Section 1: Transformation and Quality Program Information

A. CCO governance and program structure for quality and transformation:

i. Describe your CCO's quality program structure, including your process for developing and implementing your TQS:

Columbia Pacific CCO (CPCCO) is a wholly owned non-profit subsidiary of CareOregon and has two contracts with CareOregon: one to provide administrative and health plan services to the CCO and the other to manage the insurance risk for physical and behavioral health services and NEMT. In the context of the Transformation and Quality Strategy (TQS), CPCCO is ultimately accountable for the submission of the TQS as a CCO contractual requirement, but responsibility for each of the TQS components is determined by the administrative agreements between CareOregon and the CCO. CareOregon administers the following health plan services to CPCCO for physical and behavioral health and NEMT: utilization monitoring, quality of care outcomes, member services including translation and interpreter services, grievance system inclusive of complaints, notices of actions, appeals and hearings, provider relations and quality monitoring, monitoring and enforcement of consumer rights and protections, and assessment of the effectiveness of the fraud, waste and abuse program. CareOregon also supports and administers the CPCCO IT infrastructure, assures and monitors network adequacy, administers value-based payment models, and supports the Equity and Diversity plans of CPCCO. CareOregon is responsible for ensuring that all CareOregon and CPCCO delegates are provided appropriate oversight and are operating in full compliance with state and federal regulations. The CPCCO Board receives reports from CareOregon at least annually that include but are not limited to: Monitoring, Delegation Oversight status and any relevant Corrective Action Plans, outcomes of the state External Quality Review, health plan operations compliance dashboard, and the progress of the TQS. The CPCCO Medical Director sits on the CareOregon Quality Management Committee (described below) to provide alignment between CPCCO and CareOregon.

The CPCCO Board of Directors oversees the development and implementation of the strategic plan for CPCCO and is accountable for setting performance expectations for the CCO, which include metrics for quality and transformation. The Clinical Advisory Panel (CAP), at the direction of CPCCO Board's Network and Quality Committee, provides the strategic leadership and direction for clinical transformation. The CAP ensures CPCCO's clinical transformation efforts and quality priorities are strategically aligned with those of its constituent organizations, the CPCCO community advisory councils as well as the CPCCO board, and that these efforts have the active support of clinical and executive champions at the highest organizational and community levels. The CAP has developed a strategic approach to quality that combines the CPCCO Board's strategic plan, the state mandated TQS components, clinical priority initiatives, and Performance Improvement Projects (PIPs) into a defined set of well-articulated goals to improve and transform the health and wellness of the CPCCO population.

The annual CPCCO TQS process leverages the CareOregon quality governance structure and staffing to ensure CPCCO consistently meets its contractually required OHA deliverables. Senior CareOregon staff partner with CPCCO leadership team and CareOregon department leaders to interpret the TQS requirements, establish timelines for completion, and ensure that TQS projects, programs, and performance improvement activities are aligned with the applicable OHA guidance and CCO contractual language. The CPCCO Project Manager is responsible for creating content and overseeing deliverables for programs included in the TQS. The TQS is reviewed and executed by the Columbia Pacific CCO Clinical Advisory Panel (CAP) and, for relevant work, CPCCO's local Community Advisory Councils (CACs).

ii. Describe how your CCO uses its community health improvement plan as part of its strategic planning process for transformation and quality:

CPCCO conducted a value-based community health needs assessment in Clatsop, Columbia and Tillamook Counties in 2018 and 2019. The assessment was created and implemented using a participatory process

that was trauma informed, equity oriented and included key community stakeholders who support health and wellbeing from the health care and social safety net sectors, health plan members, public health and others associated with providing and facilitating good community health.

Our unique approach, yielding qualitative and quantitative data, involved conducting a value-based narrative survey and completing community presentations focused on collecting and hearing from community members their experiences of health and well-being (and participants' visions of the future related to the experience they shared) allowed CPCCO and our partners to collect the experiences of community members in their own voices. This process gave a framework of meaning related to not only health care needs but also the social determinants of health and health equity.

Over 1,250 narratives were collected over a six-week period in October and November 2018, at 33 sites (including an app and on-line option at the CPCCO website) in Clatsop, Columbia and Tillamook Counties in the fourth quarter of 2018. Paper, app and on-line options were offered in Spanish and English. Results were analyzed and workshop was held with community partners and health plan members to review and theme including reviewing survey responses from Latinx and American Indian community members.

The process allowed CPCCO and their community partners to prioritize community driven strategies for the regional health improvement plan, empower community members and health plan members to participate in the prioritization process, amplify service user voices and the perspective of health plan members with a special focus on Latino and Tribal communities, promote health equity in the community, promote collaboration across the coalition of partners seeking similar goals, and create an on-going data base of community and health plan member voice to be used by key community stakeholders making decisions about services and investments in health improvement.

One area where equity was assessed in the value-based narrative survey was through asking for the "attitudes" of participants if they felt everyone should be treated the same, diversity is good, or some people are worth more than others. Overall, respondents who were American Indian/Alaska Native or Latinx had a strong leaning toward "everyone should be treated the same".

Additional analysis of Latinx/American Indian status where the story topic was dental, healthcare or mental health narratives revealed opportunities to walk together through good customer and trauma informed customer services, support increased access to internet information and free/low cost supports for eating healthy, increase the number of advocates/navigators available to members, increase help for people to access supports in a way that's meaningful, support the increase of services through Community Action programs, and to stop separating OHP health plan members from the conversation thereby reducing stigma/differences through doing something that is the same for everyone.

In the first quarter of 2019, 16 community presentations were conducted including results of the CPCCO led value based narrative story collection, population health indicators using rural health and state/national data, social determinants of health data, research related to evidence-based practice, the impact of social determinants of health and trauma informed care. Presentations were held at a variety of locations to a variety of audiences. Some were open forums arranged by Columbia Pacific, and many were existing open or closed meetings such as Community Advisory Council meetings, Hispanic/Latinx parents with the Migrant Education Program, Tillamook County Wellness Task Force meeting or Early Learning Hub Leadership Council.

With input from the public presentations, final selection of the eight priority areas of the Regional Health Improvement Plan were made by CPCCO's Regional Advisory Council (with input by the three local councils). The Regional CAC also included the partners who signed Letters of Agreement to collaboratively develop a

regional community health needs assessment across hospital, federally qualified health centers/rural health clinics, behavioral health, public health, Tribal, and coordinated care organization stakeholders.

Needs assessment and health improvement plan LOA signers:

Clatsop	Columbia	Tillamook
Columbia Memorial Hospital	Columbia Community Mental Health	Tillamook Public Health Department
Providence Hospital	Columbia Public Health Department	
Clatsop Behavioral Health Care		
Clatsop Public Health Department		

iii. Describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, community mental health programs, local government, tribes, early learning hubs) to advance the TQS:

Regional Health Improvement Plan

The 2019 Regional Health Improvement Plan (RHIP) and associated eight priority areas for 2020-20204 has been adopted as the community health improvement strategy in all three counties of the CPCCO service area. Clatsop and Columbia County's Board of County Commissioners adopted the RHIP through Resolution and Order affirming their commitment to support the regional health assessment and regional Health improvement plan county wide. Tillamook Counties Public and Environmental Health Department Health Advisory Council adopted the RHIP as the plan for Tillamook County.

CPCCO in partnership with public health departments, hospitals, outpatient clinics and community mental health programs are collaborating on meeting the goals, objectives and strategies of the RHIP. CPCCO, in partnership with their Clinical Advisory Panel has developed key strategic initiatives in order to achieve the RHIP goals. This includes agreement on what indicators will be evaluated as demonstrating progress towards meeting the goals of each priority area. The RHIP Dashboard will be shared quarterly with our community partners and key stakeholders to communicate the progress towards meeting the goals of the Regional Health Improvement Plan.

