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:

The Eastern Oregon Coordinated Care Organization (EOCCO) Board of Directors is the authority of and has the responsibility for the EOCCO transformation and quality program strategy (TQS). The board of directors has designated the EOCCO Quality Improvement Committee (QIC), with the responsibility for the operations of the transformation and quality improvement program.

The EOCCO QIC provides oversight to transformational and quality assurance and performance improvement activities to ensure that EOCCO members receive high quality physical, behavioral and dental care and services. The multidisciplinary committee is a decision-making body that has the authority and representation to develop and implement integrated quality improvement and transformative activities with the goal of advancing the Triple Aim for EOCCO members. Membership includes representation from the physical health, behavioral health, and delegated dental care organizations.

EOCCO uses continuous quality improvement methodologies to assess, plan, and improve the quality of care and service we provide to EOCCO members. The most used is the Plan-Do-Study-Act (PDSA) methodology. This tool is the basis for: P) assessing the current situation and completing root cause analysis, determining interventions, identifying the required resources and timeline, and the tracking/monitoring/reporting methods; D) implementing the intervention to the targeted population segments; S) measuring and evaluating the results of the intervention; and A) deciding next steps: adapt, adopt, abandon.

Designated EOCCO representatives and/or subcommittees are responsible to complete and report TQS and other Oregon Health Authority (OHA) contractual assignments and outcomes to the EOCCO QIC. These include the development and implementation of integrated policies and procedures and performance improvement projects, progress toward incentive measures improvement targets, and preparedness for OHA mandated external quality reviews. Ongoing responsibilities include the assessment and analysis of the quality and effectiveness of initiatives for access to services, integration of care, cultural competency of the CCO and our provider network and health equity, patient-centered primary care home, utilization review, the care management system (including severe and persistent mental illness and special healthcare needs), grievances and appeals system, health information technology and fraud, waste and abuse detection and prevention.

The EOCCO QIC meets at least quarterly. The EOCCO QIC is chaired by the QIC Coordinator. Agendas, direct meetings, and documented minutes provide a record of the committee's activities, recommendations, and actions.

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

EOCCO develops, monitors, and manages the quality and transformation activities for the CCO. The activities are determined through a combination of addressing contractual requirements and implementing activities that are aligned with the EOCCO Board of Directors, Clinical Advisory Panel (CAP), and our Regional Community Advisory Council (RCAC) and Local Community Advisory Council (LCAC) initiatives.

The Community Health Assessment (CHA) process for EOCCO is unique, as our service area covers Oregon Health Plan (OHP) members in 12 Eastern Oregon counties. From its inception, EOCCO has been committed to the concept of being local. Each county has its own LCAC, and each LCAC develops their own unique community health improvement plan (CHP), at the local level.

EOCCO collaborated on a shared CHP with stakeholders and key partners throughout the EOCCO service area. Through the RCAC, which convenes at least quarterly, each of the 12 LCACs provides a county-level CHP that requires the collaboration and input from local consumers, clinics and providers, hospitals (if one exists in the county), public health authorities, early learning hubs, school based health centers, tribes, and community members that work with members experiencing health disparities and social determinants of health.

The process for generating CHP priority areas took place over a one-year time period. The process began with the RCAC reviewing and approving a script for focus groups, which would represent the qualitative portion of the CHA. EOCCO conducted twenty-one focus groups between May and September 2018 where seventeen of the focus groups were conducted in English and four were provided in Spanish. Each focus group generated an individual county report that was shared to the LCACs. The Regional CHP was a combination of the LCAC reports and presented at the February 2019 RCAC meeting,

When reporting on the CHP for EOCCO, not all of the required and suggested organizations exist in each county, such as Type B Area Agencies in Aging. Where they do exist, EOCCO makes every effort to involve them in the development of the CHP. It is also important to recognize that many of them serve multiple counties, some of which are not in the EOCCO service area.

The CHP represents issues and areas that are prioritized by our plan members and community partners. It reflects local needs and opportunities to be a guide to how best to create strategies that take advantage of existing and new relationships, in order to leverage community support for addressing the prioritized needs.

It's is also important to note that the chair of the EOCOO RCAC serves on the EOCCO Board of Directors. The RCAC Chair and the RCAC members serve as the link between the EOCCO Board of Directors and the LCACs.

The EOCCO Board of Directors and CAP are heavily involved in the development of activities that support and promote the use of high-functioning patient-centered primary care homes (PCPCHs) and in the development of EOCCO's value-based payment (VBP) strategies.

The EOCCO Board of Directors authorizes annual funding to our LCACs, which they can use to improve incentive measure results within their respective communities and/or to address CHP initiatives identified for their respective communities.

The EOCCO Board of Directors has invested funding in the development of a regional OHA-certified Community Health Worker (CHW) training program which includes training new CHWs and providing continuing education courses to existing CHWs. EOCCO has also developed a CHW billing and payment policy to help ensure a sustainable revenue source for the EOCCO provider partners that employ CHWs. The EOCCO Board of Directors' CHW investment is one of our primary tools for addressing the social determinants of health and health disparities within our region.

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:

There are a number of examples for how EOCCO works with community partners to advance the TQS.

EOCCO has a 17-member governing board that includes hospital, physician, clinic, local community mental health, public health, and county commissioner/judge representation. As discussed above, the board of directors is heavily invested in a number of transformation activities.

Within our region an average of 250 individuals participate in our LCACs. Each LCAC has broad community partner representation including health systems, clinics, community-based organizations, local public health, local mental health, local government, early learning hubs, and OHP members. These community partners participate in the development of county-specific CHPs, which is discussed in more detail below.

EOCCO has taken a unique approach to involving the community in our CCO. From each LCAC, the chair, along with a county commissioner (or designee), serves on a RCAC. The RCAC serves as the official CAC for EOCCO. Each LCAC completes its own CHA and CHP, which is then combined and incorporated into a regional (CCO-wide) CHP that includes both county-level needs/priorities and CCO-wide needs/priorities. The RCAC is also charged to help ensure each LCAC is responsive to member and community health needs.

Additionally, each year the RCAC produces and delivers an annual report to the EOCCO Board of Directors with an update on LCAC activities that EOCCO formally responds to. EOCCO utilizes the input from community partners and the CHP plan to address transformation and quality strategies as applicable.

Some other examples include:

Community Mental Health Programs (CMHPs) were directly involved in establishing the 2019 CHP. Each of the 12 LCACs have a representative from the local CMHP. As a participant on the LCAC, they have the opportunity to participate in priority setting and selecting LCAC leadership that services on the RCAC. Through this participation, the CMHPs are closely aligned with the overall goals and objectives of EOCCO.

CMHPs in various capacities throughout the service area partner with School Districts, County Public Health Departments, Head Start, Early Learning Hubs, Child Welfare, Local Public Safety Coordinating Councils and Multi-Disciplinary Teams, among many other collaborative efforts. These activities make them aware of the needs of their communities and thus, inform decision making around the CHP. In addition to their participation in the CHP, CMHPs have an integral role in behavioral health integration, through their collaboration with PCPCHs. EOCCO has four Certified Community Behavioral Health Clinics (CCBHCs).

