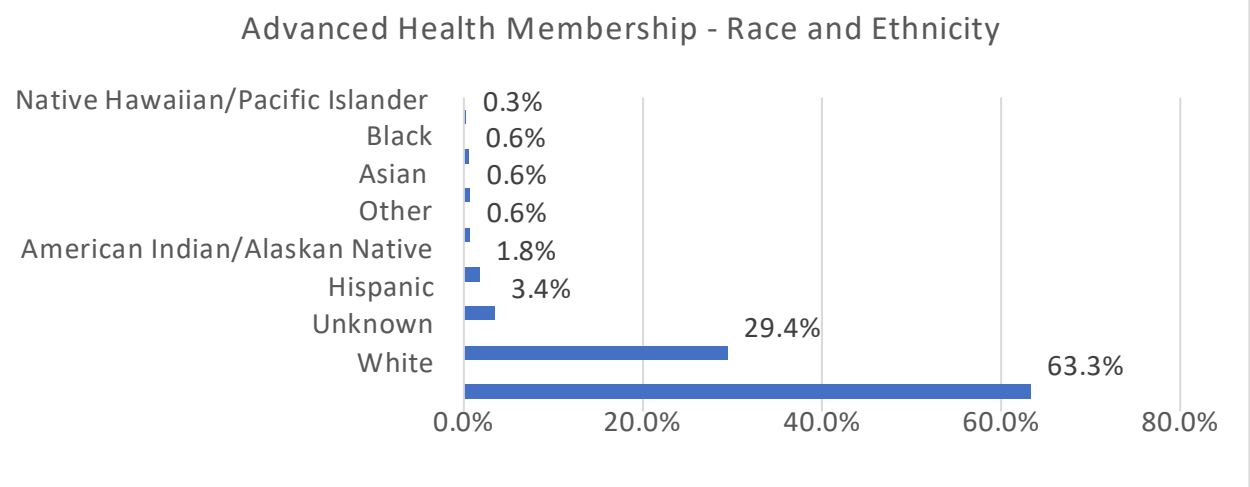
Advanced Health currently serves nearly 30,000 Oregon Health Plan Members in Coos and Curry Counties. That is 1 out of every 3 residents of Coos and Curry Counties.

OHA provides a rich set of demographic data in the 834 enrollment files. This is the most comprehensive source of READ and other demographic data available to Advanced Health.

Advanced Health doesn't have any language groups that meet the definition of a Prevalent Non-English Language as defined in OAR 410-141-3575 (1) (h). A Prevalent Non-English Language is the lesser of 5% of the CCO's membership or 1,000 members. Despite this, Advanced Health commonly makes Spanish-language materials available, such as the Member Handbook and other important forms and information to ensure access to care and member rights.



While there is still a sizable population of Members whose race and ethnicity is "unknown" in the OHA 834 data, the amount of missing data is shrinking. The proportion of "unknown" race and ethnicity data decreased by five percentage points from 34.5% in 2022 to 29.5% in 2023.



Disability Reported - Advanced Health Membership	Percent of Total Members
Blind	2.5%
Deaf	2.3%
Difficulty Walking or Climbing Stairs	5.4%
Difficulty with Dressing or Bathing	3.0%
Issues with Memory	6.9%
Limited Activity in Any Way	7.0%
No Disability Reported	85.9%

Note: Figures in the table above will not add up to 100% because some members report more than one disability.

b) CCO Workforce demographics (please report staff, senior leadership, and board demographics separately):

The REAL-D Survey window, which anonymously collects employee REAL-D data, opened July 3, 2023, and will run through September 15, 2023. The survey is open to all staff including senior leadership. At this time, due to small company size, it is not feasible to report senior leadership separately from all staff and still remain an anonymous survey. The REAL-D Survey collection for board and committee members also opened July 3, 2023, and will run through September 15, 2023.

The data collection date changed from an April – June window to a July – September window for the following reasons: Midyear reporting may give us a better reflection of the calendar year's employee data. Second, July through September have been high recruitment months, year over year. And last, this timeframe provides opportunity for new board members to complete the survey. This change will hopefully increase the percentage of employees, and board and committee members completing the survey.

Results of both survey collection windows will be included in the 2024 Health Equity Plan report.

Advanced Health Staff

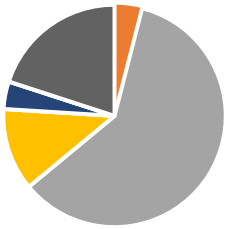
Advanced Health had a 22% response rate for the 2022 REALD data collection cycle, which was a slight increase from 2021 response rate (20%). Demographic data collection for Advanced Health's workforce, committees and board members opened April 1, 2022 through June 17, 2022. Advanced Health continues to implement the organization's REALD Data Collection Policy and Procedure to collect demographic data on their workforce, committees, and board of directors. The Oregon Health Authority's REALD data collection form continues to be used in an electronic survey format. This ensures a secure, organized, consistent data collection process. The data collection results were only viewable by the HR department to ensure confidentiality.

From the responses, Advanced Health was able to gather comparison data of workforce diversity based on REALD data collection. The data showed employees identifying as racially, ethnically, and ability diverse as documented in the following pie charts. There also seems to be increased in employee diversity based on this information. Specific categories have been de-identified to protect data confidentiality. Advanced Health has expanded recruitment location efforts significantly in the past two years. This supports an adequate applicant pool and supports applicant diversity initiatives. Advanced will continue this practice.

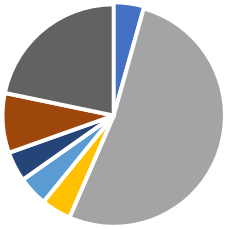
Advanced Health Board of Directors and Committee Members

The 2022 survey was completed by approximately 15% of Advanced Health's board and committee members, which is about the same as 2021. From the responses, Advanced Health was able to gather comparison data of board- and committee- member diversity based on REALD data collection. The data showed board and committee members identifying as racially, ethnically, and ability diverse as documented in the following pie chart, however, there was a shift towards a less diverse make up. Advanced Health will use the results of the 2023 data collection to gage the

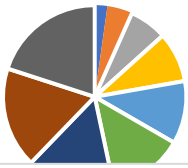
Advanced Health 2021 REALD Data Collection Responses - Employees



Advanced Health 2022 REALD Data Collection Responses - Employees



Advanced Health 2021 REALD Data Collection - Board and Committee Members



Advanced Health 2022 REALD Data Collection - Board and Committee Members

effectiveness of board and committee recruitment efforts. Specific categories have been de-identified to protect data confidentiality.

Section 1: Focus Area Updates

Each contract year CCOs are to provide a status update on **Focus Area (FA) strategies** and develop new or update existing strategies. OHA has provided a table for each focus area below.

Please note that **Year 4 (CY 2023) Focus Areas (FAs)** differ from Year 3 (CY 2022) Focus Areas. For some focus areas, previous strategies will be carried over from Year 3 FAs. In these cases, reporting sections will include spaces for progress updates on previous strategies and goals, as well as space to modify or introduce new strategies and subsequent goals.