PRIORITY AREA	MEASURE
Community Resilience and Trauma Informed Care	1. Number of organizations participating in the Trauma Informed Network 2. Number of individuals trained in Trauma Informed Care
Access to Care: Primary Care	3. Percent of health plan members seen versus assigned: Adults 4. Percent of health plan members seen versus assigned: Pediatric
Access to Care: Behavioral Health	1. Behavioral health penetration by county (including CMHP, primary care and other): Adults 2. Behavioral health penetration by county (including CMHP, primary care and other) : Pediatric

Access to Care: Oral Health and Dental Care	1. Oral health access for 0-14-year-old on Oregon Health Plan 2. Oral health access for adults on Oregon Health Plan
Access to Care: Social Safety Net	1. Number individuals served by community help desks. 2. Number of partners actively participating in Unite Us network
Chronic Disease Prevention	1. # Individuals or families served by funded programs 2. Individuals per 1,000 whole population accessing harm reduction services
Suicide Prevention	1. Number of individuals trained to train QPR, ASSIST and RESPOND 2. Number of people trained in QPR, ASSIST and Respond
Housing	1. Number of projects invested in housing stock, house-lessness services, and supports 2. Number of health plan members receiving housing supports or housing through funded projects

Childhood Trauma Informed Networks

Based on research and the feedback from the community through the health needs assessment process, the first area of CPCCO's eight priorities in the Regional Health Improvement Plan is Community Resilience and Trauma Informed Care (pages 42 & 43 of the plan). The goal of this priority area is to increase the number of programs, organizations, and sectors aware of the trauma informed perspective and its relation to engaging individuals (including children and adolescents) in the services and supports for those experiencing health disparities.

CPCCO believes that the promotion of health and prevention and early intervention for children and adolescents can be supported by increasing the number of organizations committed to trauma awareness for their service recipients and within their workforce. This in turn has a health equity impact in that adverse childhood experiences which are a root cause of ill health (and can further exacerbate health disparities) can be addressed through increasing the number of community-based organizations providing trauma informed services. CPCCO has invested in supporting the development of Trauma Informed Networks in two of the three counties in the service area with plans of starting work in the third county in 2021. Currently there are 44 organizations in two counties who have signed agreements to work together on developing the strategic plan for the networks and to support on-going efforts, leverage funds for training and implementation of trauma informed practices in their respective organizations.

B. OPTIONAL

i. Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS:

CPCCO is a wholly owned non-profit subsidiary of CareOregon. Founded in 1993, CareOregon is a nonprofit, community benefit company serving over 300,000 Oregon Health Plan and Medicare members and their communities with integrated managed care services. In addition to a owning Two CCOs, a

Medicare D-SNP plan, CareOregon Dental, and HouseCall Providers (HCP), CareOregon manages the physical health benefits for a majority of the HealthShare CCO and the behavioral, oral and NEMT benefits for all HealthShare members, maintains collaborative relationships with all nine Sovereign Tribal Nations and NARA, providing care coordination and culturally appropriate services for approximately 18,000 tribal members them across the state. Together, the collective organizations and programs that comprise CareOregon focus on the total health of low-income, disabled and marginalized members, over and above traditional health care. CareOregon connects with members, their families, providers and communities to help Oregonians prevent illness, respond effectively to health issues and live better lives.

CareOregon's Quality Management Program is operationalized through the Medical Management division at the direction of the Chief Medical Officer, who is delegated by the CareOregon Board to be the accountable executive of the quality program. This accountability occurs through CareOregon's Quality Management Committee (QMC) as well as through integrating responsibility for quality in key positions throughout the organization, including (but not limited to):

- CMO
- Vice President, Health Services Operations
- CCO Medical Directors and Dental Director
- Vice President, Pharmacy
- Vice President, Behavioral Health and Integration
- Vice President, Network and Clinical Services

The CPCCO Medical Director sits on the CareOregon QMC to provide alignment between CPCCO's Board, CAP, CACs and Leadership team, and CareOregon.

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. Project or program short title: Access: Quality of Care Pilot

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

B. Components addressed

i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. Background and rationale/justification:

The purpose of the Quality Pilot Funding is to incentivize and ensure resources for clinic partners to lead improvement projects that specifically address CCO Incentive measures that need additional efforts or resources allocated, those that are, for example, historically challenging, a CCO priority, or new measures.

D. Project or program brief narrative description:

The 2019 quality pilot funding was available for clinics proposing improvement projects related to the following topics:

- Chronic diseases (must include Diabetes Poor Control or Controlling High Blood Pressure)
- Tobacco Cessation
- Maternal Child Health (Developmental Screening and follow-up, Childhood Immunization Status, Timeliness of Prenatal/Postpartum Care, Adolescent Well Care, or Effective Contraceptive Use)

Five clinics participated in the 2019 quality pilots. The clinics collectively represent 48.5% of all CPCCO members. The pilots focused on:

- Adolescent Well Care – 2 clinics
- Controlling High Blood Pressure – 2 clinics
- Diabetes Control – 1 clinic

Final project reports detailing pilot outcomes were due 2/28/2020. 3 out of the 5 clinics met pilot targets. Reports were reviewed by CPCCO clinical team staff and individualized feedback and continued technical assistance will be provided to each clinic throughout 2020. Learnings from the pilots will be shared in Quality Improvement Workgroups, a cross-regional monthly learning collaborative focused on metrics and quality improvement principles.

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

Activity 1 description (continue repeating until all activities included): Add text here

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Percent of clinics who met stated pilot goals

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	100%	2/28/2020	N/A	N/A

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

F. **Project or program short title**: Access: Applied Behavioral Analysis (ABA) Providers

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

G. **Components addressed**

i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Special health care needs
iii. Component 3 (if applicable): Access: Quality and adequacy of services
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

H. **Background and rationale/justification**:

There is currently an identified need for increasing the number of ABA provider in the CPCCO service region. The need/demand for ABA services, specifically in Columbia County and Clatsop County, currently outpaces provider capacity. Additionally, the majority of ABA providers in Oregon operate on a business model that is focused on 'center-based' services. In rural communities, there is need/demand for ABA, but not always enough total referrals at any one time for providers to reach 'economy of scale' for establishing a brick-and-mortar ABA program in each local community.

OHA Transformation and Quality Strategy (TQS) CCO: Click here to enter text.

Given the lack of local providers, CCOs in rural regions typically contract out-of-area ABA providers (e.g. in Portland metro area), which requires members to utilize NEMT or transport themselves to those services.

I. Project or program brief narrative description:

In order to address the gap in ABA services; CPCCO is carefully tracking/monitoring all requests for ABA services and analyzing the demand for these services in each county. In 2020, CPCCO has also undertaken efforts to contract with additional facility-based providers in Portland Metro area which will have the net result of increasing access. Most importantly, in 2020 CPCCO is launching pilot which is collaborative partnership between two different providers to deliver in-home ABA services in Columbia County.

J. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
1 total Facility-Based ABA Provider contracted w/ CPCCO	Add 1 Additional Facility-Based ABA Provider contracted w/ CPCCO	6/30/2020	Overall increase in access/throughput for ABA services for CPCCO members	12/31/2020

Activity 2 description: Add text here

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current in-home ABA services available in Columbia County	Start Pilot serving children for in-home ABA services in Columbia County	5/30/2020	Pilot will provide ongoing in-home ABA services to 3-4 children in Columbia County	12/31/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. Project or program short title: Access: Seaside Recovery Center

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

B. Components addressed

i. Component 1: Access: Quality and adequacy of services

ii. Component 2 (if applicable): Access: Timely
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Since 2015, CPCCO has been collaborating with our regional partners to address the opioid epidemic, which we now have expanded to include all substance use disorders (SUD). A large part of this is expanding access to SUD services, including medication assisted therapies. We have partnered with multiple local primary care organizations and one behavioral health organization to support them financially and operationally to start MAT programs within their organizations. This has greatly expanded access to outpatient medication services for people with SUD. At the same time, we had evaluated our NEMT data, and discovered that a significant portion of our population with opioid use disorder was driving from our service area into Portland or Salem every day to receive methadone treatment for OUD. This was a bug cost on the system, as well a huge burden to their lives. Given that, and the need to broaden our continuum of care for SUD, we partnered with CODA to start an opioid treatment program in Seaside, OR.

D. **Project or program brief narrative description**:

CPCCO partnered with CODA to build and open an opioid treatment program (Seaside Recovery Center) in Seaside, OR. This program opened the end of January 2020, as allows for an increase in access to treatment for SUD. With the advent of this program, the region now has a higher level of care option for members with more complex needs. This program also serves as an important referral source and consultation service for our other organizations providing MAT and SUD treatments. With this program, we can offer quick and easy access to SUD services in a way that never existed before. This can transform the lives of members who have previously had to drive daily 2 hours each way to get the same services, as well as greatly improve treatment options at large for the region.