Through our collaboration with the Youth Development Council, there has been six Youth Development Council Community Investment Grants funded in the EOCCO Region for 2019-2020, including:

- The Juvenile Department – Youth Workforce and resiliency
- Community in Action – Youth in Action
- Boys and Girls Clubs of Western Treasure Valley – Great by 8 and Targeting Anti-Gang Strategy
- Confederated Tribes of Umatilla Indian Reservation – DCFS/lost and found

EOCCO collaborates with partners in the children and adolescent area and has done research to address the health needs of the population, including Adverse Childhood Experiences (ACEs). EOCCO has helped sponsor the Eastern Oregon Early Learning Summit, which gathers educators, health care professionals, early learning specialists, child advocacy organizations, and many more. The conference has grown to over 500 people. Led by national thought leaders, the curriculum began with learning together about the impacts of childhood trauma and the value of resiliency. It has progressed to include deeper dives into collaborate problem solving, conscious discipline, positive parenting partnership, and other evidence-based practices.

Additionally, EOCCO staff provides oversight and understanding of the barriers to promoting trauma informed care in the healthcare system and looks for opportunity for change. EOCCO is supporting the research and implementation of tools to provide pathways to referrals and the integration of early childhood behavioral health into pediatrics clinics in Eastern Oregon.

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:

EOCCO provides coverage to over 52,000 members across 12 rural and frontier counties in Eastern Oregon. Our service area is approximately 50,000 square miles covering just over half the land area in the State of Oregon.

EOCCO has a diverse eight-member ownership structure that includes a number of provider and hospital systems that provide care for OHP members within the EOCCO service area. EOCCO has a 17-member governing board, 12 Local Community Advisory Councils and a Regional Community Advisory Council that includes participation from 250 community partners and a Clinical Advisory Panel.

Within our service area there are 10 hospitals, 7 of which are Type A/Critical Access hospitals, five of 10 are part of health districts, and there are no tertiary hospitals within the EOCCO counties. There are 60 widely dispersed clinics and individual primary care practices within or outside of our 12 counties that serve the primary care needs of EOCCO members. 23 of those clinics are Rural Health Clinics and seven are Federally Qualified Health Centers (FQHCs).

Despite some of our challenges with respect to our rural geography and a lack of access to services not available in our communities, EOCCO remains committed to moving forward with transformation and advancing the Triple Aim for our members. We believe that our commitment to transformation to date, including what we have planned throughout the next two years, will be evident throughout the TQS.

Section 2: Transformation and Quality Program Details

A. **Project or program short title**: Project 1: Increase Access to Assertive Community Treatment (ACT) or Alternative, Intensive, Community-based Services

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): Special health care needs
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**:

EOCCO is committed to ensuring members have access to medically appropriate, covered services. Due to the rural and frontier geographic nature of the EOCCO service area, identifying members with severe and persistent mental illness (SPMI) who require the supports offered through intensive outpatient services has not always been feasible prior to an acute hospitalization or multiple emergency department (ED) visits for symptoms associated with their mental health diagnosis. Historically, screening for intensive outpatient services, such as ACT or intensive case management, has been conducted as the member is discharged from acute care, a residential treatment facility, or a stay at the Oregon State Hospital.

Initial reports have indicated that approximately one percent of EOCCO members identified as potentially ACT eligible have received ACT services. Almost 80% of the members identified in the matching process had not received any mental health services in the last 12 months. Based on this early assessment, EOCCO believes that this is an area that has potential for improvement.

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

EOCCO will introduce a new activity to use data pulls for analysis to help identify likely ACT-eligible members by monitoring data reports. Once identified, key indicators will inform how to offer individual members community-based interventions before higher levels of care are necessary. Immediate interventions will include, but will not be limited to, offering care coordination and creating Individual Management Plans (IMP). Utilizing EDIE, ACT outcome reports, and claims data, EOCCO will pull monthly reports to pull the following data:

- Members with severe psychiatric, behavioral, or other comorbid conditions
- Recurrent inpatient admissions (e.g., 2 or more inpatient psychiatric admissions in past 12 months)
- Inpatient lengths of stay greater than 30 days in past 12 months
- Excessive use (e.g., 2 or more visits in 30-day period) of crisis or emergency services
- Chronic homelessness (e.g., continuous homelessness for at least 1 year, or 4 or more episodes of homelessness in past 3 years)

In addition, EOCCO will pull reports to include utilization of the following services:

- Members with severe psychiatric, behavioral, or other comorbid conditions who are not currently receiving ACT services or alternative, intensive community-based treatment, or intensive care coordination (ICC), but are receiving:
    - Pharmacotherapy
    - Psychosocial therapy
    - Supported Employment Services
    - Social skills training
    - Peer Delivered Services
    - Case management
- Members with severe psychiatric, behavioral, or other comorbid conditions who are not currently receiving ACT services or alternative, intensive community-based treatment, or ICC, and also:
    - Are having difficulty engaging in traditional, office-based outpatient treatment
    - Consistently no-show for traditional, office-based outpatient treatment appointments

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

Activity 1 description: Beginning in March 2020, EOCCO will utilize the special health care needs data report to match claim data that identifies members with SPMI diagnoses who utilize individual, distinct services that are part of the ACT program, but are not active ACT participants. EOCCO will then provide lists of potentially ACT-eligible members to certified ACT providers who will conduct outreach, screen, and offer information about ACT and other intensive outpatient services and community supports to the members with the intention of decreasing utilization of higher levels of care in the future.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Admissions to the ACT program

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)

Provider education and matching reports.	Increased screening efforts and more admissions to the ACT program.	01/2021	Increased ACT admissions or enrollment in community based behavioral health services.	06/2021

A. **Project or program short title**: Project 2: Language Access Plan

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): 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 National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards as well as the health equity plan highlight the importance of the delivery of culturally appropriate services, which involves providing linguistic assistance to individuals who need it. Barriers to providing culturally responsive care include member engagement, health literacy, and language proficiency. EOCCO is in the process of strengthening its language access plan by updating workflows, creating innovative strategies, and tracking and monitoring systems within and across our health service domains (physical, behavioral, dental). Written communications with our members and utilization of interpreter services are both critical components of this set of activities that make-up our language access plan.

In our previous TQS, we focused on improving our language access plan by evaluating employees who participated in the plain language training course, improving the total number of interpreter services, and encouraging employee participation in cultural competency training. We met our targets and benchmarks for the employee-focused interventions, but we did not meet our target for the interpreter services project. This is partly due to conflicting priorities and partly because we didn't have a focused intervention outlined. We have modified our activities to include projects that are more feasible to complete with a narrow focus topic. Both of our activities are member focused since that is an area that we have identified for improvement.

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

This project will strengthen our language access plan. Specifically, we will focus on the written materials that we use to communicate with our members as well as the utilization of interpreter services by EOCCO members and providers. We will: (a) track all member materials and evaluate readability, (b) regularly test action-oriented member materials for health literacy and actionability with focus groups, (c) track the utilization of interpreter services through EOCCO's interpreter service, Passport to Languages, and (d) develop a provider and member outreach campaign to increase awareness and utilization of interpreter services.