Other focus areas were not included in the scope of Year 3 FAs. For these FAs, sections are provided for background / context for the FA and the introduction of new strategies and goals. Information may be drawn from other areas of Year 3 Health Equity Plan submission, including Section 1, Health Equity Plan Update. See *2022 – 2023 Section Area Contents and Focus Area Crosswalk* section of Guidance Document for further details. When applicable, OHA has provided some guidance and prompts based on CCO contract *Exhibit K Part 10 Health Equity Plan (b) (2) (a – e).*

Provide a progress update on Year 3 FA strategies and plans for Year 4 FA strategies in the table below.

Please note there is a 25-page limit for this section but please strive to be brief while also being comprehensive.

Focus Area 1: REALD / SOGI
Year 3 Progress Update (Progress Report) Provide a status update on CCO Year 3 strategy for Year 3 FA 2 below
The Advanced Health Analytics Department has been integrating REALD data into all reporting. Advanced Health has contracted with Reliance HIE and UniteUs. Reliance is a Health Information Exchange platform that most local provider organizations also use. Unite Us is the Connect Oregon platform for Community Information Exchange. Beginning in February 2023, Unite Us is available to Advanced Health's provider network and local community-based organizations as a platform to coordinate closed loop referrals for social health needs. Unite Us has some built-in functionality to gather REALD and SOGI data from screenings in community organization settings. We are exploring what data is collected and shared by community partners through Unite Us. In year 2, we discussed utilizing Reliance to enhance our REALD data. We have taken pause on including any data outside of Oregon Health Authority (OHA) data until we

can properly identify what data came from what location. The purpose of this is to ensure that we have an internal source of truth data (OHA data files), and then other files can add additional information. This would need a bigger data warehouse to encompass all data from all sources we receive data from.

Goal 1:

All internal reporting dashboards will include REALD data. By including REALD data in all reports, it may display a trend (or not).

Goal 1 Status Update: ☐ Completed. ☒ Ongoing. ☐ Modified.

Advanced Health has gone through an internal Analytics restructuring which has included reviewing each reporting dashboard for data accuracy and data addition. This is on-going as there are many internal dashboards to work through with stakeholders.

Baseline:	**Metric/Measure of success:**
Internally published dashboards that have been evaluated for the need of REALD to be added: 15%	All internal reporting dashboards will be evaluated for REALD data addition by end of 2024.
Monitoring:	**Person responsible:**
Analytics Team to add REALD data into dashboards as appropriate/requested.	Chief Information and Technology Officer

Updated Resources Attained / Needed:

Staff time

Year 4 Strategy

Please select one option for Year 3 strategy and complete the appropriate portion of the table below.

☐ Strategy is the same as Year 3
☒ Strategy has been modified for Year 4
☐ A new strategy has been developed

If strategy has been modified for Year 4

The strategy from Year 3 is going to continue forward, with a slight modification with the introduction of SOGI data. Advanced Health will receive SOGI data from OHA in September 2023 which we will use to create a process to analyze the data and then we can utilize SOGI data to enhance member care.

Focus Area 2:
CLAS Standards as an organizational framework to advance health equity

Year 3 Progress Update (Progress Report)

- **CLAS- Governance, Leadership, and Workforce**

Advanced Health's strategies related to CLAS governance, leadership, and workforce are reflected in the training plans discussed in Section 2 of this report, beginning on page 31. In addition, the Equity Policy Analyst is leading an interdepartmental group of CLAS Champions as means to examine operations for opportunities to further integrate CLAS standards in day-to-day work and increase staff understanding of the impact of CLAS Standards.

- **CLAS-Communication and Language Assistance**

Advanced Health year 3 Focus Area 3 strategy for Culturally and Linguistically Appropriate Services continued throughout 2022 with its education to members and the Provider Network on language access services, including the supports offered at no cost by Advanced Health. This included encouraging the Advanced Health Provider Network to utilize Advanced Health's scholarship offer to pay the training and testing costs for staff to become Qualified/Certified Healthcare Interpreters. Advanced Health has continued to educate and provide resources to our Provider Network through ongoing presentations, mailings, and social media. Throughout 2022 we also continued to outreach members and educate them on language access services through multiple efforts as described below. Internally Advanced Health continues to require yearly Language Access Training along with training in best practices for staff. Training opportunities will continue to be announced via Advanced Health's website, the quarterly provider newsletter, the Interagency Quality Committee, provider services orientations and trainings, the local hospital Continuing Medical Education (CME) program, and clinic HR/business communications. Advanced Health continues to update members and the community via social media and community meetings. Training courses are now being transitioned to on-site in-person with continued remote availability for those needing this accommodation.

Advanced Health continued its efforts in 2022 to identify members who need language access services. We increased outreach and education to our members to encourage the self-reporting of their language access needs. Advanced Health continued to monitor services provided by utilizing an internal Language Dashboard. The quarterly chart review for interpreter services allows us to monitor the language needs of the members and assess if additional materials or resources are needed. This quarterly chart review encompasses encounters for all members currently flagged as needing an interpreter to access services. An internal log is kept by Advanced Health to monitor the use of our on-staff Qualified Healthcare Interpreter services to continually monitor the communities needs and identify gaps in access to services. Data collected from the chart review and the internal interpreter services log is submitted quarterly to OHA for review.

- **CLAS-Engagement, Continuous Improvement, and Accountability**

The Member Engagement and Education Committee (MEEC) was formed to focus on member education and engagement projects such as translation of member-facing documents and ensuring large-print materials are readily available. The Committee meets monthly to develop new ways to engage and educate the CCO members and community. The MEEC continues to meet monthly to discuss ways to engage our members through ensuring we are offering Culturally and Linguistically appropriate services and resources. It also continues to recruit additional members to join the committee to increase member participation and input of members from diverse cultural backgrounds and members with limited English proficiency to evaluate and break down barriers.

Status update on CCO Year 3 **Governance, Leadership, and Workforce** strategy:

- **Governance, Leadership, and Workforce**

CLAS champions workgroup

Advanced Health created a CLAS champions workgroup which emerged from the Health Equity Steering Committee. The champions within the workgroup represent several departments, Compliance, Intensive Care Coordination, Customer Member Services, Health Policy and Grievances and Appeals. The champions created a CLAS channel within Microsoft Teams to relay all CLAS information that affect the organization as a whole and any community based CLAS events. The goal of the workgroup is to continue using the CLAS lens to fill the gaps within departments and the resources that the departments share internally and externally.

Diversity Conference

Advanced Health continued to sponsor the local Annual Diversity Conference, which was held in person in 2023. 24% of Advanced Health staff attended, including attendance from various departments such as Administration, Community Engagement, Intensive Care Coordination and Member Services. This is a 10% increase in staff attendance compared to 2022.

Attachments: South Coast Diversity Event Guide Final, Annual South Coast Diversity Conference 2023

Below is a summary of the overall attendance of the conference.