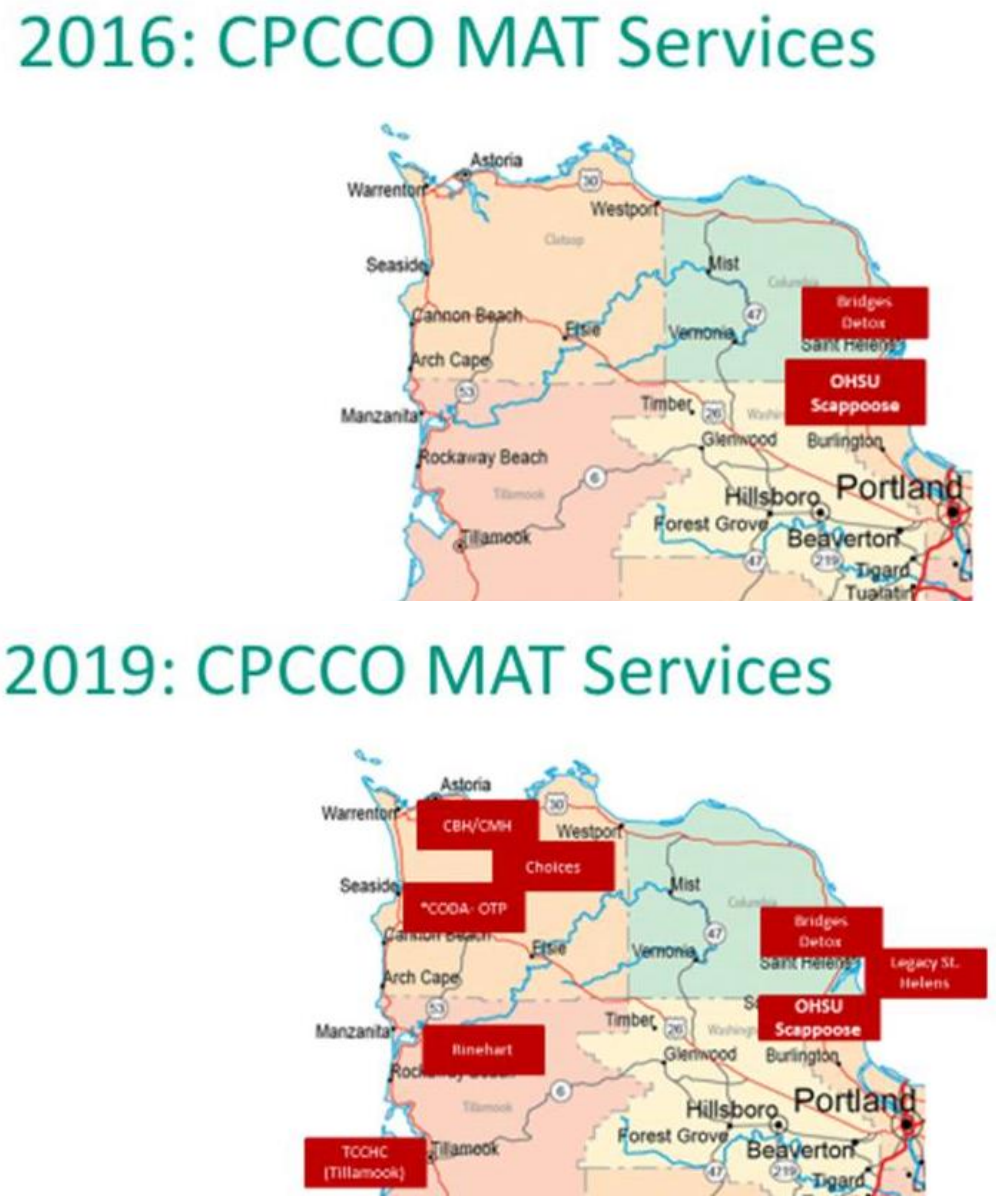
E. **Activities and monitoring for performance improvement**:

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☐ Long term

Monitoring activity 1 for improvement: Number of members served through the program

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	250 unique patients	12/31/2020	250 unique patients	12/31/2020



Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Access: NEMT Improvement Plan

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

B. **Components addressed**

i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Access: Timely
iii. Component 3 (if applicable): Choose an item.

iv. Does this include aspects of health information technology? ☒ Yes ☐ No

v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education

☒ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

CPCCO's geographic region poses a lot of transportation barriers for accessing care. There is a limited transportation infrastructure within our counties, which is exacerbated by insufficiencies in our in-area provider network for oral, behavioral, and physical health. CPCCO members regularly need to leave their counties for care and the most vulnerable often need to rely on our NEMT benefit to access that care.

D. **Project or program brief narrative description**:

CPCCO is working to optimize our care coordination and NEMT teams to improve our NEMT benefit. Our transportation brokerage's capacity is often limited by inadequate details from providers and/or members that are scheduling rides, inadequate lead time, and poor understanding of the benefit by clinical providers. In building up our NEMT and care coordination teams CPCCO hopes to better coordinate the transitions of care that require transportation and enhance the technical assistance we are able to provide to our brokerage and clinical providers.

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

Activity 1 description (continue repeating until all activities included): To enhance our NEMT team we would like to increase the number of staff, develop an operational definition of network adequacy for NEMT within our region, and eventually bolster our brokerage's volunteer drive program.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Increase staffing of NEMT team.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
9 transportation coordinators	11 transportation coordinators	4/30/20	Develop monthly workgroup meetings	12/31/20

Activity 2 description: Build up our care coordination team's ability to proactively case find members being discharged who need NEMT and proactively connect them to the NEMT brokerage.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Develop a workflow using HIT to identify discharging members, outreaching to clinical providers for discharge plans, and connecting the brokerage to this information for efficient transportation planning.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No proactive case finding	Proactive case finding workflow developed	8/30/20	Proactive case finding workflow implemented	12/30/20

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Access: Interpreter Training

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

B. **Components addressed**

i. Component 1: Access: Cultural considerations
ii. Component 2 (if applicable): CLAS standards
iii. Component 3 (if applicable): Health equity: Cultural responsiveness
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

More than 25 million Americans speak English, "less than very well," according to US Census Bureau. This makes it harder to access health care and puts patients at great risk of adverse outcomes such as drug complications and decreased patient satisfaction. Title VI of the Civil Rights Act, 1557 of ACA, and OHA mandate that interpreter services be provided for patients with Limited English Proficiency (LEP) who need this service. Despite this requirement we have found a lack of interpreter utilization for patients in our region.

Upon investigation with clinics, community-based organizations, members, and interpreters it was determined a big barrier was the lack of professional certified or qualified interpreters in the region and the lack of training availability in the region. For an interpreter to become qualified or certified they must pay up to $1000 and take 60+ hours to complete coursework, and for rural interpreters that want an in person training they must travel to a large metropolitan area. For many these barriers may be insurmountable. This project meets CLAS standards 5-8.

D. **Project or program brief narrative description**:

To help mitigate the travel and cost we will provide a local training free for interpreters that will serve our members in clinic, with our interpretation vendors, or at community-based organizations. In addition, we will reimburse for Language Proficiency Testing and testing for certification. Simultaneously we will be educating the providers and members on the requirements for interpretation, the resources we have available and how to access them. On a monthly basis we will review interpreter utilization at each contracted clinic in our region to monitor for increases.

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

Activity 1 description (continue repeating until all activities included): Monitor each organization monthly to determine if they are utilizing interpreter services.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: # of local organizations utilizing interpreter services or sharing their interpretation data on CPCCO patients

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
3	6	12/31/2020	9	06/30/2021

Activity 2 description: Monitor # of certification/qualified interpreters in the region

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: # of qualified or certified interpreters in region

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
3	10	12/31/2020	15	06/30/2021

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Access: Cultural Considerations: Alternative Payment Methodology (APM) Equity Narrative

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

B. **Components addressed**

i. Component 1: Access: Cultural considerations
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Columbia Pacific CCO (CPCCO) launched a new alternative payment methodology for primary care partners in 2020 that aligns with state and national level efforts to achieve the triple aim of health care and encourage movement away from traditional volume-based health care payments. The (PCPM) program was designed to invest in critical services that are not adequately represented by fee for service (FFS) models.