This project addresses CLAS standard #5 ("offer language assistance to individuals …") and CLAS standard #6 ("informing individuals of availability of language assistance …").

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

Activity 1 description: EOCCO has developed a process in 2020 to inventory all member materials to evaluate readability, understandability, and actionability. Our EOCCO member materials have been revised to meet OHA's health literacy standards. We use the Flesch-Kincaid Readability Statistics to assess member communications and website member materials to ensure that they are written between a sixth and seventh grade reading level. EOCCO will track the percentage of materials that follow the readability guidelines and evaluate additional materials that need to be assessed. EOCCO plans to test specific action-oriented member materials with focus groups identified by the EOCCO local community advisory councils and/or the consumer caucus. A survey will be administered to the focus group with specific questions related to health literacy and readability measurements.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Track the percentage of member materials that are tested with focus groups that contain both local community stakeholders and EOCCO members.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0%	5%	12/2020	25%	12/2023

Activity 2 description: EOCCO arranges for interpreter services at members' medical appointments. EOCCO member handbooks and participating provider manuals include instructions on how to request these services from EOCCO's interpreter service, Passport to Languages. In 2018, EOCCO arranged for interpreters at 588 medical office visits and 569 in 2019, which shows a decrease in utilization of Passport to Languages. Out of the 569 interpreter services, 374 were for the Spanish language. This equates to 65.73% of translation services in Spanish; however, 84.8% of non-English speaking EOCCO members speak Spanish. Together, our recent data on total interpreter utilization as well as the portion of translation services in Spanish, lead us to revisit our efforts to make these services known to Spanish-speaking individuals with Limited English Proficiency. EOCCO plans to develop a member outreach campaign targeted at Spanish-speaking members to increase awareness and utilization of interpreter services.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Track the percentage of Spanish interpreter services provided at member's medical appointments through Passport to Languages.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
65.73%	70%	03/2021	85%	03/2023

A. **Project or program short title**: Project 3: Access to Initial Behavioral Health Assessment within (7) Seven Days

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): 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**:

EOCCO is committed to ensuring members have access to medically appropriate, covered services. On a monthly basis, EOCCO will collect provider data reports to monitor members' access to initial behavioral health assessments. These data reports will be included in an analysis of GeoAccess analysis, gap analysis, and claims analysis.

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

EOCCO will collect monthly data reports that monitor the number of initial referrals and inquiries for behavioral health assessments. If it is assessed that the access to the initial behavioral health assessments does not meet standards in OAR 410-141-3515 within two consecutive reporting periods, EOCCO will work with providers to develop performance improvement plans. Additionally, if access remains insufficient, EOCCO will consider multiple options to ensure appropriate access to initial behavioral health assessments, including, but not limited to, recruitment of additional providers.

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

Activity 1 description: Monitor the number of initial referrals and inquiries for behavioral health assessments.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Collection of monthly data reports from outpatient behavioral health providers.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Baseline will be established after (3) three months of reports.	Improvement over previous period.	06/2020	Improvement over previous period.	06/2021

A. **Project or program short title**: Project 4: Behavioral Health Integration within EOCCO Primary Care and PCPCH Clinics

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): Patient-centered primary care home
iii. Component 3 (if applicable): Social determinants of health & equity
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**:

Integration of behavioral health services into primary care is an evidence-based process for providing comprehensive, collaborative and quality care for all members within the EOCCO service area. Additionally, this process has been established as a requirement under the CCO 2.0 guidelines. EOCCO is committed to meeting the triple aim of healthcare by supporting and enhancing integrated care efforts into primary care practices within our 12-county region. The program narrative outlines the need for behavioral health contracts. These contracts allow for necessary oversight of

integrated services provided in primary care, establish the need for appropriate data collection, and allow opportunities for technical assistance (TA) and support for workflow, data tracking, and clinical service oversight by the EOCCO behavioral health integration team.

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

EOCCO will assess current primary care clinics with integrated behavioral health services and determine best practices for integration (completed, Primary Care Behavioral Health Model and Collaborative Care Model contracts with EOCCO). Development of community-wide plan for behavioral health integration, including repapering of contractual agreements for Collaborative Care Model and Primary Care Behavioral Health Model within primary care. Provide assurances that primary care clinics have clinic capacity and adaptive reserve for integration, including a PCPCH tier status of Tier 4 or higher. Our goal is to integrate behavioral health services into primary care in 50% of all primary care health systems.

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

Activity 1 description: Assess current behavioral health integration contracts within EOCCO and create a plan for ongoing monitoring of activities and integration workflow by EOCCO team. Other considerations include 1) PCPCH status monitoring, 2) data collection capabilities and tracking and 3) provide continued support for primary care and collaboration with Community Mental Health Programs (CMHPs).

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Track number of current contracts and develop a plan for continued TA by EOCCO staff. Provide quarterly reports to EOCCO leadership on progress, concerns, and improvements needed for workflow of integrated efforts in primary care. Continue to monitor PCPCH status and work with clinics on PCPCH renewal or increase in tier recognition. Determine data collection capabilities within integrated primary care clinics and provide TA for monitoring of access, penetration rates and serious and persistent mental Illness (SPMI) service referrals to the CMHPs.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Current number of contracted PCPCHs with integrated care	Increase by 10%	12/2020	At least 50% of all EOCCO clinics have some form of integration in primary care and adequate TA	12/2025
Establish TA support for Behavioral Health Clinicians in primary care (i.e. Community of Practice)	Hold monthly meetings to discuss strategies for improvement of quality of patient care through integration. At least 50% of contracted clinics participate in calls.	12/2020	Review TA process through Community of Practice and determine if this is meeting the needs of behavioral health clinics; increase participation to all contracted clinics with integration	12/2025

Activity 2 description: Develop standardized process for recruiting and ensuring readiness for new PCPCH practices interested in pursuing integrated care for behavioral/mental health services. This process is currently in development by

EOCCO staff that includes (but not limited to): 1) Readiness assessment for integration of care, 2) PCPCH status, 3) clinic capacity for change (using the Institute for Healthcare Improvement model for rapid cycle improvement) and understanding of adaptive reserve efforts (part of the PCPCH status TA mentioned in Activity 1), and 4) data collection capabilities.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Track the number of PCPCHs and clinics with integrated care.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Current number of contracted PCPCHs with integrated care.	Recruit new practices (at least 10% per year) to engage in integration.	12/2020	At least 50% of all EOCCO clinics have some form of integration in primary care and adequate TA.	12/2025

A. **Project or program short title**: Project 5: Health Equity Data Improvement and Stratification

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): CLAS standards
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**:

Accurate and reliable descriptions of the service population is an essential aspect to plan for and provide services that account for the diversity of the service population, and for example, include linguistic and culturally responsive components. OHA has accordingly provided standards on demographic indicators that should be routinely used to describe service populations and examine specific programs and health status sub-populations (e.g., those with a chronic disease). These standards are known as Race, Ethnicity, Language and Disability (REALD) and call for the stratification of individuals receiving services based on these indicators.