Conf,erence Evaluation

2023 Annual South Coast Diversity Conference

Aprill l 2t & 13th, 2023, 8:30-3:30pm

Held in-perso:n1, !Mill Casino, Nortlh Bend

Attendee Demographies:

Tot·al 1u!,gist,ra1.ts = 41-41·1

- **April** 12•h **regi**s;trants = 2.16
- April l 3,1hregi.stlrants =2.25

Total atte,liidlees = 2.38 (!.4% of registrants:)

- April 12 Attende.e.s.= 114
- April l 3, A:ttlendee,s = 121

'T'otal evah11ation,s **citmp** leted! = 96 40% Of il/Uerulees)

- Respondents who attended Apriil 12' = 55.%
- Respondents who attiende.cl April l 3.,i, =: 50%
- Respondents,.uho attended bo·th day.s. = !..2

P1(mary Service Area .as **reported** viiille-valuatio111,:

- OR - South Coast (Coastal Dollglas !Coos l Curry) = Total: 91.7%
  - Coo.s County = 8&.596,
  - C1.11rry County = 31.4%
  - Coa.s.tall Douglas = 9.4%,
- CA - North Coast (Curry. OR I D,el Norte l Humboldt) = Totall: 2..1 96-
- Greater· Oregon = Total: '6.2%

S,ector Rep·rese1nted as **r·ep,aer-ted** via evah1atio111:

- Health Care = 2596,
- Govern me,nt = 2496
- Family Support Service,:s and/or Parenting Education 23,
- K-12. Educatiion = 2.0. 896
- Early Care & Ed1.11c:illtion l&..&%
- Community e,mber 13. .5%
- Special Education 10..4%
- Voluntee.r = 9..496,
- B:us.ine.s.s = 7.3'
- Mentall H'e.altlh = 3 ..1%
- Philanthropy = 3 ..1 96,
- Student = 3.1%
- law Enforcement and/o:r First Re.s.ponde.r 2..1%

Age grou1p s,e1111e-dlas **re p-otrted** via eval·u,at·01n:

- P,re,naital = 31 _l %
- B:irth-3 years = 47.996-
- 3-S ye.ar:s := S7.3,%
- 5-12.,•eair:s = 5'5..2%
- 12- l years = 63.5
- Adults.:= 62..596,
- Do not provide sernce.s. to any groups 3..1%

Status update on CCO Year 3 **Communication and Language Assistance** strategy:

- **Communication and Language Assistance**

In year 3, Advanced Health continues to utilize data from OHA's 834 enrollment files to obtain REALD information to identify and track our members' communication and language access needs. Toward the end of 2022 with the introduction of OHA's CCO Data Submission Portal we saw an increase in completeness of REALD data. Advanced Health Customer Service Representatives continue verifying the members' demographics and language preference upon each incoming call.

In April 2022, we contracted with Language Line Solutions for an On Demand InSight Video program. In 2022 we had two laptops available for our Qualified Healthcare Interpreter to facilitate in person interpretation at the provider's office. The InSight Video Program can access translators in over 240 languages including American Sign Language. A Certified Spanish Interpreter is available to our members and Provider Network to provide this service in any appropriate community setting.

In October 2022, language letters were sent to all enrolled members informing them of the implementation of our new On Demand InSight Video Interpretation Program through Language Line Solutions. We also encouraged our members at that time to reach out to us with any language and communication preferences. The letter included an I Speak Card and a Communication and Accommodation Card for the members to carry with them and use as needed while out in the community.

Advanced Health continues to promote the availability of cost-free, in-person qualified healthcare interpreter services to our members through every available avenue including community meeting presentations, internal language access presentations, Provider Forums, member letters, website postings, provider flyers, and the use of the CCO's social media platforms. The Provider's Healthcare Interpreting Guide was updated and sent out to the providers with instructions for the new InSight Video Interpreting Program. Advanced Health also continues to promote the use of Language Line Solutions by ensuring provider organizations have Language Line materials to post and utilize in their offices.

Advanced Health continues to offer any member translation of any CCO document in their preferred language or format upon request by contacting the Customer Service Department.

Advanced Health granted six scholarships in 2022 to providers who enrolled staff in training courses to become a Certified Healthcare Interpreter. This has increased the availability of qualified and certified interpreters available locally for in-person, telephonic, and virtual language assistance. Scholarships will continue to be offered through 2023 until funds have been exhausted.

In 2022, more questions were added to the Health Risk Assessment (HRA) to obtain additional information on members' culture and language preferences. The questions include, "Is English your primary language? What is your preferred language? Do you need an interpreter or use any assistive devices to help you see or hear?" We have also added language to include beliefs or customs to the question inquiring if the

member has any cultural needs. We want to make sure the member understands the question so they can provide the appropriate information. The HRA Dashboard has also been updated to extract the information more easily.

Advanced Health website translates to 103 languages, and we continue to add additional translated documents in Spanish.

The Member Engagement and Education committee continues to meet monthly and develop ways for Advanced Health to better communicate with its members. We continue recruitment of additional CCO members to make sure we have inclusive representation.

In December 2022 to ensure we were meeting our members' language preferences for healthcare educational materials, we contracted with Krames. Krames provides health educational sheets at a 5th grade reading level and videos in multiple languages including 100% pictorial materials. We are currently training staff and plan to roll out member access to the service via a link on the Advanced Health's website later in 2023.

In 2022, to guarantee high quality translation, we began to utilize Language Line Solutions to ensure all translated materials were translated appropriately. Our Qualified Spanish Healthcare interpreter reviews the Spanish materials to verify appropriate translation upon completion and prior to releasing the information.

The Director of Member Services continues to complete listening sessions with members of the populations who are within special healthcare groups most at risk of continuing to break down cultural and linguistic barriers.

Advanced Health continues to utilize the internal Language Dashboard in Tableau to identify members flagged in Medicaid Management Information System (MMIS) as needing interpreter services. This identification mechanism also allows us to identify members who need to receive mailings in Spanish. Advanced Health maintains a log of language assistance provided to members by our on-staff Qualified Healthcare Interpreter. Language Line utilization data is also reviewed monthly through the Language Line Solutions online reporting dashboard.

Goal 1:

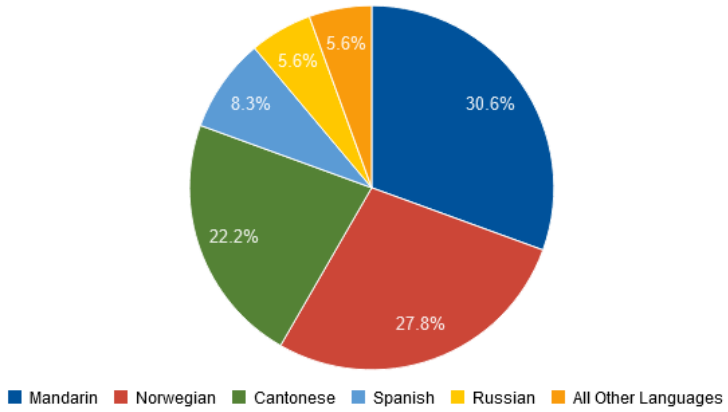
Add and offer InSight Video Interpretation to our members and provider network

Goal 1 Status Update: ☒ Completed. ☐ Ongoing. ☐ Modified.

Goal met by the CCO expansion of the contract with Language Line Solutions with the Insight Video Service and providing it to our members.