One component of the program was designed to begin holding primary care partners accountable for advancing equity. The pursuit of the highest standard of health for all people is the heart of CPCCO's values and mission. We recognize that the process of achieving health equity includes the intentional deployment of resources to identify disparities and redress them when found. It also requires giving special attention to the needs of those at greatest risk of poor health, based on social conditions and socially defined constructs, such as racial categories, language and poverty. In this program, we ask that clinics work to improve language access systems and processes for Limited English Proficient CPCCO members.

D. **Project or program brief narrative description**:

Clinics participating in the 2020 PCPM must submit a narrative report that describes their activities to advance language access, through process or policy, and increase the provision of services in a member's preferred language. This is a reporting only requirement that will be passed provided that the clinic submits the equity narrative report, responds fully to each section and demonstrates advancement of project activities.

The payment methodology for the 2020 PCPM program is structured so that if a participating clinic's equity narrative report does not meet all requirements, that clinic's payment is reduced by one level (from $8.10 PMPM to $4.95 PMPM, from $4.95 PMPM to $3.05 PMPM, and from $3.05 PMPM to $0 PMPM) depending on their performance on all other clinical quality measures.

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

The clinics participating in CPCCO's 2020 PCPCM program collectively cover 70.3% of all CPCCO members; thus, this program will have potential impact for the majority of CPCCO members. Participating clinics must submit the equity narrative twice per measurement year: a mid-year report covering activities from January – June that is due in August 2020, and a final report covering activities from July – December that is due in February 2021.

The percentage of clinics who meet equity narrative requirements will be tracked for each reporting cycle. Narrative reports will be evaluated qualitatively and assessed by type of intervention (e.g. policy or process) to ensure activities will result in meaningful improvements.

Activity 1 description (continue repeating until all activities included)

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Percent of clinics meeting equity narrative requirements.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0% - new activity	60%	8/31/2020	100%	2/28/2021.

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Access: Timely: Dental Vans

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

B. **Components addressed**

i. Component 1: Access: Timely
ii. Component 2 (if applicable): Oral health integration
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

CPCCO covers a large geographical region with widely dispersed dental clinics. This requires many members to travel significant distances to a clinic that accepts our insurance.

D. **Project or program brief narrative description**:

Make use of mobile dental vans to make dental services more accessible. These mobile clinics will be co-located at primary care locations to provide members with opportunities to receive more care in a single location and/or receive oral health care closer to their locations.

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

Activity 1 description (continue repeating until all activities included): Add text here

☒ Short term or ☐ Long term

OHA Transformation and Quality Strategy (TQS) CCO: Click here to enter text.

Monitoring activity 1 for improvement: Continue mobile dental services in Columbia county and pursue better integration with primary care.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Mobile Clinic is available 1day a week at OHSU Scappoose & 2 days a week at Legacy St. Helens	Build workflow for CPCCO care coordinators to collaborate with DCOs so members can receive integrated care..	04/2020	CPCCO Panel Coordinators actively collaborating with DCOs so members can receive co-located care.	05/2020

Activity 2 description: Launch integration pilots in our other two counties to replicate what we have established in Columbia County.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Mobile dental clinic acquired in Tillamook but not operationalized, no integrated strategy for Clatsop	Operationalize mobile clinic in Tillamook and convene FQHC, CMHP, and local dental provider in Clatsop to develop an integrated strategy	08/2020	Operational mobile clinic in Tillamook that provides full integrated care: oral, physical, and behavioral health. Launch integration pilot in Clatsop County	12/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Behavioral Health: MAT Collaborative

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

B. **Components addressed**

i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Patient-centered primary care home
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

The North Coast region of Oregon has one of the highest rates of opioid use disorder (OUD). CPCCO has heard through its close network partnership that primary care and specialty behavioral health are struggling with

Medication for Addiction Treatment (MAT) work and treating substance use disorders (SUD). CPCCO wants to create access to MAT and expand on a service that was non-existent in the region just several years ago. There is further opportunity to advance medical neighborhood integration in addressing OUD with MAT services. CPCCO seeks to advance and standardize regional practice. Regional data demonstrates the need to focus on expanding access to OUD care and changing prescribing practices. There are anticipated cost savings reduced mortality implications for this work as well as increasing provider satisfaction. Ultimately CPCCO sees the opportunity to make a generational impact on SUD care in the region.

D. **Project or program brief narrative description**:

CPCCO has developed a learning collaborative series which aims to increase the number of CPCCO Network Primary Care Medical Homes and specialty behavioral health providers that provide MAT. The learning collaboratives also seek to establish community standards for MAT and support care teams to build or expand sustainable, effective MAT programs so that the total number people receiving MAT is increased.

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

Activity 1 Description: Columbia Pacific CCO Behavioral Health Innovation Specialist and Senior Clinical Coordinator of Pharmacy will host a 7-part learning collaborative series with primary care, specialty behavioral health and other community partners that focuses on operationalizing Medication for Addiction Treatment (MAT).

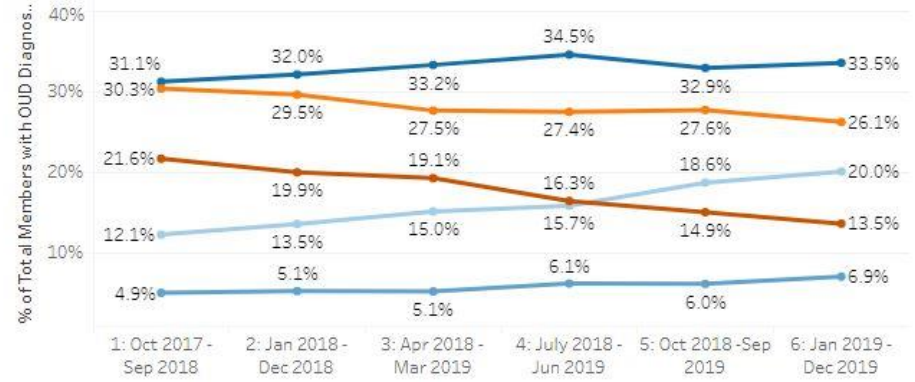
The following topics will be covered:

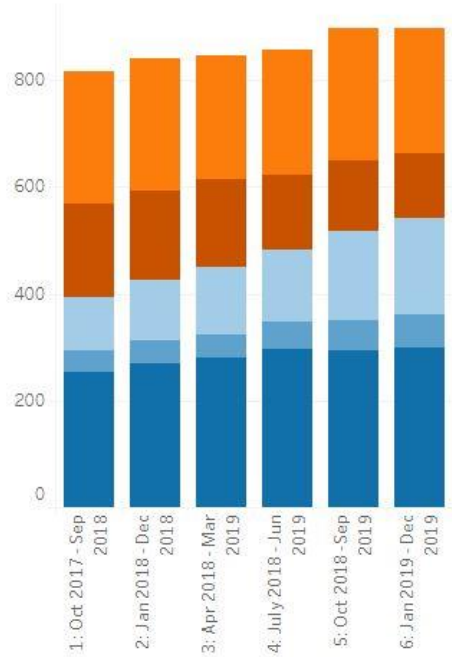
- MAT 101
- Data Waiver Training
- Harm reduction
- How to utilize peers and other community resources
- MAT Workflows
- Trauma Informed Care
- Co-Occurring Substances
- Co-Occurring Diagnoses
- Prescribing during pregnancy and breastfeeding
- Neonatal Abstinence Syndrome and Eat Sleep and Console
- Chronic Pain and Complex Dependency
- Provider Burnout
- Initiation and Engagement with Treatment/SBIRT (CCO Metrics)

Monitoring activity 1 for improvement: Number of members who are highly engaged on Medication for Opioid Use Disorder as monitored by their medication possession ratio (MPR).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
33.5%	36.5%	(12/2020)	36.5%	(12/2020)

	1: Oct 2017 - Sep 2018	2: Jan 2018 - Dec 2018	3: Apr 2018 - Mar 2019	4: July 2018 - Jun 2019	5: Oct 2018 -Sep 2019	6: Jan 2019 - Dec 2019
No Treatment	30.27%	29.52%	27.54%	27.39%	27.62%	26.12%
SUD Only	21.57%	19.88%	19.15%	16.32%	14.92%	13.50%
MAT Initiation	48.16%	50.60%	53.31%	56.29%	57.46%	60.38%





Enrollment of at least 6 months or diagnosis within last 6 months of period.
If MPR gt 0 and MPR <.5 then engage='Early/Low/Drop'; else if MPR ge .5 and MPR lt .75 then engage='Moderate'; else if MPR ge .75 then engage='High';

Activity 2 description: Attendees

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Number of total participants in the MAT learning collaborative series during 2020

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	210	(12/2020)	210	(12/2020)

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: CLAS Standards – Internal Language Access Assessment

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

B. **Components addressed**

i. Component 1: CLAS standards
ii. Component 2 (if applicable): Access: Cultural considerations
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Effective communication is critical to ensuring understanding, empowering patients, and providing high-quality care. A language access plan can help ensure that an organization provides high quality and appropriate language services. A

language access plan can also help ensure that an organization's staff members are aware of what to do when an individual with limited English proficiency needs assistance. This project meets CLAS standards 5-8.