In this Quality Improvement project, we will strengthen further our capabilities to use REALD standards in our ongoing health service planning, evaluation, and monitoring. In addition to assessing and updating our current procedures and capabilities to apply REALD standards across our critical database systems, we will also carry out a project to improve our demographic data collection efforts. We will use our Health Information Exchange (HIE), Arcadia Analytics that draws data from our health care provider's Electronic Health Records (EHR) and provides population health management functions such as calculating performance metric rates and data-dashboard displays with timely data and gap lists that are inclusive of demographic data.

We offer tobacco cessation services to our members and perform outreach to encourage members to utilize these services. The 2020 Surgeon General's report on Smoking Cessation indicated that nearly 70% of adult cigarette smokers with Medicaid coverage reported an interest in quitting. The Surgeon General's report identified disparities in the

prevalence of current cigarette smoking among Medicaid enrollees and among American Indian/Alaska Natives. EOCCO's cigarette prevalence incentive measure rate for 2018 was 20.2%.

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

This project will strengthen our ongoing procedures to store, retrieve, and use demographic data of our EOCCO members that meet the REALD standards. We will reassess and update our procedures to extract and report race, ethnicity, and language data from our HIE, Arcadia Analytics. With improved demographic data collection, EOCCO will stratify members who identify as cigarette smokers by REALD standards to assess for health disparities/inequities and produce targeted educational materials to refer members to EOCCO's inhouse tobacco cessation program.

This project addresses CLAS standard # 11 ("Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes …"). It also addresses CLAS standard #. 12 ("conduct regular assessment of … health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area").

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

Activity 1 description: EOCCO is evaluating demographic data including race, ethnicity, and language from Arcadia Analytics to improve our member records in our data analytics warehouse. Arcadia Analytics pulls EHR data from 13 of our largest EOCCO health providers, data from our internal claims system, and member demographic data from the 834 files. Arcadia will save the most updated demographic data from any of the aforementioned data sources to store in the member's profile. Based on review of EOCCO's race and ethnicity data received on the 834 files, 53.3% of our membership reported "unknown" when identifying their race as of December 31, 2019. EOCCO plans to decrease the rate of members who report "unknown" for their race through this data collection and improvement activity.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: EOCCO aims to decrease our percentage of members who report "unknown" when identifying race by 10%, which would equate to identification of race by approximately 5,000 more EOCCO lives.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
53.3%	43.3%	03/2021	43.3%	03/2021

Activity 2 description: EOCCO will evaluate demographic data of members who are cigarette smokers identified through EHRs via Arcadia Analytics, health risk assessments, and prior authorization requests for elective surgeries to determine whether disparities exist. Strategically target educational materials to the impacted demographic(s) once disparities are identified.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: EOCCO will monitor this activity through the cigarette prevalence incentive measure once disparities are identified.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
We are not aware of disparities based on REALD demographics.	We have identified disparities based on REALD demographics.	06/2020	Strategically target educational resources to smokers in demographics	12/2020

			experiencing a disparity.	

A. **Project or program short title**: Project 6: Culturally Responsive Services by Community Health Workers

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): CLAS standards
iii. Component 3 (if applicable): Social determinants of health & equity
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**:

Both the OHA vision for health equity as well as the National CLAS standards underscore the need to augment culturally responsive services. OHA's recently endorsed definition of health equity states that "people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, or other socially determined circumstances." In that vein, culturally and linguistically responsive services promote health equity because they both impact health and are responsive to an individual's cultural health beliefs and practices, preferred language, health literacy level, and communication needs. CHWs are positioned to deliver culturally and linguistically appropriate services. CHW services are part of the broader set of Traditional Health Worker (THW) services that also include, for example, peer-based support, doulas and patient navigation. This set of services are delivered by providers who have a high level of knowledge and or experience with the health conditions of the individuals they serve. Typically they are also familiar with (a) the barriers to accessing services experienced by individuals in the community, such as the challenges of navigating a complex array of services, as well as (b) the characteristics of the local social settings (e.g., neighborhoods, local communities) where the service populations live. As such, CHWs have first-hand knowledge of the cultural health beliefs and norms that impact health behaviors as well as health care utilization; in other words, they are equipped to provide culturally responsive services.

The importance of CHW-based health care services is largely shared across Eastern Oregon according to our community engagement initiatives. For example, CHW-based services appear among the three top-ranked priority areas in our most recent EOCCO CHP.

Accordingly, we have chosen our CHW program as a focus for this Quality Improvement project that addresses culturally responsive care. We will apply a health equity lens to our CHW program and attend to both: (a) health priorities that have been articulated by our LCACs, and (b) our ongoing examination of the demographic profiles of the 12 counties that we serve in Eastern Oregon and that are rural or frontier by REALD standards.

Preliminary data on EOCCO's CHW workforce and services were collected via an electronic survey in Q1 of 2019 for the 2018 calendar year. This survey was sent to all EOCCO clinic and community partners; 29 CHWs completed the survey. Among the survey findings, three are particularly relevant to this Quality Improvement project:
1. We found notable distribution of CHWs across Eastern Oregon health care and community settings. Roughly half of the CHWs were appropriately located in the counties with the two largest populations, nearly one-third and one-fifth, respectively. The remainder of the 10 counties ranged from 1% to 6% in their share of CHWs. Notwithstanding, the capacity of our CHW workforce to impact specific sub-populations defined by health risk status, health condition, and/or demographic background remains largely unknown.

2. Respondents estimated that only 50% of their employer organizations were billing claims for CHW services to EOCCO for reimbursement.
3. Among the "high need" areas for CHW services reported by participants, almost three-quarters of respondents (74%) regarded health disparities as a high need area; this was the second-ranked "need area".

Notwithstanding our progress in disseminating CHW-based services across Eastern Oregon, concentrated efforts to impact health equity are an important area of growth. Taken together, the following set of activities will focus on augmenting culturally responsive care in our CHW program.

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

To increase the capacity to provide culturally responsive care through Traditional Health Worker-delivered services, EOCCO will implement a plan that will ultimately result in increased levels of CHW-based care that will impact health equity. This Quality Improvement project will entail further aligning CHW-based services with local/regional health priority agendas across the EOCCO service area, completing an implementation readiness process that will update both the CHW workforce and our provider network organizations on: (a) best practices for CHW service utilization including billing processes, and (b) pilot calculations of a revised performance measure portfolio for our culturally responsive care emphasis.

This project addresses CLAS standard #3 ("Recruit, promote, and support a culturally and linguistically diverse … workforce that are responsive to the population in the service area").