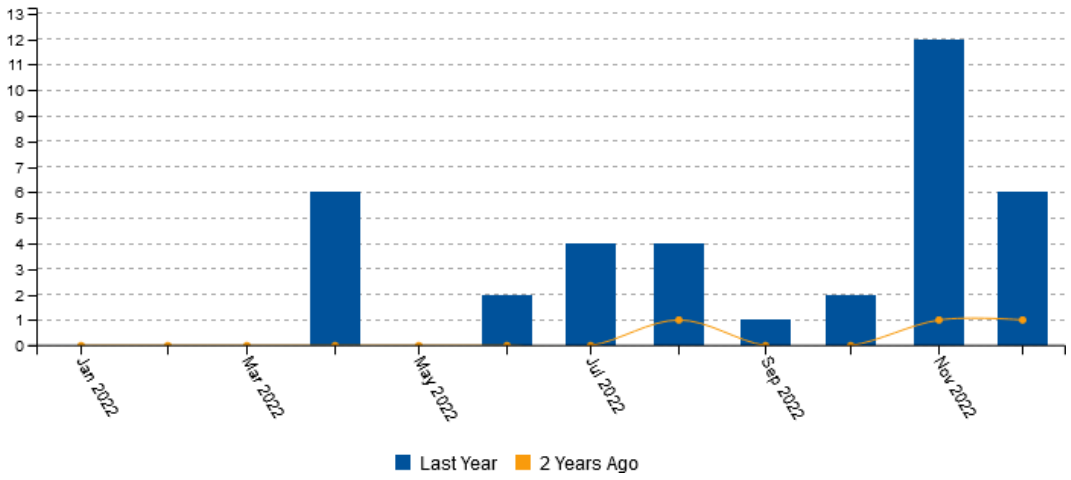
Language Line Solutions utilization data for 2022 is summarized below.

Top 5 Languages



Language	Calls	Avg. Duration	Connect Time
Mandarin	11	22 min	3s
Norwegian	10	9 min	4s
Cantonese	8	10 min	43s
Spanish	3	19 min	6s
Russian	2	17 min	12s
All Other Languages	2	24 min	3s

Call Volume



Solutions Summary

Audio	35 Calls
	484 Total Minutes
	16 Min Avg. Duration
Video	2 Calls
	4 Total Minutes
	4 Min Avg. Duration

Baseline:	**Metric/Measure of success:**
Prior to the addition of the InSight Video Program Advanced Health was only able to offer face to face translation in Spanish. All other interpretation was completed via phone	Insight Video contract completed, staff trained, and services currently being offered by Advanced Health's Qualified Healthcare Interpreter who facilitates the InSight Video Program throughout our Provider Network as needed. Now members can receive interpretation assistance at their medical appointments and are able to see body language and other visual cues offered by the interpreter.
Monitoring:	**Person responsible:**
Utilization monitored through the Language Line Solutions Dashboard online.	Director of Member Services

Updated Resources Attained / Needed:

Language Line InSight Video Interpretation Program

Qualified Interpreter

Tablets to provide the service

Status update on CCO Year 3 **Engagement, Continuous Improvement, and Accountability** strategy:

Engagement, Continuous Improvement, and Accountability

The Member Engagement and Education Committee continues to meet monthly to discuss ways to engage our members through ensuring we are offering Culturally and Linguistically appropriate services and resources.

In December 2022 to ensure we were meeting our members' language preferences for healthcare educational materials, we contracted with Krames. Krames provides health educational sheets at a 5th grade reading level and videos in multiple languages including 100% pictorial materials. We are currently training staff and plan to roll out member access to the service via a link on the Advanced Health's website later in 2023.

In 2022, Advanced Health also expanded the Language Line program to include InSight Video interpretation to allow for face-to-face translation via video in over 240 languages including American Sign Language. A Certified Spanish Interpreter is available to our members and Provider Network to provide this service in any appropriate community setting. In 2022 all members were mailed a notification informing them of this new service along with an I speak card, Communication & Accommodation Card, and encouraged to contact the CCO to let us know what their language access needs are.

The Provider HCI pamphlet was updated and sent to all providers and their staff, internal education on the program was completed, and this is announced in community and partner meetings attended by Advanced Health Staff.

Goal 1:

Increase access to CCO's healthcare interpreter services by completing a review of interpreter services available in our provider network. Updating provider and member education materials about CCO's healthcare interpreter services. Providing training opportunities for staff members at our local clinics to become certified healthcare interpreters and including evaluation of health care interpreter services utilization when developing and planning changes to the Delivery System Network (DSN).

Goal 1 Status Update: ☒ Completed. ☐ Ongoing. ☐ Modified.

This goal update encompasses all the goals from Focus Areas 3 and 4 of the 2022 Health Equity Plan report. All were completed, and for ease of reporting have been combined here.

Baseline:	Metric/Measure of success:
At the start of 2022 Advanced Health had an initial version of the provider HCI Pamphlet that provided the Provider Network information on Interpretation Services offered by the CCO. Advanced Health would inform members of the interpretation services and document their preferred language upon successful inbound and outbound outreaches. Advanced Health's website contains a section on the Member's page specific to language interpretation services. The CCO had few qualified or certified healthcare interpreters within the Provider Network. Advanced Health has maintained a utilization list of interpretation services provided to CCO members	Metrics met through the updating of the Provider HCI Pamphlet, sending out the I Speak cards and language letter to all active members, updating the CCO's website information on interpretation services available for free, offering of scholarships to Advanced Health Provider Network, and continued monitoring of the CCO's Interpretation Log.
Monitoring:	**Person responsible:**
Monitoring of the language log is conducted quarterly. All others are monitored on an ongoing basis and annually to ensure all information is accurate and up to date.	Director of Member Services

Updated Resources Attained / Needed:
CCO Budget line item to fund scholarships
Access to the Language Line OnDemand Interpretation Program
Access to the Language Line InSight Video Program
Qualified Healthcare Interpreters

Year 4 Strategy
Please select one option for Year 3 strategy and complete the appropriate portion of the table below. ☐ Strategy is the same as Year 3 ☐ Strategy has been modified for Year 4 ☒ A new strategy has been developed

New Strategy:

Increase participation and from members with limited English proficiency and diverse cultural backgrounds by recruiting additional members to participate in Advanced Health committees and activities. Get feedback by increasing listening sessions to collect data on needs and barriers.

Background/Context:

This strategy was selected to help increase the number of members represented with limited English proficiency and those from diverse cultural backgrounds. Advanced Health wants to successfully engage and assess their needs to help break down barriers, making sure everyone has equal access to the care they need. The more members we can engage equates to the more members we are able to assess and connect to appropriate services which ultimately lead to improving their health outcomes.

Issues and barriers:

By improving the engagement and participation of members, Advanced Health hopes to address low response rates to member outreaches, mailings, and surveys. Some of the barriers to improve include updating incorrect contact information, incorrect language preference information, members not returning calls or surveys due to not understanding the information received, locating appropriate communication avenues to reach specific populations such as people who are unhoused, and breaking down the stigma and distrust in using a third party to help interpret.

Goal 1:

Increase engagement of members with limited English proficiency and members from diverse cultural backgrounds.