D. **Project or program brief narrative description**:

CPCCO will assess our current language access plans to ensure persons with limited English proficiency have meaningful access to our programs. A cross departmental team will complete an organizational assessment to determine areas for improvement with the organizational language access plan. This assessment will focus on the below components of Language Access Plan.

- Needs Assessment for members
- Language Services we provide
- Notices for patients and providers
- Training of staff and network
- Evaluation and ongoing monitoring of plan

Following this assessment CPCCO will roll out changes to network and internal organization.

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

Activity 1 description (continue repeating until all activities included): Add text here

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Completed organizational assessment by each contributing department

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	9	12/2020	n/a	n/a

Activity 2 description (continue repeating until all activities included): Add text here

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: All CPCCO Staff Trained on Language Access Plan

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	35	06/2020	n/a	n/a

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: CLAS Standards – Baseline Assessment

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

B. **Components addressed**

i. Component 1: CLAS standards
ii. Component 2 (if applicable): Access: Cultural considerations
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Having meaningful language access is a fundamental strategy for any health system organization to ensure equity in the delivery of healthcare and ultimately elimination of health disparities for our limited English proficient, Deaf, hard of hearing, speech impaired, and for our blind patients. In order to get an idea of current state we will partner with organizations to perform a baseline assessment. The findings in the assessment are important in helping the region identify areas for improvement. This project meets CLAS standards 5-8.

D. **Project or program brief narrative description**:

Contracted interpreters will perform a baseline assessment (secret shop) clinics in Columbia Pacific network. Interpreters will visit and call organizations request information about services as if they were a patient with Limited English Proficiency. During the assessments the interpreters evaluate their interactions with frontline staff. Looking at the following items;

- Communication about interpretation availability
- Availability and language diversity of required signage and documents.
- Ease of access
- Knowledge of staff
- Effectiveness

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

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Clinics with completed baseline assessment report

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	5	12/2020	10	12/2021

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Improved access to grievances and appeals for members with Limited English Proficiency

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

B. **Components addressed**

i. Component 1: Grievance and appeal system
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

CareOregon administers CPCCO's grievance and appeals processes. Late in 2019, CareOregon conducted a study of its dual-eligible population that analyzed two years of grievance data that was grouped by age, ethnicity, and (when possible), primary language. The data suggest that non-white, non-English speakers are far less likely to complain (file a grievance) than members who are white and speak English. By extension, CareOregon extrapolated that this likely made them less likely to appeal as well. As the CareOregon Member Engagement Coordination Committee reviewed these findings, it prompted a discussion about whether or not the translation and interpretation services in place were adequately providing all members (both dual-eligible and OHP) with LEP adequate access to the grievance and appeal processes to which they are entitled.

D. **Project or program brief narrative description**:

On behalf of CPCCO, CareOregon will develop and implement a process to assess and improve the accessibility, accountability, and quality of language assistance as it relates to grievances and appeals.

Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): CareOregon will conduct an analysis of CPCCO grievance and appeals data and processes to understand if the lower rates of grievances and appeals among members with LEP observed in the 2019 findings demonstrate a statistically valid trend among CPCCO members.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Establish a monitoring process and data source to assess appeals and grievances filed by members with LEP.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No mechanism in place for analysis of appeals and grievances by members with LEP.	CareOregon will establish a mechanism to assess the LEP status of grievances and appeals.	6/30/2020	Integrate LEP data into regular grievance and appeal reporting to the CPCCO Network & Quality Committee	12/31/2020

Activity 2 description: Ensure that translated grievance and appeal notices and letters ensure members with LEP meaningful access to the grievance and appeal process; encourage and create a streamlined process for LEP members to understand their rights to grievances and appeals.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Anecdotal evidence suggests current	CareOregon will assess the	6/30/2020	CareOregon will implement standard	12/31/2020

translated information is not understandable by members. Current phone tree offers Spanish as only non-English option.	adequacy of current processes and systems in place to meaningfully translate availability of appeal and grievance processes and associated notices for members with LEP. CareOregon will utilize the CPCCO CAC as a focus group to solicit feedback and recommendation about current processes.		operating procedures to ensure members with LEP are provided with grievance and appeal information in their preferred language. Potential measures and outcomes include: -increase in interpretation and translation services for grievances and appeals - An appeals and grievances dashboard with key indicators around language accessibility with be shared with the CPCCO Network and Quality Committee	

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Health Equity: Equity Focused Metric

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

B. **Components addressed**

i. Component 1: Health equity: Data
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

As Columbia Pacific works towards achieving equitable care for all patients, a better understanding of the inequities that exist within our member population, as well as accurate and useful measurement of efforts, are critical. A measurement framework which focuses on equity will help us to understand which components of our strategic plan need additional resources to reduce inequities and guide our decisions about creating and implementing interventions with an equity lens. It will also serve in monitoring the effect of our interventions in the area of equity.

D. **Project or program brief narrative description**:

Columbia Pacific quality metrics team has spent time reviewing CCO Incentive Metrics data stratified by race, ethnicity, age, sex, and health complexity to identify where disparity exists to determine an area of focus. Last year, we decided not to narrow down to focus on disparity in one measure because we realized it would be more impactful to, instead, critically evaluate all CPCCO's strategic priority areas through an equity lens. As we build out our 2020 strategic plan, we are creating a framework for how we assess inequities across our population. During this process, we continue to work to further de-aggregate our data as much as possible and better understand the definitions of available data sources to ensure correct interpretation.

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

Activity 1 description (continue repeating until all activities included)

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Completion of Data Framework

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	1	4/1/2020	N/A	N/A

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Health Equity: Interpreter Utilization

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

B. **Components addressed**

i. Component 1: Health equity: Data
ii. Component 2 (if applicable): Access: Cultural considerations
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Language can be a major barrier to accessing health services for many. There is a well-documented body of evidence that shows a patient inability to communication meaningfully with their health care team leads to poor outcomes, and increased spending.

The CCO has heard through Limited English Proficiency (LEP) members and that interpretation has been a struggle in the region. To improve Columbia Pacific has taken an approach that includes:

- Education for members and healthcare facilities
- Improved access by increasing the number of interpreters in the region
- Spread of Clinical Best Practices for how to work with an interpreter

D. **Project or program brief narrative description**:

In order to address interpretation struggles CPCCO worked in 2019 to increase vendor satisfaction, educate members and providers on benefit, and meaningful language access interpretation training. Throughout 2020 we will meet bi-weekly with language access vendors to monitor utilization in our network. For organizations with little or no utilization

follow up will be completed to get an understand of how language needs are being met. In 2020 we will explore various ways to get interpretation data from organizations that do not use our vendor.

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

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Interpreter Utilization Data for our members for all contract primary care and CMHP clinics in region

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
4	7	12/2020	11	12/2021

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Health Equity: Cultural Responsiveness Training

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

B. **Components addressed**

i. Component 1: Health equity: Cultural responsiveness
ii. Component 2 (if applicable): Access: Cultural considerations
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Research has established that socio-cultural differences between patients and health care professionals influence many aspects of the medical encounter that can impact patient satisfaction, adherence, and health outcomes.