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

Activity 1 description: Align CHW-based culturally responsive care to EOCCO-wide priority health agendas. Assess CHW capacity for culturally responsive care. The EOCCO Traditional Health Worker Liaison will work with the Community Health Team and the Analytics team to examine our counties': (a) demographic make-up based on REALD standards by using our latest CHA and Population Assessment, (b) stated health priority needs for each county based on our latest CHA and CCO metrics performance tracking, and (c) latest roster of CHW workers. Based on the analyses of this set of information, gaps in each county's service population and health priority area will be identified for CHW-based care that addresses health equity gaps in local communities. Because this is a community-engaged process that involves our ongoing work with our 12 LCACs, we will plan accordingly and stagger these analyses across the remaining quarters of 2020 and will distribute the activities across three different timelines (see table below). This process will be stratified by county-population size noted as tiers shown in the table below. The county size tiers are based on the county's portion of our EOCCO total estimated enrollees derived from our latest Population Assessment: (1) *Tier-1* consists of two counties (Umatilla and Malheur) that together approximately total 55% of our enrollees (each county accounts for 20% or more of total EOCCO members), (2) *Tier-2* consists of three counties (Morrow, Union and Baker) that together approximately total 25% of our enrollees (each county accounts for 6% to 12% of total EOCCO), and (3) *Tier-3* consists of seven counties (Sherman, Gilliam, Wheeler, Grant, Wallowa, Harney and Lake) that together approximately total 20% of our enrollees (each county accounts for a range of 1% to 4% of total EOCCO).

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: The EOCCO Traditional Health Worker Liaison will work with the Community Health Team and the Analytics team to evaluate the CHW capacity needs by county.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)

CHW capacity needs have not been examined for two *Tier-1* counties that account for 55% of our members.	Capacity needs analyses examined for at least 1 of 2 *Tier-1* counties.	05/2020	Capacity needs analyses examined for ALL (2) *Tier-1* counties.	09/2020	Capacity needs analyses examined for ALL (2) *Tier-1* counties.	09/2020
CHW capacity needs have not been examined for three *Tier-2* counties that account for 25% of our members.	Capacity needs analyses examined for at least 1 of 3 *Tier-2* counties.	05/2020	Capacity needs analyses examined for at least 2 of 3 *Tier-2* counties.	09/2020	Capacity needs analyses examined for ALL (3) *Tier-2* counties.	01/2021
CHW capacity needs have not been examined for seven *Tier-3* counties that account for 20% of our members.	Capacity needs analyses examined for at least 2 of 7 *Tier-3* counties.	05/2020	Capacity needs analyses examined for at least 4 of 7 *Tier-3* counties.	09/2020	Capacity needs analyses examined for ALL (7) *Tier-3* counties.	01/2021

Activity 2 description: Ensure implementation readiness of CHW-based culturally responsive care. EOCCO will equip CHWs and their employer-organizations to implement CHW-based culturally responsive services by updating training for CHWs based on identified needs, updating the materials and resources used by the program, and training provider organizations in EOCCO's CHW program. We will assess the training needs of CHWs who will be working on culturally responsive care following the results of Activity 1. Training will include culturally responsive care per OHA's Office of Equity and Inclusion (OHA-OEI) standards, updating certification as a THW per OHA-OEI standards, and or other content-specific training per assignment in their target county service sector. The CCO Traditional Health Worker Liaison will work with organizations that train CHWs in Eastern Oregon, organizations who employ CHWs, and LCACs for input and guidance. We will update materials and resources and complete production – including approval – of materials and resources needed to carry out CHW-based care to meet both best practice standards as well as culturally and linguistically appropriate standards for the identified priority sub-population. The CCO Traditional Health Worker Liaison will work with contracted trainer and with member services to update program materials to conduct services with CCO members. Health service providers in our provider network that are most critical to accomplish our local health agendas will be re-trained/updated on the utility of CHW program including the purview of their work, how they can impact health goals such as the CCO metrics program as well as billing procedures that allow organizations to get reimbursed for those services.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Monitor the percentage of CHWs who are trained/certified to work with identified health priority populations. Track completion and OHA approval of materials and resources that meet cultural

and linguistic standards for identified priority populations. Monitor training on billing procedures for CHW-based culturally responsive services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Training needs for CHW-based culturally responsive care have not been determined nor completed.	50% of CHWs trained/certified to work with identified health priority population(s).	08/2020	100% of CHWs trained/certified to work with identified health priority population(s).	01/2021
Materials and resources (e.g., written brochures) that meet cultural and linguistic standards for identified priority population have not been identified.	Materials and resources (e.g., written brochures) that meet cultural and linguistic standards for identified priority population produced.	08/2020	Materials and resources (e.g., written brochures) that meet cultural and linguistic standards for identified priority population approved by OHA.	01/2021
Training (re-training) on billing procedures (e.g., CHWs, claims staff) that account for CHW-based culturally responsive services has not been completed.	Train/update all necessary parties involved in billing procedures (e.g., CHWs, claims staff) that account for CHW-based services connected to identified health priority subpopulations and programs.	05/2020	Train/update all necessary parties involved in billing procedures (e.g., CHWs, claims staff) that account for CHW-based services connected to identified health priority subpopulations and programs.	08/2020

Activity 3 description: To prepare for demonstration of the value of the CHW-Culturally-Responsive care program, we will carry out a performance measures pilot and identify initial benchmarks through internal benchmarking methods. First, we will review our portfolio of measures in our CHW program to track CHW service utilization and outcomes so that our renewed activity to strengthen culturally responsive care is accounted accurately. Second, we will carry out pilot calculations and pilot reporting of the chosen measures including average rates, and an assessment of variability within organizations and counties, as well as EOCCO-wide calculations. Comparisons of these process measures that will be common across CCO will enable us to carry out internal benchmarking methods that involve performance across sites that are reasonable (e.g., within county size Tier, as described in Activity 1, or stratified by health status conditions).

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: The Traditional Health Worker Liaison will work with the Analytics team to identify process and outcome measures that account for CHW services that are culturally responsive as identified in

Activity 1 and following completed training in Activity 2. Measures of impact of those services will vary by county given our emphasis on community-engaged decision-making.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Process and outcome measures to demonstrate value of CHW-based, culturally responsive care have not been determined	Process and outcome measures to demonstrate value of CHW-based care per identified priority populations are identified.	06/2020	Process and outcome measures to demonstrate value of CHW-based care per identified priority populations are identified.	06/2020
Performance and outcome measures have not been calculated.	Performance and outcome measures have been pilot-tested across counties, and reporting periods (year quarters).	11/2020	Performance and outcome measures benchmarks are identified (year quarters).	02/2021

A. **Project or program short title**: Project 7: Assessment of Oral Health Integration within EOCCO

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): 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**:

Oral health is an essential factor in a person's overall health and a key component of comprehensive primary care. Through the integration of oral, behavioral and physical health, care is aligned with the goals of the OHP to provide whole person coordinated care and promoting health equity. EOCCO is dedicated to helping members achieve the triple aim, aligning with the goals of the OHA.

Studies have shown that poor oral health is linked or associated with chronic diseases, such as diabetes and heart disease. From a social and community health perspective, it can also lead to missed work or school days and, over time, have a negative impact on a person's self-image and overall wellbeing.

Data shows that 52% of children ages 6-9 in Oregon have tooth decay and it is one of the most prevalent chronic conditions of childhood and can lead to problems with eating, speaking, self-confidence, and learning. In 2013, Oregon ranked last out of 50 states regarding children having at least one preventive dental visit during the year.