Baseline:	**Metric/Measure of success:**
No members currently active on the MEEC	At least two members or service providers representing members with limited English proficiency or members from diverse cultural backgrounds will join the MEEC committee by December 2023.
Monitoring:	**Person responsible:**
Monitor MEEC attendance and recruitment efforts	Director of Member Services

Resources Needed:
Access to Advanced Health Members
Member incentive/ compensation for participation
Access to HRA Dashboard
Access to Advanced Health's Social Media Platform

Focus Area 3: People with Disabilities and LGBTQIA2S+ People
Background / Context: Current CCO Status
• **People With Disabilities**
During this reporting period, System of Care (SOC) Grant funds were provided to the Starfish Program at Waterfall Clinic to purchase sensory playground equipment for children with Autism. The playground will be made available to children in the program and to the public during certain hours of the week. The SOC is a philosophy based on cross system collaboration that supports youth and families who have complex and significant behavioral and mental health needs. After a community-based organization found it difficult to offer SOC needs, Advanced Health reached out to offer its support and has been doing so since 2019. Barriers about lack of access and timely crisis dental care for Intellectual, Developmental, and Disabled children and youth has been brought to the State System of Care Advisory Committee and Oregon Health Authority for resolution. Continued efforts to resolve the barriers are ongoing. Additionally, barriers/gaps in the system for Applied Behavioral Analysis (ABA) services exist in both Coos and Curry Counties. The Behavior Therapist at the Waterfall Starfish program, System of Care representatives, and the Advanced Health Behavior Health team are actively discussing ways to partner with School districts in Coos Bay to provide ABA services which will serve to help bridge existing rural Education funding gap restraints. Intensive Care Coordination (ICC) is a program that offers care coordination services to Advanced Health Members that have been identified as having Special Health Care Needs (SHCN) or who belong to a priority population such as Members with disabilities and/or are showing signs of social, emotional, or behavioral problems. As part of the program, members will have access to either a Nursing or Traditional Health Worker (THW) Care Coordinator who provides holistic and culturally competent care to diverse populations. To improve the Member experience, Advanced Health has sponsored Mental Health First Aid and Safe Zone training to ICC and Customer Service staff who provide coordination of Member healthcare. Mental Health First Aid is a national program and course that teaches how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The training gives students the skills needed to reach out and provide initial help and

support to someone who may be developing a mental health or substance use problem or experiencing a crisis. A certificate is awarded to each participant.

Advanced Health's Customer Service Representatives continue to reach out to each Member to complete the Health Risk Assessment (HRA) upon enrollment, annual renewal, and with any significant change in the member's level of functioning. In 2022, the HRA was updated, and some questions were transitioned to open ended questions allowing the CCO to gather additional information about Member's disability, and what is important to them about their disability. Throughout the HRA survey, the Customer Service Representative also assesses Member's need for the above-mentioned Intensive Care Coordination Program, and refers Members as needed. In 2022 a new HRA dashboard was developed to identify the information more efficiently. This went live in early 2023 and now allows us to target certain populations based on the need to help fill gaps in care.

Through each incoming phone call Advanced Health Customer Service Representatives (CSR) assess the Member's needs and connect them to appropriate resources. Throughout 2022 Advanced Health identified a mid-level need for care coordination and those members with disabilities that may not have the intensive need for ICC but are still in need of an ongoing link to assistance. These members are now assigned to a specific CSR who is identified and noted as their ongoing point of contact.

- **People who identify as transgender, nonbinary, or gender diverse**

During Advanced Health's information gathering for the Community Health Assessment (CHA), we held focus groups for LGBTQIA2+ communities in both Coos and Curry County. We were also a sponsor and vendor at the Pride in the Park events in Coos and Curry counties. We had staff participate on the planning committee for this event in Curry.

In the fall of 2022, the System of Care (SOC) put on two health equity fairs in Coos and Curry counties. Advanced Health provided Cultural Diversity books that were distributed in English and Spanish. Youth from the LGBTQIA2S+ community volunteered to be greeters at the Coos Health Equity Festival. Coos and Curry Pride group also joins the System of Care health equity fairs as vendors.

During the fiscal year of 2022-23, LGBTQIA2+ members from the SOC Youth Council participated in other outreach festivals and assisted in youth recruitment efforts. Members from the System of Care Advisory Committee and Practice Level Work group include representatives of the South Coast Equity Coalition, Queers and Allies, and Pride who organized the annual Pride in the Parks and Cultural Diversity Conference.

SOC provided grant funding for the LGBTQAI2+ clothes closet, equity education materials, equity activities and scholarships for job related needs, leadership training, cost of certifications, applications, and education costs. Grant funds were also used to pay for the Pride Book Club, cultural diversity books and potluck events and leadership and advocacy workshops. Additional funds were made available to a non-profit agency who serves LGBTQIA2+ and developed a U Matter safe space for youth

to develop writing skills, learn resume writing, access free Wi-Fi, print/scan, do homework, conduct job search, and offers a graphic design computer.

SOC Practice Level Work Groups and Advisory Committees use pronouns when introducing themselves, provide a safe place by use of a team compact, and the Coos Drop provides a free weekly meeting space for the LGBTQIA2+ youth group. The Coos Drop is an after-school program for teens and is a branch of Youth Era. In early 2023 Coos County dissolved funding to the Coos Drop and since the need was still there, Advanced Health stepped in to keep it operating.

While incorporating additional open-ended questions to the HRA Advanced Health added the optional question “What gender do you identify with?” This gives members the choice to share within their comfort zone. In early 2023, Advanced Health created a new HRA dashboard to allow us to more easily quantify the information obtained in the HRAs and can now more clearly identify where there is a need for additional resources. The CCO will continue to work with the Provider Network to gather additional information from members to identify gaps in care and resources.

- **People with sexual orientation diversity**

Staff from Advanced Health’s Community Engagement team participate in the Voices of Curry Community Group, South Coast Equity Coalition, and the local Allies group. The CCO has also worked hard to partner with United Way and Southern Oregon Coast Pride team to enhance outreach efforts for participation in the Community Advisory Council, Community Health Assessment focus groups, and questionnaires and the Community Health Improvement meetings.

System of Care Grant funds provided Safe Zone workshops for member representatives from public and private agencies such as the Oregon Youth Authority, Juvenile Justice, Education Department, Mental/Physical Health providers, Intellectual, Developmental, Disability organizations, Police Officers, Oregon Department of Human Services, Substance Abuse Treatment programs, and child, youth, and family agency representatives. Safe Zone trainings are opportunities to learn about LGBTQIA2+ identities, gender, and sexuality, and examine prejudice, assumptions, and privilege. The 3-hour Safe Zone workshop serves as a “101” crash course of definitions and explanations. It involves a lot of activities and discussion, with plenty of opportunities to ask questions. Participants walk away with a solid foundational understanding of LGBTQIA2+ identities and how to best support them. A certificate is awarded to each participant.

Advanced Health continues to increase internal awareness and education through new employee trainings on Policies and Procedures, including the CCO’s Non-discrimination Policy and DOCS Anti-bullying, Anti-discrimination, Anti-harassment, and Retaliation Protection Policy and Procedures. The Health Equity Steering Committee continues to meet monthly to identify new trends, barriers, and review new legislation and requirements surrounding the Queer community. The CCO also continues to grow and learn from individual member feedback and make changes accordingly.

Year 4 Strategies

- **People With Disabilities**

Advanced Health shall collaborate with the National Association of Developmental Disabilities and Mental Health Needs (NADD) for trainings and consultation. Additionally, select CCO staff will attend monthly Community Living Case Management (CLCM) meetings to identify additional barriers and gaps in the intellectual and developmental disabilities (I/DD) population.

- **People who identify as transgender, nonbinary, or gender diverse**

Work with Advanced Health Provider Network and the community to gather additional information, offer additional training, and continue to seek new resources for this population. Currently, the CCO lacks data on these populations. The first step in our strategy will be to collect accurate data on members who identify as transgender, nonbinary, or gender diverse. Once data is collected and quantified, we can develop additional strategies and goals to identify gaps and secure access to new and existing services within the community.