- Patients respond better when care instructions are delivered in their own language and their cultural background is considered.
- Knowledge of, and sensitivity to, cultural issues can impact the way patients share their medical needs, and how physicians and nurses can enhance communication, diagnosis, and treatment.
- For all patients, awareness of cultural subtleties by physicians and other health professionals can help improve patient care.

Cultural education for health care professionals is an important component of improving the quality of care delivered to diverse patient populations and can help in addressing racial/ethnic disparities in health care.

D. **Project or program brief narrative description**:

Columbia Pacific is committed to building a trusted network of providers so we may connect our members with truly personal health care. To demonstrate this commitment, CPCCO has purchased cultural competency (responsiveness) training courses specifically for providers and office staff participating in our network. This courses are from OHA-

Approved CCCE Training courses so that they may align with licensing boards. In order to hold accountability to this a provider manual policy has been created requiring contract providers to complete training annually.

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

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Organizations with completed Cultural Competence Training

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	11	12/2020	11	12/2021

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Oral Health Integration: Connecting Members with Diabetes to Oral Health Care

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

B. **Components addressed**

i. Component 1: Oral health integration
ii. Component 2 (if applicable): Access: Timely
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Diabetes control is directly related to oral health. There is a bidirectional relationship between glycemic levels and periodontal disease. Diabetes, especially poorly controlled, leads to increased prevalence and severity of periodontal disease. Periodontal treatment is associated with glycemic control improvements and improved health outcomes.

Data shows that periodontal therapy can lead to a 0.4% improvement in HbA1c.[i] This improvement supports overall efforts for glycemic control. Benefits of 1% HbA1c reduction leads to better health outcomes such as 14% reduction in myocardial infarction, 37% reduction in microvascular complications, and 21% drop in deaths.[ii]

Understanding the importance of oral health care by physical and behavioral health providers for their patients with diabetes is critical. Primary care currently has patient messaging for routine diabetes procedures such as annual blood work, foot and eye exams. Key messaging should also include oral health and the importance of an annual dental exam. Patients will often follow through with procedures when recommended by a trusted care team and this messaging is critical.

In addition, dental navigation has been challenging for both primary and behavioral health providers and patients. Chief among the barriers is knowing which dental clinics accept which dental plans. To mitigate this struggle, a dental care request form was created in our provider portal that allows primary care providers to submit a request for dental navigation and coordination by dental plan coordinators. This alleviates the burden of care coordination from both primary care provider and patient and allows the dental plan to provide outreach and support to patients identified by their Primary Care Provider.

D. **Project or program brief narrative description**:

CCO staff, provider networks, and community partners will receive educational materials on the importance of oral health care for their patients with diabetes and other chronic conditions as well as tools on how to discuss the importance of oral health care with their patients. The materials will be appropriate to the audience, comprehensive and evidence-based. Technical assistance for care coordination and workflow development, such as incorporating oral health messaging as part of standard diabetes care, will also be available for providers.

In addition, providers will receive information on how to use the dental care request form for their adult members with diabetes or other chronic conditions. Through the provider portal, physical health providers will access an online form and input basic patient information. From there, the dental care team sends the information to each respective dental plan for outreach and care coordination. The dental care coordinators reach out to the identified members, schedule dental visits and assist with non-emergent medical transportation and language services. Initial implementation of the dental request function has been with pediatric providers. Our goal for 2020 is to spread and implement this process outside of pediatrics to include adult members with diabetes or other chronic conditions. Concurrently, we will develop data analytics for summary reports on members engaged in care to evaluate the effectiveness of the dental care request form.

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

Activity 1 description (continue repeating until all activities included): Develop and share a set of educational and navigational tools for CCO staff and network providers on:

- the importance of oral health care for members with diabetes
- the dental care request form.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Informational tools developed and distributed to staff and providers; the total number of adult Dental Care Requests received; the number of adult practices actively using the dental care request form for patients with diabetes.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Tools not developed	Informational tools developed	08/2020	Same as target	08/2020
No tools distributed	Tools distributed to 10 sites	10/2020	Same as target	10/2020
5 adult practice sites utilize the Dental Care Request form (based on 5 or more requests received in 2019)	10 adult practice sites	12/2020	Same as target	12/2020
69 (2019 total) Dental Care Requests submitted for	138 adult Dental Care Requests	12/2020	Same as target	12/2020

adults 18+ years of age				

Activity 2 description: Analyze dental care requests and claims data monthly to determine number and percentage of members with diabetes who had a dental care request from submitted by their physical health provider and who completed a dental visit.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Develop coding and create dashboard to display data, and track the number/percentage of Dental Care Requests for members with diabetes that result in a completed dental visit within 30, 60 and 90 days of the request.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Dashboard not available	Dashboard created	06/2020	Same as target	06/2020
Baseline not available	Determine baseline	06/2021 (due to APAC claims lag and claims runout)	Same as target	06/2021

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: PCPCH Supports

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

B. **Components addressed**

i. Component 1: Patient-centered primary care home
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Columbia Pacific believes in the collaborative model of learning for our network. We believe this allows space to bring learnings and share barriers from which to learn from one another. We have chosen this model to help increase the number of PCPCH clinics and to increase the tiers for already participating clinics in PCPCH.

D. **Project or program brief narrative description**:

Columbia pacific provides coaching and continuous transformation community-level learning opportunities through our recurrent coaching-led Quality Improvement Work Groups (QIW)), behavioral health peer-to-peer meetings, and clinic-based one-on-one coaching and technical assistance support. These venues, established prior to or within the 1st year of CCO operations, are specifically designed to facilitate, disseminate, and share best practices, workflows, and staffing models of patient-centered medical homes. These venues support action planning and accountability through quality improvement monitoring and data transparency that directly motivates and equips our primary care partners to increase their levels of medical home status and progress towards achieving the quadruple aim.

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

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Maintain clinic level participation

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
9 Organizations and 18 clinics participating in QIW	Maintain clinic level participation (18)	12/2020	18 clinics still participating in QIW	12/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: SPMI – Regional Care Team

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

B. **Components addressed**

i. Component 1: Serious and persistent mental illness
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

We know that members with serious and persistent mental illness (SPMI) have poorer outcomes when it comes to physical, social, and mental health; in addition to higher rates of utilization across the health care delivery system. We also know that members with SPMI diagnoses have comorbid physical health conditions that are poorly managed. As a result, the OHA created a CCO quality metric in 2018 that captures Emergency Department (ED) visits for physical health concerns among those with an SPMI diagnosis. The CCO has readily adopted the use of the HIT tool, Collective, to manage and coordinate follow up of ED visits and other hospitalizations. The OHA partnered with Collective to proactively create a registry of CCO members who meet the SPMI diagnosis criteria and utilize the registry ("group") to inform a cohort in PreManage for monitoring hospital utilization, follow up, and care coordination.

The CPCCO Regional Care Team is a multi-disciplinary team which hosts regular, county-specific case conferences including PCPs and Community Mental Health which allow cross-system collaboration, reduction in duplication of effort, increased insight into who is involved with the member and improved workflows. During case conferences, the multi-disciplinary, multi-system team reviews several member cases, creates or reviews existing care plan, determines priority areas of need and identifies a lead person to conduct the follow up and outreach.

D. **Project or program brief narrative description**:

The ED Disparity Measure will be prioritized when proactively case finding for RCT and County specific huddles which occur weekly (Columbia county), bi-weekly (Clatsop county) and monthly (Tillamook county). Identify and track how many members brought to huddle are from ED disparity measure to better understand specific needs of this population and gaps in care opportunities.

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

Activity 1 description (continue repeating until all activities included): Prioritize members for county case conferences who are part of Collective's ED Disparity measure

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No standardized prioritization or tracking of members from ED Disparity cohort brought to County case conferences	Standardize prioritization of members from ED disparity cohort with inappropriate ED utilization being brought to county case conferences for team review	12/2020	175 unique members identified as part of ED disparity cohort will be brought to county case conferences for review.	12/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Trauma Informed Network

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

B. **Components addressed**

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☒ Education
☒ Neighborhood and build environment ☒ Social and community health

C. **Background and rationale/justification**:

In recent years, we have learned a lot more about the impact of unaddressed childhood trauma on future health and wellbeing. Studies show that higher adverse childhood experience (ACE) scores are associated with higher risk of health and social problems. ACEs are traumatic events occurring before age 18 including emotional, physical or sexual abuse, neglect or household dysfunction such as a parent with mental illness or who is incarcerated. According to the California Surgeon General, "… a person who has 4 or more ACEs … [has] … double the risk of heart disease, two and half times the risk of stroke, double the risk for cancer, 11 times the risk of Alzheimer's."