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

Assessment of current primary care clinics, primarily FQHCs, with integrated oral health services and determine best practices for integration in a rural geography. EOCCO will develop a community-wide plan for oral health options, with a

pathway for children and adults (specifically those with diabetes). The goal is for members to receive comprehensive oral healthcare services in their county by collaborating with EOCCO dental partners, providing community-wide services in Educational Service Districts (ESDs) and, sharing resources and best practice for continuity of oral health services and comprehensive education.

This project will focus on creating a tool kit and best practice guidance to help clinics who are looking to implement oral health services into their clinics or strengthen the services already embedded. We will: (a) determine clinics with integrated oral health services currently (primarily FQHCs) and those with capabilities in the next two years (via collaborative assessment with the Oregon Primary Care Association (OPCA); (b) work with our LCACs to develop a process for oral health options in the community and successful pathways to access services for children and adults; (c) review plan with DCOs partners; (d) utilize LCACs and other partners to continue to support outreach efforts in ESDs for children; (e) conduct regular reviews of integrated clinic performance through quarterly data progress.

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

Activity 1 description: EOCCO will establish a baseline by identifying the number of clinics providing integrated oral health services. We will survey EOCCO contracted clinics and identify what oral health services are being performed/available. Additionally, we will obtain information about what is working well and areas of need to create our oral health toolkit. This toolkit and partnership with OPCA, will help increase the number of services and/or the number of clinics with oral health options. We will establish a baseline and set goals for improvement.

☐ Short term or ☐ Long term

Monitoring activity 1 for improvement: Identify and increase the number of clinics with oral health options embedded in clinics, with a specific focus on FQHCs over the next two years.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Number of clinics providing integrated oral health services. Baseline will be established after survey of contracted providers.	Improvement over previous period.	09/2020	Improvement over previous period.	09/2022
Total number of available oral health services available in integrated clinics. Baseline will be established after survey of contracted providers.	Improvement over previous period.	09/2020	Improvement over previous period.	09/2022

Activity 2 description: Conduct regular reviews of integrated clinic performance by evaluating the number of preventive dental services for members ages 1-14 and the number of oral evaluations for adults with diabetes.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Track and monitor clinic's performance through quarterly data reports, showing the increase of utilization of services at integrated clinics.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
% of members ages 1-5 that receive a preventive dental service at integrated clinics.	Baseline data to be calculated once all clinics are identified. Baseline data will be for calendar year 2019. Target will be to have a 3% increase.	12/2020	3% over 2020 results	12/2021
% of member ages 6-14 that receive a preventive dental service at integrated clinics.	Baseline data to be calculated once all clinics are identified. Baseline data will be for calendar year 2019. Target will be to have a 3% increase.	12/2020	3% over 2020 results	12/2021
% of diabetic adults who receive an oral evaluation at integrated clinics.	Baseline data to be calculated once all clinics are identified who can perform the service. Baseline data will be for calendar year 2019. Target will be to have a 3% increase.	12/2020	3% over 2020 results	12/2021

A. **Project or program short title**: Project 8: Technical Assistance for PCPCHs

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): 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**:

This project utilizes the monitoring Activity 5 from 2019's PCPCH project, EOCCO VPB Models to Increase PCPCH Adoption. However, it is drastically modified due to a large portion of the components focused on value-based payments. We are also introducing new activities specifically related to PCPCH certification only.

Over the past seven years, EOCCO has continuously strived to increase the number of clinics and level of tier certification of primary care clinics in Eastern Oregon and has seen a steady increase in the results of the PCPCH enrollment incentive metric. Additionally, to enhance the quality and adequacy of services members receive, EOCCO assigns/attributes members to a PCPCH-certified clinic or strives to make one available in their county. This has been challenging but a rewarding task, based on EOCCO's geography, sheer volume of miles within the service area, and the fact that some counties only have one primary care clinic.

To accomplish this, EOCCO has utilized different mechanisms, such as adopting various forms of value-based payments, conducting learning collaboratives, and providing clinics with technical assistance.

Our goal and activities for this element are to enhance and evolve what we have accomplished over the past seven years and assist clinics in navigating the changes to the PCPCH certification process, effective July 2020.

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

EOCCO staff will work with clinics to provide TA for becoming a newly certified clinic or maintaining or increasing PCPCH certification. This will also be done through learning collaboratives and additional one-on-one TA needed to support practice workflow and individual clinics' needs.

EOCCO will: (a) provide continuous one-on-one technical assistance to clinics in the EOCCO service area; (b) provider clinics options for EOCCO hosted learning collaboratives, focusing on introducing new PCPCH guidelines, effective July 2020; (c) vet the need for monthly check-in calls/video conferencing, aligned with the rollout of the new PCPCH guidelines.

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

Activity 1 description: Increase the number of certified PCPCHs to achieve tier 4 or higher certification.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Measure the percent of EOCCO members assigned/attributed to a PCPCH.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
As of December 2019: No certification: 10% Tier 1: 0 Tier 2: 0 Tier 3: 16.8% Tier 4: 47.7% Tier 5: 25.5% Total: 100%	No certification: 9% Tier 1: 0 Tier 2: 0 Tier 3: 16% Tier 4: 49% Tier 5: 26.0% Total: 100%	12/2020	No certification: 7% Tier 1: 0 Tier 2: 0 Tier 3: 16.5% Tier 4: 50% Tier 5: 26.5% Total: 100%	12/2021

Activity 2 description: Increase the number of certified PCPCHs to achieve tier 4 or higher certification.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Measure the total number of clinics certified by tier, increasing the number of tier 4 or higher clinics, within the EOCCO service area.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
As of December 2019: Tier 1: 0 Tier 2: 0 Tier 3: 14 Tier 4: 26 Tier 5: 3 Total: 43	Tier 1: 0 Tier 2 :0 Tier 3: 13 Tier 4: 26 Tier 5: 5 Total: 44	12/2020	Tier 1: 0 Tier 2: 0 Tier 3: 11 Tier 4: 28 Tier 5: 6 Total: 45	12/2021

A. **Project or program short title**: Project 9: 3-day Follow-up Post Emergency Department (ED) Visit

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**:

The Emergency Medical Treatment and Labor Act (EMTALA) explicitly includes psychiatric and substance use related behavioral health problems in its definition of a medical emergency. Therefore, all hospital EDs must be understood as integral and included as a necessary part of the local behavioral health care delivery system.

Nevertheless, just as with auto accidents or any other health emergency, an emergency room visit means something that should not be happening has happened. ED visits should never be planned or thought of as a substitute for community-based services.

While the hospital ED is the wrong place to treat SPMI and substance use disorder (SUD) issues, it is one of many right places to identify and follow up with members who, for whatever reason, may not have found their way to outpatient treatment. EOCCO views an ED visit as a "right door" to access its behavioral health and SUD treatment capacities.

In 2018, EOCCO reported on a HEDIS measure related to follow up within 7 and then within 30 days of an SPMI- or SUD-related ED visit. The results were not good.

Measure (2018)	Numerator	Denominator	Rate	Goal	Goal Met (Y/N)
7-day follow-up post ED visit	66	192	34.4%	40%	N
30-day follow-up post ED visit	85	192	44.3%	54.7%	N

Quantitative Analysis:

- EOCCO did not meet either the 7- or 30-day follow-up goals, which were set against 2017 HEDIS Medicaid measures for these domains.