- **People with sexual orientation diversity**

Work with Advanced Health Provider Network and the community to gather additional information, offer additional training, and continue to seek new resources for this population. Currently, the CCO lacks data on this population. The first step in our strategy will be to collect accurate data on members who identify as transgender, nonbinary, or gender divers. Once data is collected and quantified, we can develop additional strategies and goals to identify gaps and secure access to new and existing services within the community.

Goal 1:

All Advanced Health staff that communicate directly with members, either verbally or in-person, will complete Safe Zone and Mental Health First Aid (MHFA) trainings.

Baseline:	Metric/Measure of success:
Not all member-facing staff have taken the Safe Zone or Mental Health First Aid trainings within their first year or at all as of 2023.	Year 1 of Goal (2024): 50% of identified departments or positions with direct member interaction will complete Safe Zone and Mental Health First Aid training (Intensive Care Coordination, Customer Service, Community Engagement, Grievances and Appeals, or other applicable care management role). Year 2 (2025) 75% identified departments or positions, listed above, will complete Safe Zone and Mental Health First Aid training.
Monitoring:	**Person responsible:**
Training courses are scheduled twice a year to ensure availability to all new hires. Verified via training attendance records twice yearly. Departmental staff quarterly reviews will be used to monitor knowledge gained and how training is utilized in daily work, department operations, and quality of member services.	Director of Care Coordination Human Resources Manger Behavioral Health Program Manager
Resources Needed:	
Experienced Trainers Curriculum Conference room space	
Goal 2:	
To obtain accurate SOGI data from the Advanced Health Provider Network to identify barriers and implement innovative programs.	

Baseline:	Metric/Measure of success:
Advanced Health does not currently collect SOGI data on all member nor request it from our Provider Network	A process has been established to exchange SOGI data between Advanced Health and Provider Network. Needs and barriers have been identified for our members who identify with various genders and/or members with various sexual orientations.
Monitoring:	**Person responsible:**
Survey providers on their current processes used to obtain SOGI data directly from members by December 2023. Identify a universal SOGI data gathering tool with the Provider Network by June 2024. Begin receiving data by December 2024 to utilize in conjunction with REALD data from OHA. Review data with the Health Equity Steering Committee to identify gaps in our Provider Network where we could provide support and resources. Advanced Health will then develop goals to fill these gaps and reduce barriers for 2025.	Director of Member Services
Resources Needed:	
Provider Network Survey (to be created in the third quarter 2023) Dashboard	
Goal 3:	
Increase participation in National Association of Developmental Disabilities and Mental Health Needs (NADD) trainings and participation in monthly CLCM meetings.	
Baseline:	**Metric/Measure of success:**
Advanced Health Behavioral Health Department staff have not attended NADD trainings.	Advanced Health Behavioral Health Manager shall attend a minimum of 2 NADD workshops and an Advanced Health representative will attend at least 10 monthly CLCM meetings per year.

Monitoring:	Person responsible:
Attendance list during meetings (virtual and in-person meetings)	Director of Behavioral Health Behavioral Health Program Manager

Resources Needed:

Meeting minutes after each meeting

Staff time to attend assigned trainings and meetings

Focus Area 4: Community Engagement

Background / Context: Current Status

Advanced Health currently meets monthly with the Community Advisory Council (CAC), a group of 25 voting advisory council members and typically around 15-20 community partners to discuss the health needs of underserved persons in our community.

The Community Health Improvement Plan (CHIP) steering committee. Which consists of around 20 community partners all focused on projects to improve and meet the goals of the Community Health Assessment (CHA) for Coos and Curry Counties. This includes several sub committees and community partners such as the South Coast Equity Coalition, the local Regional Health Equity Coalition (RHEC).

Advanced Health focuses on outreach to Community partners by contributing time to the projects they are supporting that drive CHIP initiatives. These projects include administrative support for South Coast Together, who provide ACEs training. As well as having a master trainer for South Coast Together on the CCO Staff.

Advanced Health helps support several community events by providing sponsorship and including a table at that event for outreach, we have also contributed raffle prizes for raffles to encourage participation in those community events,

The Community Engagement team headed a project for a Coat Drive in Curry County and provided Coats, Hats, and gloves to 200 children 18 years old and under.

The Community Engagement team has assisted several organizations who required funding to provide services throughout the year. Advanced Health assisted them in finding and attending grant writing workshops and educating them about the grant opportunities provided to our communities.

In Coos and Curry counties Advanced Health awarded 30 schools with $5,000 each for funding for the at-risk youth during the holidays, for a total of $150,000. This allowed families who would have otherwise gone hungry over the holidays to have food during a time when they are used to really struggling without school lunches being provided.

Advanced Health has provided letters of support to several agencies in Coos and Curry for local projects like the Coquille 100-acre woods and Brookings CORE / Oasis Turnkey project. These letters of support are required by the grant application allowing them to apply for funding to support their projects. Without the required number of supports letters the grant application would be denied.

Advanced Health has presented several opportunities to CAC and CHIP members in both counties to join different committees, discussion groups and meetings to participate in the development of the Community Health Improvement plans and the Community Health Assessment.

Year 4 Strategies

Engage more members in the CAC meetings by providing them with alternate methods to access resources discussed during meetings. Therefore, more participation within the community to address health equity gaps.

Goal 1:

Increase the amount of information and updates provided during monthly CAC meetings available to meet the needs of all individuals including 3 new ways for CAC members to access information by 2024.

Baseline:	**Metric/Measure of success:**
Not all current CAC members that choose to attend the meetings in person rather than virtually have the ability to access electronic mail systems.	All CAC members who choose to attend meetings in person will have access to information shared via email in printed hard copies, large font print and Spanish formats when requested.
Monitoring:	**Person responsible:**
Monitor by feedback from CAC members twice yearly.	Community Engagement Manager

Resources Needed:

Access to Spanish interpreter services

Focus Area 5:
Continued development of organizational Health Equity infrastructure

Background / Context: Current Status

Advanced Health continues to have Anna Warner, Executive Program Director, in the Health Equity Administrator role. This executive leadership position has broad oversight of the health equity initiatives and programs within Advanced Health which span the majority of departments in the organization. This role is an integral part in

the success of Advanced Health's health equity infrastructure. In collaboration with the Health Equity Steering Committee, and two designated positions – the Health Policy Analyst and the Equity Policy Analyst, Advanced Health has allocated staff and resources to support the progress of health equity and associated goals, as seen in the attached organization chart. The policy analyst positions are instrumental in providing subject matter expertise and providing organization and project management to specific contract deliverables that address health equity. The Human Resources Department allocates time, knowledge, and budget to various equity initiatives, such as fair and equitable hiring practice evaluation, data collection for workforce diversity, accessible benefits administration, professional development and training, and safety and wellness initiatives, all of which are further described below.