The Oregon Health Authority estimates the financial impact of child maltreatment to top $124 billion based on an average yearly cost of $210,000 per person who survives childhood abuse. Note: this estimate is based only

on financial costs associated with *confirmed* cases of child maltreatment and includes lost productivity as well as costs associated with health care, special education, child welfare and criminal justice.

The Adverse Childhood Experiences Study conducted by Kaiser Permanente in the 1990s identified the strong relationship between ACEs and adult mental, physical, and social wellbeing. The impact of unloved and traumatized children on society is profound and widespread. 85% of inmates were traumatized as youth. 27% of hospital visits can be traced to causes linked to childhood trauma. Hurt kids grow up to hurt people. The generational cycles of trauma and abuse are as stubborn as they are tragic. But there is hope.

There are doctors, researchers, teachers, nurses, social workers and law enforcement officers that are turning the tide against the cycle of trauma and abuse. A movement is rising, one that sees aberrant behavior as a symptom rather than a moral failing. This movement asks not what is wrong, but rather what has happened. The paradigm is shifting from punishment and blame to a deeper commitment to understanding and healing the underlying causes of aberrant behavior. With this shifting paradigm comes the promise of great improvements in many of the society's costly ills. Simply put, it is cheaper to heal than to punish.

D. **Project or program brief narrative description**:

Community partners, together with Columbia Pacific CCO, are working to change the community context around childhood trauma and build resilience in Clatsop and Columbia counties.

In both counties, community discussions of childhood trauma, adverse childhood experiences (ACEs) and the challenges that children and their parents face inspired the creation of Trauma-Informed Networks to integrate trauma informed care (TIC) county-wide. The overarching goal of this effort is to improve health and life outcomes for children, families and communities by addressing childhood trauma and building resilience in children and families.

The networks bring together providers and organizations from critical sectors in the community to coordinate and improve trauma informed strategies and promote the adoption and/or expansion of trauma informed care across sectors and services. The targeted sectors include education, healthcare, child welfare, criminal justice, business and the community.

The network infrastructure is made up of a steering committee and 6 sector workgroups. The steering committee is made up of local leaders. People who participate in the sector specific workgroups will be people who are familiar with their sector, are implementing/managing projects and would love to work on reducing childhood trauma and build resilience in their community. The goal is to partner with systems from the target sectors and work together towards a common goal.

Each network will develop a county-wide strategy to address childhood trauma and build resilience in children, families and communities. The vision of the Trauma-Informed Networks is to create resilient communities engaged in a network which is supported by a community investment plan to support the implementation of their strategy.

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

Activity 1 description (continue repeating until all activities included): Add text here

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Launch trauma-informed networks in Clatsop and Columbia counties

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
O	2	12/31/2020	N/A	12/31/2020

Activity 2 description: Add text here

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Member organizations develop action plans (i.e., strategic plan) to address childhood trauma and build resilience

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0	2 (one per county)	12/31/2020	N/A	12/31/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Food Roots

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

B. **Components addressed**

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☒ Economic stability ☒ Education
☒ Neighborhood and build environment ☒ Social and community health

C. **Background and rationale/justification**:

The overall purpose of this project is to increase the health, nutrition, and well-being of children in Tillamook County by expanding and enhancing Food Roots' Farm to School programming over the next two school years. Specifically, this project will focus on providing high quality, hands-on Farm to School educational activities related to agriculture, food and health; increasing local food procurement in schools by promoting and serving seasonal produce in the cafeteria, as snacks, and as taste tests; and increasing the long-term capacity for Farm to School education throughout Tillamook County.

The need for this programming is clear. Tillamook County suffers from hunger, food insecurity, and poor nutrition. Over 15% of individuals are below the federal poverty level and families with children under 18 suffer from a 25% poverty rate. According to data from Feeding America, Tillamook County has a child food insecurity rate of 20.6%.

OHA Transformation and Quality Strategy (TQS) CCO: Click here to enter text.

The National Farm to School Network has summarized research that shows the benefits of Farm to School programming. Farm to School programs increase students' preferences for fresh fruit and vegetables, improve performance in school (science in particular), and impact positive social behavior. The programming we provide is rooted in this research: we focus on hands-on activities that encourage inquiry and critical reasoning and prioritize activities that complement Next Generation Science Standards and Common Core ELA and math standards. These Farm to School lessons and projects help improve the health and nutrition of students by increasing their familiarity with and consumption of fresh, healthy fruits and vegetables and improve student performance in school by providing hands-on activities that align with educational standards.

D. **Project or program brief narrative description**:

Our first goal is to increase capacity for Farm to School education in Tillamook County schools. We plan to do this by implementing and training teachers in a new, comprehensive Garden Education Curriculum designed by Food Roots. This curriculum will provide unique but interlocking, 20-lesson tracks for grades K-6, that build upon each other through the school year and across grades.

This new curriculum will facilitate two main objectives during the 2019-20 and 2020-21 school years. The first objective is to increase Food Roots capacity to directly provide garden-based education in Tillamook County schools, along with supplemental and complementary Farm to School activities, such as local-produce tasting tables, farm field trips, farmer classroom visits, and family engagement events.

The second objective is to launch and develop a new professional learning community (PLC) of select, committed Tillamook County teachers who will receive Food Roots-led training and technical assistance in garden-based education strategies based on Food Roots' Garden Education Curriculum.

Our second goal is to expand procurement of locally-produced food in select partner schools who have indicated their readiness. We will do this through two key objectives. First, we will continue providing multiple tasting tables at our four partner schools, providing a local, in-season fruit or vegetable sample directly sourced from a Tillamook County farmer to all students. Second, we will carry out an initiative to support schools in serving locally-grown salad greens direct-purchased from local farms in their lunch salad bars. **Activities and monitoring for performance improvement**:

Activity 1 description (continue repeating until all activities included): Improving access to nutrition education

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Food Roots facilitates Farm to School education	Develop and launch Farm to School Professional Learning Community of teachers trained in new program.	End of 2020-2021 school year	One partner school identified to fully transition to learning community-led programming.	End of 2020-2021 school year
Use of Garden Ed Curriculum is Food Roots-driven and inconsistent	Teachers implement new Next Generation	End of 2020-2021 school year	750 students receive regular, garden-based lessons.	End of 2020-2021 school year

	Science Standards-aligned program.			
Immersive trips, parent events, and farmer visits are inconsistent.	Provide additional immersive experiences on a consistent basis.	End of 2020-2021 school year	3-4 farm field trips provided per school year; 20 classroom farmer visits per school year; 2 family engagement events per school year at each school.	End of 2020-2021 school year

Activity 2 description: Expand access to Oregon and local, coastal-grown healthy food

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
A few tasting table events occur each school year.	Consistent events for tasting table to expose children to new in-season fruit or vegetable samples from local farmers and/or school gardens.	End of 2020-2021 school year	Provide at least 14 tasting tables for local produce each school year.	End of 2020-2021 school year
Schools do not have consistent access to locally grown, healthful lunch options.	Pilot and then implement a full local salad bar program.	End of 2020-2021 school year	One partner school and five pilot schools participating in salad bar project highlighting local produce on a consistent basis.	End of 2020-2021 school year

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through F until all TQS components and subcomponents have been addressed)

A. **Project or program short title**: Social Determinants of Health Project 9: Traditional Health Worker

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

B. **Components addressed**

i. Component: Social determinants of health & equity
ii. Component: Access: Quality and Adequacy
iii. SDOH-E domains: Economic stability; Social and community health

OHA Transformation and Quality Strategy (TQS) **CCO:** Click here to enter text.

☐ ☐

C. **Background and rationale/justification**:

Columbia Pacific has developed a robust THW utilization and integration plan that aims to support the build out and maintenance of a thriving THW workforce. We recognize the importance of creating an infrastructure that supports the individual THW and the organizations that hire them. The plan includes a comprehensive roadmap that outlines how THWs intersect and support CPCCO's strategic priorities and initiatives.