In short, fewer than half of the people who required follow up after a SUD or ED visit were seen by the outpatient system of care within a month of their ED visit.

The EOCCO ED Utilization by Members with SPMI TQS project is being discontinued at this time due to organizational restructuring that took place during 2019. The data was not collected and is insufficient to meet the goals.

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

EOCCO receives a daily report of all EOCCO members who were in an ED the previous day. This report includes diagnostic information along with other clinical data. Each day, the members who are determined by a medical reviewer to have presented to the ED as a result of SPMI and or SUD conditions are entered into the medical management software system.

Daily calls are placed by EOCCO Care Management staff to the community-based providers who are responsible for doing the follow up, in turn generating at least one of the following OHA-approved Current Procedural Terminology (CPT) codes for follow up from acute care:

98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510, 90846, 90791, 90792, 90832-90834, 90836-90838

EOCCO will follow up with the outpatient provider regarding what appropriate connection to community-based services took place, and document in the medical management software system exactly what type (code) of follow up took place, who was the responsible person and when.

Care Management staff will monitor the software system to determine if, after the intervention with the provider, individual members are returning to the ED seeking services for mental health (MH) or SUD. If an individual member continues to return to the ED for MH or SUD services, Care Management staff will complete an individualized management plan (IMP). Interventions may include but not limited to referrals to care coordination, case management, medical services, ACT, peer delivered services, and supported employment services.

Ongoing monitoring of ED utilization for MH or SUD services at the ED will be analyzed on a periodic basis to understand trends and identify gaps in services.

The Care Management staff provides care coordination and intensive care coordination services to members with SPMI. The medical management software does not identify which members receive home and community-based services under the State's 1915(i) State Plan Amendment.

EOCCO ensures that Supported Employment Services are available for all adult members that are eligible for this service. EOCCO ensures that participating network providers that operate certified ACT programs screen and engage EOCCO members with SPMI diagnosis who may be eligible for the ACT program to encourage participation. EOCCO is addressing this activity in Project 1.

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

Activity 1 description: Develop procedure to identify (SPMI/SUD) members to access behavioral health services.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitor compliance for 3-day follow-up post ED visit.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Program began 02/2020 for 3-day follow-up post ED. Limited data collected at this time.	60% compliance for 3-day follow-up post ED visit.	05/2021	80% compliance for 3-day follow-up post ED visit, and a 10% increase the following year.	05/2023

Activity 2 description: EOCCO provides care coordination and/or case management services to members with SPMI receiving home and community-based services under the State's 1915(i) State Plan Amendment. We will establish a baseline and set goals for improvement.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: 1915(i) Members and special health care needs members identified in medical management software.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No 1915(i) or special health care needs members identified in medical management software.	1915(i) or special health care needs members identified in medical management software.	06/2020	1915(i) or special health care needs members identified in medical management software.	06/2020

Activity 3 description Individuals identified as having a special health care need will have regular care monitoring, their Individual Service and Support Plan (ISSP) monitored of their course of treatment.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Every 3 months will randomly review 1% of the SPMI records.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Baseline will be established after three months of reports.	Improvement over previous period.	09/2020	Improvement over previous period.	09/2021

A. **Project or program short title**: Project 10: Improving the Utilization and Impact of Frontier Veggie Rx

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 EOCCO Frontier Veggie Rx (FVRx) program consists of doses (booklets with produce vouchers) that are distributed to EOCCO members who screen positive for food insecurity in Harney County and to all individuals who screen positive for food insecurity in Gilliam, Sherman, and Wheeler Counties. The screenings are conducted by trained individuals, including members of our LCACs, at health and human service organizations. The FVRx program is aligned with these communities' health priorities because they chose to participate in it as part of the Community Benefit Initiative Reinvestment (CBIR) projects that aligned with their most recent Community Health Assessments and Community Health Plans.

The EOCCO FVRx has high public health value. The higher costs of fresh fruits and vegetables in frontier counties often drive families to choose between foods that are healthy, and food choices that will stem hunger but have low nutritional value; the latter choices often have high caloric content, which are potential risk factors for obesity, diabetes, and high blood pressure. In the context of such high geographic dispersion in frontier counties, there are fresh food deserts, which require long distances to access fresh produce. Both high poverty rates and transportation barriers are common in frontier communities; these two social disadvantages exacerbate the difficulties to access the limited fresh produce outlets.

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

EOCCO's long-term goal is to improve the utilization and health impact of the FVRx program. In this Quality Improvement project, we will address barriers to successful utilization of FVRx, align performance measures with targeted health impact goals, and pilot test performance targets and benchmarks. Activities to improve the utilization and impact of FVRx will be driven by formative evaluation techniques, such as focused and targeted data collection on gaps and barriers to utilization from multiple stakeholders who currently implement and use this program. The FVRx Program Manager, FVRx Steering Committee, Quality Improvement, and Analytics teams will in turn formulate feasible problem-solving approaches to the barriers and disseminate them; the teams will also revise the performance measures, and pilot test improvement targets and benchmarks for FVRx. The set of activities are feasible because (a) they will be part of our ongoing activities to coordinate FVRx through a steering committee, (b) the focused data collection approach, and (c) our experienced Analytics and Quality Improvement teams who carry out these functions routinely.

Because our FVRx addresses food insecurity in rural settings that have high poverty rates, we will be addressing the economic stability domain of SDOH. Moreover, FVRx is an intervention to increase access to healthy foods and environmental conditions such as fresh food deserts in rural counties; therefore, we will be addressing the neighborhood and built environment domain of SDOH. Lastly, our set of activities relies on LCACs, local community program implementers, and users; thus, it involves social and community health components of SDOH as well.

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

Activity 1 description: Identify local implementation gaps and barriers to FVRx programs in our counties with a community-engagement approach. For each county with a FVRx-program, we will carry out an implementation barriers gaps analyses through: (a) our Frontier Veggie Rx Steering Committee that has representatives for the four participating counties, and (b) key informant follow-up interviews that will include prescribers, and (c) a short survey to sample participants. Prescribers will inform individuals who utilize FVRx of the opportunity to participate in the survey. The survey will be designed by our Analytics and quality improvement (QI) staff with input from FVRx stakeholders; it will include five or fewer questions.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: FVRx has regular contact with the Steering Committee; we collaborate with the QI staff in a meeting in which a focused discussion on implementation barriers and gaps. The FVRx Manager and Steering Committee members also have regular contact with the individuals who prescribe the vouchers to participants, at a minimum on a monthly basis. The FVRx Program Manager will work with QI and Analytics to examine results and problem-solve solutions to barriers and gaps in utilization. The FVRx Program Manager will engage the FVRx Steering Committee to further develop possible solutions and disseminate them across prescribers and program implementers.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Barriers and gap analyses of FVRx utilization have not taken place recently.	Brief barriers and gap analysis of veggie utilization with Steering Committee and key informant methodology developed and short survey for FVRx users.	05/2020	Analyses of barriers and gaps of veggie utilization with Steering Committee completed.	08/2020
Barrier problem solving and testing of solutions has not taken place formally across FVRx sites recently.	Based on summary of barriers and gaps, stakeholders including FVRx Steering Committee will problem solve and disseminate solutions.	09/2020	Complete dissemination of solutions to implementation barriers and gaps.	10/2020