Attachments: Organization Chart Update, AH.AD.16_Executive Program Director, AH.AD.Health Equity Policy Analyst, AH.AD.Health Policy Analyst_final

On an annual basis, Advanced Health collects REAL-D data from employees, board-, and committee- members. Currently, Advanced Health is currently collecting REAL-D Data for the 2023 collection cycle. In previous years, participation has been low for all data collection groups. The 2023 goal is to increase responses from all data collection groups. Advanced Health HR will send two reminders after the initial notice to employees, and work with the board- and committee- point of contacts to increase communication and follow up reminders. Year 4 strategy will include considering collecting REALD Data from all data collection groups twice yearly. The results from the 2023 collection cycle are pending. Based on previous years and the last 18 months of recruitment activities, HR forecasts an increase in employee responses and workforce diversity. This is based on the plan to increase communication efforts and the organization's diverse recruitment efforts. Many of Advanced Health's positions can be hybrid or remote, which promotes accessibility and flexibility, leading to a more diverse candidate pool and workforce.

On an annual basis, Advanced Health reviews the company's employee benefits package for equitable access and distribution for all employees. Advanced Health has maintained the previously implemented Equity-related PTO/VTO benefit. This benefit is available to all employees. Beginning in the 2021-2022 plan year, Advanced Health added additional health plan options to ensure health plans were available that met the needs of different lifestyles, families, and health conditions. Advanced Health provides benefits packages for both full-time and part-time employees. In 2022 HR conducted a benefits survey using the new HRIS system, however, the data came back in aggregate form with no detailed information. The information was not useful in making any benefits changes.

In 2022, the Advanced Health's Safety Committee was updated to include employee wellness in the committee's initiatives. This collaborative approach ensures that

employee wellness is a focus of the committee, which further contributes to employee satisfaction and inclusivity.

Attachments: Safety Committee Charter_FINAL_2023.04.27

Advanced Health has experienced a delay in the completion of the HRIS implementation. The previously planned system's data insights evaluation and implementation is postponed until 2024.

Two areas previously mentioned are Advanced Health's Employee Performance Evaluations, which include an equity-related question. This reinforces professional development and job knowledge to further health equity as an organizational infrastructure. Advanced Health staff are required to complete equity-related trainings upon new hire and on an annual basis.

Attachments: 2023 Assigned Training List Official, redacted
sample_2022AnnualPerformance Review

2022 – 2023 Equity Assessment Summary

Advanced Health conducted an Employee Equity Assessment Summary in December 2022 – January 2023 to gain further insight into the employee perspective on Advanced Health's health equity infrastructure and capacity. The following areas were evaluated: workforce, company culture and training, use of demographic data, CLAS, Member education, community partnerships, health equity promotion, and social trends. The data from this survey is being reviewed by the Health Equity Steering Committee to determine an action plan for 2023 – 2024.

The results included strengths such as having a diverse workforce with employees from various backgrounds and experiences, as well as bilingual staff members who facilitate effective communication with a broader range of members and stakeholders. The organization benefits from workforce inclusivity, with employees demonstrating a commitment to collaboration and teamwork, leading to efficient communication both internally and with members and providers. The longevity of some staff members contributes to their deep knowledge and ability to provide valuable guidance to new hires. Advanced Health's innovative approach to hiring and retaining talent from across the nation promotes a culture of innovation. Employee benefits and work-life balance are prioritized, and the organization offers education and training opportunities. Collaboration with community partners is also a strength, supporting the needs of members effectively.

Some of the areas where Advanced Health could improve include communication. Although communication was generally seen as a positive aspect, it was mentioned that there are areas that could improve. Remote work, while advantageous for work-life balance, can pose communication and collaboration challenges. Additionally, a

need for enhanced training for both new and existing employees to ensure optimal performance was identified. Increasing the number of trained staff, particularly in the local area, could help address the growing demand for services and provide improved care for members.

Overall, Advanced Health acknowledges its strengths in terms of diversity, inclusivity, innovation, communication, and employee benefits. While there are areas of improvement, Advanced Health is committed to continuous improvement, reinforcing the dedication of fostering a diverse, equitable, inclusive, and responsive environment that is employee- and member-centric.

Attachments: Advanced Health – Health Equity Assessment_2022.12-2023.01

Organizational Health Equity

Advanced Health maintains the Organizational Health Equity Policy and Procedure which provides high-level guidance to employees to further health equity in policies, procedures, practices, and services. It is planned for a December 2023 revision date, and additional training will be provided to all staff.

Advanced Health is in process of adopting an Equity Impact Assessment Tool into the company's policy and procedure template. The proposed Equity Impact Assessment Tool was approved by both the Health Equity Steering- and Policy Review-Committees. Staff training and the revised policy and procedures template are planned for Quarter 3 2023.

Health Equity Steering Committee

The Health Equity Steering Committee continues to make efforts to bridge equity within the community. For example, in Quarter 4, 2022 the mobile shower project idea was introduced. Curry County has one shower for the public that is open once a week for a few hours. The mobile shower project idea, which is in progress to become a possible reality, would increase the number of showers within Curry County. The target population for this project is the unhoused community. Advanced Health is working alongside a community based non-profit organization to bring this mobile shower to life.

The Health Equity Steering Committee also holds space to have presentations to better support our members who may have barriers when reaching out to Advanced Health. This committee is closed to the public as Advanced Health continues to find stability within the CLAS lens. The committee has staff members who are deeply embedded in the community and attend community meetings where they hear the issues that affect members.

Year 4 Strategies

Continue with REAL-D and Employee Equity Assessment Survey data collections to further evaluate these areas. Continue with the Employee Benefits Evaluation on an annual basis to ensure equitable distribution and access for employees. And lastly, Advanced Health's HRIS data insights are planned to be rolled out in 2024.

Goal 1:

To increase the number of responses for REAL-D and Employee Equity Assessment data collection, and to consider an employee benefits survey. To utilize the HRIS's data insights to further evaluate diversity and equity amongst staff, positions, and departments.

Baseline:	Metric/Measure of success:
REAL-D 2021 – 20%, 2022 – 22%, 2023 – pending **Employee Equity Assessment** 2020 – 45%, 2022 – 32% **Benefits Survey**: none **Workforce Data Insights**: none	REAL-D increase participation: Employee: 22% to 40%, Board- and Committee Members: 25% participation goal. Employee Equity Assessment increase participation: 32% to 50%, and an established communication plan for the Equity Assessment Action plan. Benefits Survey: improved data collection, usable data to evaluate benefits Workforce Data Insights: to utilize HRIS data insights, such as genders or disability statuses in different roles (management roles for example), to evaluate workforce diversity further.

Monitoring:

REAL-D Communication Plan

1. July, August, September email communication
2. Monitor monthly submissions
3. Share progress with Health Equity Steering Committee
4. Add a “Do Not Wish to Participate” option in 2024.

Employee Equity Assessment

1. Complete review by Health Equity Steering Committee
2. Create and implement SMARTIE Goals & Action Plan
3. Communication Plan similar to REAL-D Communication Plan
4. Equity Assessment due in Q1 of 2024

Benefits Survey

1. Draft survey for HR, Finance, CEO review
2. Rollout 2024 Q2

Workforce Data Insights

1. HR preparation – 2024 Q1
2. Executive presentation – 2024 Q2
3. Action Plan – 2024 Q3

Person responsible:

Human Resources Manager

Health Equity Steering Committee (see charter for committee roster)

Board- and Committee point of contacts

Executive Leadership Team

Resources Needed:

Staff Time

Goal 2:	
To progress health equity infrastructure into each of the organization's departments.	
Baseline:	**Metric/Measure of success:**
Organizational Health Equity Policy and Procedure implemented December 1, 2021 with training provided to all staff.	Revised Organizational Health Equity Policy and Procedure with updated training and technical assistance for all staff.
Monitoring:	**Person responsible:**
Policy revision due December 2023	Executive Program Director Equity Policy Analyst Human Resources Manager CLAS Champions
Resources Needed:	
Staff time	

Section 2: Annual Training and Education Report (2-page maximum)

Attestation:

Has the CCO adopted the definition of Cultural Competence set forth in OAR 943-090-0010 and is utilizing it to guide its development of cultural responsiveness materials and topics in its Cultural Competence Continuing Education training activities into its training plans for Health Care Professionals?