CI. **Project or program brief narrative description**:

The CCO will be working on building the supportive infrastructure that is essential for the successful implementation of the THW strategy and serve as the foundation upon which we will be able to integrate THWs into the overall CCO population health strategy that we will be implementing over the next 1-3 years. Such supportive activities that will occur in year 1 include completing an environmental scan and gap analysis, development of a payment strategy, identifying role and scope of work of the THW liaison, and development of a sustainable documentation and reporting mechanism.

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

Activity 1 description (continue repeating until all activities included): Development of an enhanced payment model to sustainably support THWs in clinical and community settings.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Completion of Year 1 THW payment grid	Draft enhanced payment model that is aligned with VBP roadmap	12/2020	Enhanced payment model aligned with VBP roadmap	12/2021

Activity 2 description: Add text here

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Finalized THW strategy for implementation in 2021

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Review of Oregon state THW registry to assess current workforce capacity	Completion of environmental scan and gap analysis	06/2020	Updated and finalized THW strategy ready for implementation	09/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

OHA Transformation and Quality Strategy (TQS) CCO: Click here to enter text.

A. Project or program short title: Community Wellness Investment Funds

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

B. Components addressed

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Access: Timely
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☒ Economic stability ☒ Education
☒ Neighborhood and build environment ☒ Social and community health

C. Background and rationale/justification:

Community Wellness Investment Fund (CWIF) grants are community investments that support the goals of the eight priority areas of the Regional Health Improvement Plan and meet the criteria for Health-Related Services/Community Benefit.

D. Project or program brief narrative description:

Utilizing a shared decision-making model CPCCO's local and regional advisory councils review, rate and recommend funding CWIF grant proposals. Final recommendations for funding are made by the Regional Advisory Council (51% of regional council members represent consumer/OHP). CWIF proposals are required to have goals, process or outcome measures and demonstrate potential support for the applicant to develop a sustainable program or service. This program as well as our large grant investment program is working on increasing investments that integrate services addressing social needs and the social determinants of health into the delivery of health care.

E. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Expand social needs care services and optimize the effectiveness of social services to improve health and health care.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
CWIF grant process includes activities applicants can apply for funding that can support organizational development towards sustainable practices that support the coordination of care for health, wellbeing and the	Library of Best or Evidence Based practices for CWIF applicants to support the development or implementation of services to improve health and health care in the social safety net or primary care setting.	6/30/2021	CWIF applicants utilizing best practices that support the expansion of social services to improve health and health care including supporting the evaluation of those efforts.	6/30/2022

social determinants of health between social services and health care providers.				

Activity 2 description: Better coordinate roles for social needs care providers in interprofessional care teams across the range of clinical and community health settings

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Informal care coordination between health care and social safety net services	Formal agreements and use of technology for referrals between social safety net and health care providers	6/30/2021	Readiness assessment and interested organizations identified	12/30/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Special Health Care Needs: ASQ Follow Up

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

B. **Components addressed**

i. Component 1: Special health care needs
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

With the inclusion of ASQ screening measure we partnered with the Oregon Pediatric Improvement Project (OPIP) to rollout a pilot project focused on improving ASQ screening and follow up, specifically on improving referral pathways to ensure receipt of services for kids at highest risk. This work elucidated major gaps in services in our region; however, we did see an increase in referrals to Early Intervention and Early Learning and an increase in receipt of EI/EL services for the highest risk kids. While we did see an overall improvement in referral and receipt of services, this was not observed in all three counties and was inconsistent. As a result, we developed a proposal with OPIP to continue our partnership to improve this important body of work.

D. **Project or program brief narrative description**:

CPCCO is partnering with OPIP to upskill the CPCCO team to engage and facilitate clinic partners and community stakeholders around the shared goal of ensuring children identified at-risk receive follow-up services that are the best

match for the child and that are coordinated across systems. This will take place through five collaborative sessions focused on the following areas:

- Learning Session 1: Facilitating Primary Care on Follow Up to Developmental Screening
- Learning Session 2: Deep Overview of Medical Decision Tree and Referral Entities and Services They Provide
- Learning Session 3: Specific Focus on Children with Social Emotional Delays
- Learning Session 4: Data and Measurement- Part 1 Specific to CCO and clinics
- Learning Session 5: Data and Measurement- Part 2 Specific to EI

The five collaborative learning sessions will inform a robust technical assistance package that will be developed to support primary care, behavioral health, EI/EL, and community partners. This work will be the first part of a larger Maternal Child Youth (MCY) strategy specifically focused on supporting kids 0-5 with social developmental delays and help them be ready to start kindergarten.

E. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): CPCCO-OPIP Social Developmental Screening and Follow-up Learning Sessions

☐ Short term or ☐ Long term

Monitoring activity 1 for improvement: Training sessions completed

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Five learning sessions have been scheduled and curriculum developed.	All five learning sessions will be delivered	06/2020	Development of social developmental screening and follow-up technical assistance package	09/2020

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. Project or program short title: Cost and Utilization Steering Committee

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

B. Components addressed

i. Component 1: Utilization review
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. Background and rationale/justification:

CCO 2.0 includes a major focus on cost containment, as such, the OHA has rolled out a new tool for CCOs to use to monitor costs related to defined episodes of care. Examples of episodes include diabetes, pregnancy, and COPD. The OHA has asked each CCO to select three episodes to conduct cost and utilization review, monitoring, and improvement

activities on. Each episode is defined by costs split into two categories; (1) typical costs associated with the episode, and (2) Potentially Avoidable Complication (PAC) costs. The goal of this work is to identify opportunities to reduce PAC costs and to achieve cost savings or containment.

D. **Project or program brief narrative description**:

CPCCO conducted a deep dive into the data in the current Prometheus dashboard released by the OHA. During exploration, it was decided that the CCO would focus on three key episodes which presented the most opportunity for intervention, improvement, and the potential to realize savings related to PAC costs. The following episodes were selected: diabetes, asthma, and substance use disorder. CPCCO completed a draft action plan focused on the three identified episode types.

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

Activity 1 description (continue repeating until all activities included): Prometheus Action Plan

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Draft PROM Action Plan submitted to OHA	Final PROM Action Plan submitted to OHA	03/31/2020	Updated PROM Action Plan	Deliverable due date TBD

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: OUD Prescribing – Buprenorphine

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

B. **Components addressed**

i. Component 1: Utilization review
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☒ Social and community health

C. **Background and rationale/justification**:

Columbia Pacific CCO has been working with primary care clinics to screen for, diagnose, and treat use disorders. The numbers of clinics providing medication for addiction treatment (MAT) has grown quickly in the past several years, but some areas of our CCO still lack providers who are waivered to prescribe buprenorphine. One of our counties has the highest overdose death rate in the state and high rates of risky prescribing and low numbers of waivered providers.

D. **Project or program brief narrative description**:

We aim to increase the number of members receiving buprenorphine for the treatment of Opioid Use Disorder and increase the number of providers waivered to prescribe this medication.

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

Activity 1 description (continue repeating until all activities included): Expand treatment services for OUD in primary care.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Number of unique patients being prescribed buprenorphine

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
233 patients	Increase by 20% (280 patients)	12/2020	Increase by 50% (350 patients)	12/2021

Activity 2 description: Host two DATA-waiver trainings in Tillamook County

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Number of waivered providers in Tillamook County

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
4 providers	10 providers	12/2020	15 providers	12/2021

Section 3: Required Transformation and Quality Program Attachments

A. Attach your CCO's quality improvement committee meeting minutes from three meetings
B. Attach your CCO's consumer rights policy
C. OPTIONAL: Attach other documents relevant to the above TQS components, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.

Submit your final TQS by March 16 to CCO.MCODeliverableReports@state.or.us.

[i] Janket S-J, Wightman A, Baird AE, Van Dyke TE, Jones JA. Does periodontal treatment improve glycemic control in diabetic patients? A meta-analysis of intervention studies. J Dent Res 2005;84(12):1154-9.

[ii] Simpson TC, Weldon JC, Worthington HV, Needleman I, Wild SH, Moles DR, Stevenson B, Furness S, Iheozor-Ejiofor Z. Treatment of periodontal disease for glycaemic control in people with diabetes mellitus. Cochrane Database of Systematic Reviews 2015, Issue 11. Art. No.: CD004714. DOI: 10.1002/14651858.CD004714.pub3.