☒ **Yes** ☐ **No**

In an ongoing commitment to promoting cultural responsiveness, addressing implicit bias, and fostering inclusive communication, Advanced Health has maintained the organization's education plan and training opportunities for its employees, board and committee members, and provider network. This plan enhances cultural awareness, sensitivity, and understanding among CCO staff and healthcare providers, enabling the delivery of equitable care and support to all individuals served.

Through the following continuous efforts and updates to our employee and provider network education plan, Advanced Health is committed to cultivating a culture of cultural responsiveness, addressing implicit bias, and focusing on a health equity infrastructure. By fostering understanding, self-reflection, and continuous learning, Advanced Health is dedicated to delivering equitable, patient-centered care to individuals from diverse backgrounds. Advanced Health will continually assess and enhance health equity initiatives to ensure that cultural responsiveness and health equity remain central pillars of the organization's values and practices.

Annual and New Hire Comprehensive Training Modules: Advanced Health offers a series of comprehensive training modules that focus on cultural responsiveness, covering topics such as diversity, equity, and inclusion (DEI), implicit bias, culturally and linguistically appropriate services, language- and disability- accessibility, communication, and discrimination and harassment prevention. Advanced Health requires all employees to complete the list of approved training modules upon new hire and on an annual basis.

Attachments: Mandatory Education_2023, Mandatory Education/Training Policy, Staff Training & Development Policy, Required Staff Training 21 - 23

Employee Lunch and Learn Opportunities: To foster a collaborative learning environment, Advanced Health continues to offer monthly Lunch and Learn events. These regular learning forums and group discussions offer learning opportunities to learn more about the CCO and its requirements, department activities and goals, and network with fellow employees. Many times, as seen in the Lunch and Learn schedule, the topics are health equity-related. These sessions promote understanding of the CCO's approach and how everyone can contribute to the company's adoption of health equity as an infrastructure.

Attachments: Lunch and Learn Lookback and 2023 Schedule

Diversity and Health Equity Event Sponsorship: Recognizing the impact of Advanced Health's support for the local South Coast Diversity Conference, continuing sponsorship of the event has occurred in 2022 and 2023, and is planned for the future. The South Coast Diversity Conference offers interactive workshops and learning tracks to bring "…diversity, equity, and inclusion training in a collaborative effort by sharing resources of multiple organizations to offer our region an engaging and educational experience". These workshops promote self-reflection and provide strategies to recognize and mitigate implicit biases that may influence decision-making and treatment of people with diverse backgrounds, abilities, and access.

Advanced Health sponsored 35 individuals to attend, opening up scholarship opportunities for network providers and their staff that were interested in attending. Initial RSVP's included twenty Advanced Health staff, including two executive leadership members, and fifteen network providers and staff members.

Attachments: South Coast Diversity Event Guide Final, Annual South Coast Diversity Conference 2023

Health Equity Fair: During the Health Equity Fair in Coos Bay (Coos Restoring Hope) free immunizations, vouchers for birth certificates, and HIV testing (located in a private office location within the mall) were provided. There were 25 vendors from a variety of organizations, business programs, hospice, child and youth organizations, substance use disorder programs, Pride, and Homeless programs. Our local clinic, Waterfall clinic signed up families for free dental care and Bay Area Ambulance provided blood pressure checks. Spanish translation serves were provided by Advanced Health. A total of 227 food vouchers were handed out to fair attendees and 134 passports were given to each family in Coos County.

During the Health Equity Fair in Curry County (Catch the Wellness Wave), the System of Care information booth volunteers handed out Help the Help Guidebooks for families and Cultural Diversity Books (English and Spanish) which were donated by Advanced Health. Advanced Health also donated Helmets which were part of the prize giveaways. There were 66 families who attended, 86 cultural diversity books handed out, and every child, youth, and family left the festival with something from every vendor. It was the first in person event since COVID and the networking and collaborating provided a day of community healing.

Board of Director's Cultural and Linguistic Appropriate Services Training Overview: In July 2022, Advanced Health conducted a CLAS Standards training session for the Board of Directors. The training covered what, why, and provided insights on how to implement CLAS Standards within a healthcare organization.

Attachments: July 22 Board Pkt Add – CLAS Standards Discussion

Employee Resource Library: Advanced Health has established an online resource library that includes articles, videos, and online courses on cultural responsiveness, implicit bias, and health equity. This resource repository serves as a reference for staff to further deepen their knowledge and understanding of these important topics. Some examples include:

2023

- Advancing Equity in Collective Impact
- How Implicit Bias Impacts Healthcare Delivery & What You Can Do About It
- History of Racism in US Healthcare: Root Causes of Today's Hierarchy and Systems of Power

2022

- Limited English Proficiency Cultural Competency
- Health Literacy and Clear Communication for CCO's
- Collaborative Problem Solving (ACE's, trauma-informed practices)
- Using REAL-D Data to Advance Health Equity

Attendance of these trainings is not currently being tracked. Review of requiring attendance for certain employee populations will be considered for 2024.

Performance Evaluation and Feedback: Advanced Health added an equity-related question to the 2022 Employee Performance Review, asking the manager to review whether the employees meets the following expectation: "Employee identifies health equity-related activities within their scope of work and the organization's commitment to health equity". In summary, all employees met or exceeded this expectation. Next steps for this equity-related workforce objective will be to continue to include in performance reviews to get another year of baseline information, while addressing any unmet expectation with additional training or resources. This encourages accountability and reinforces the importance of ongoing professional development in the area of health equity.

Provider Learning Opportunities: Advanced Health continues to offer CEU-accredited learning modules for the provider network and their staff. The online, self-guided learning modules address cultural responsiveness, implicit bias, and strategies for delivering culturally sensitive care.

Course objectives include an interactive approach designed to equip mental health care professionals with the necessary skills to engage effectively with diverse individuals throughout the entire care process, from diagnosis to ongoing management of mental health conditions, with a specific focus on depression; to address key Hispanic/Latino population data, healthcare disparities, and offers person-centered strategies to establish strong relationships and explore cultural traditions and beliefs related to healthcare; equip clinicians with the skills to effectively navigate cross-cultural issues and negotiate care management plans using the ResCUE Model™, and address legal requirements for healthcare organizations to provide interpreters and translated materials for patients with limited English proficiency (LEP).

2022 – Cross-Cultural Care in Mental Health & Depression, Working with Specific Populations: Hispanic/Latino

2023 – ResCUE Model for Cross-Cultural Clinical Care, Ensuring High-Quality Care for Patients with Limited English Proficiency

Attachments: QIFlyer_Mental Health, QIFlyer_HispanicLatino, Course Flyer – ResCUE Clinical, LEP Course Flyer