Activity 2 description: Performance measures and benchmark pilot calculations to demonstrate value of FVRx. The Analytics team, FVRx Manager, and Steering Committee will re-examine and update FVRx program data workflow, including data-capturing, storage, retrieval and reporting. This activity will facilitate per-member utilization calculations as well as additional performance metrics. Currently total doses, as well as doses to new cases and “re-fills” are easily retrieved. However, through the data workflow activity, we will be prepared to perform per-member utilization (number of doses) calculations across time. Moreover, the Analytics team will pilot test procedures to link FVRx individuals with their health services utilization and health indices data. The Analytics team, FVRx Program Manager, and FVRx Steering Committee will identify process and outcome measures that will be used to demonstrate the value of FVRx. For example, we will examine the feasibility of linking FVRx utilization to additional service utilization, including education regarding nutrition and physical activity. Measures of impact of FVRx utilization will be considered such as impact on food insecurity, and distress regarding food security. Level of readiness across sites to link FVRx data to EHR indicators such as body mass index and blood pressure will be examined as well.

☐ Short term or ☐ Long term

Monitoring activity 2 for improvement: Once indicators are determined, the Analytics team will perform calculations across year quarters, examine variability within and across counties, and compare indicators across sub-groups stratified by age and gender. Taken together, these analyses will provide the bases to identify improvement targets and benchmarks for 2021.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Training (re-training) on data recording, retrieval and extraction of FVRx service units by member and prescriber has not been updated recently across all parties involved.	Train/update all necessary parties involved in recording FVRx transactions by CCO member, prescriber, and linking to health information data by CCO member.	08/2020	Complete training of all necessary parties involved in recording FVRx transactions by CCO member, prescriber, and linking to health information data by CCO member.	12/2020
2019 total number of doses across four FVRx counties = 3,966.	Determine per-member VRx doses metric methodology.	06/2020	Determine per-member metric improvement targets and benchmarks.	01/2021
Process and outcome measures to demonstrate value of FVRx have not been recently updated.	Initial identification of process and outcome measures to demonstrate value of FVRx.	06/2020	Process and outcome measures pilot calculations to determine improvement targets and benchmarks completed.	01/2021

A. **Project or program short title**: Project 11: Maternal and Baby Linkage to Support

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): Social determinants of health & equity
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**:

EOCCO has implemented tracking mechanisms to identify members with special health care needs (SHCN). We have also developed and implemented a process for members with SHCN to directly access specialists, even without a funded diagnosis and service code, which completed one of the activities in the prior TQS. While all members have access to specialists without a referral, and additional resources are available to address social determinants of health in the adult membership, EOCCO has identified the need to increase engagement with at-risk moms and their newborns. The Mother/Baby program identifies prenatal cases through claims and authorizations and refers them to the Babies First/Universal Home Visits program in the participating counties. This work will be done in partnership with the Eastern Oregon Early Learning Hub and Department of Human Services (DHS) child welfare staff. Referrals are available to high-risk members with prenatal diagnoses through 6 months post-natal as well as families of children under the age of 6 months in Foster Care. The program offers qualifying families (including foster and adoptive families) up to 3 at-home

visits by a state licensed registered nurse to address social and health conditions associated with poor health outcomes. These visits include assessments, case management and health screenings for the mother, child and home environment.

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

EOCCO analyzes SHCN indicators in order to monitor the impact of the flag on member access, outcomes and utilization of resources. For the purposes of this project, EOCCO will specifically monitor high-risk members with a pregnancy diagnosis and more than 3 indicator flags in order to refer them to the existing Mother/Baby program for additional support.

EOCCO will implement an educational and informational campaign for specialty providers within the EOCCO network regarding members with SHCN, resources available through EOCCO and best practices for access and continuity of care for these members in order reduce barriers to care and increase awareness of programs and resources. This material will be made available on a new EOCCO Provider Education page of the EOCCO website, as well as Constant Contact e-newsletters and print material that can be available for distribution and utilization in clinics.

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

Activity 1 description: Analyze claims query for members with more than 3 SHCN indicator flags. At risk members with a current prenatal diagnosis and infants up to 6 months old will be identified for referral to the Mother/Baby program. EOCCO will continuously track this target population for outreach by home health nurses in partnership with local DHS offices to ensure members are receiving up to 3 at home visits.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Qualifying members will be tracked on a spreadsheet and the outreach and referral efforts will be logged.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No coordination or referral of members with SHCN and the Mother/Baby program at this time.	Evaluate current data and identify baseline.	06/2020	Implement focused intervention for referral to the Mom-Baby program based on member acuity level.	03/2021

Activity 2 description: Develop and distribute educational and informational material to specialty providers regarding members with SHCN and resources offered by EOCCO. Newly developed material will be made available on the EOCCO.com website and communication regarding the availability of these resources and materials will be distributed via Constant Contact, provider trainings and mail.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor the development and transmission of informational material for specialty providers regarding the resources available for members with SHCN.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Specialty providers may be unaware of	Informational material regarding	09/2020	Informational material regarding	03/2021

resources offered by EOCCO for members with SHCN.	members with SHCN is developed for specialty providers.		members with SHCN is provided to specialty providers.	

A. **Project or program short title**: Project 12: Impacting Acute Incidents Resulting from Negative Member Outcomes through Care Coordination

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): 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 our previous TQS, we developed a cost and utilization dashboard and optimized the monthly provider progress reports; all targets and benchmarks for the activities were met. The dashboard is presented quarterly and includes county-level data. This year, we are reviewing a subset of the data we collect to determine over-utilization of services. We will identify interventions we can implement to support members and providers in accessing the most effective and economic care. We are focusing on reviewing members who have been hospitalized with a primary diagnosis of sepsis, chronic obstructive pulmonary disease (COPD), or heart failure. We seek to improve health outcomes through care coordination and case management interventions.

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

This project will inform care coordination activities through the review of utilization data. We will: (a) develop and generate a report to identify the target population; (b) analyze the report to set a baseline, target, and benchmark for measurement; (c) analyze the monthly data to identify care coordination interventions; (d) implement care coordination interventions to improve member outcomes; and (e) re-evaluate the data and interventions.

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

Activity 1 description: Develop a report to identify members who have emergency department or inpatient claims with target diagnosis codes.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: A report will be generated; we will be able to run this report monthly and on demand.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
We do not have reporting that allows us to target this population.	A report will be developed.	05/2020	The report can be run monthly and on demand.	08/2020

Activity 2 description: Utilize the data in the report to measure the success of care coordination interventions in reducing readmissions and increasing member engagement in care. Once we have identified the baseline, we will set a quantitative goal to reduce the rate of readmissions for this population.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: We will run and analyze the report to determine the baseline readmission rate for this population. We will then set a target and benchmark to work toward and monitor through the report.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
To be determined.	Improve the readmission rate.	12/2020	Improve the readmission rate.	12/2021

Activity 3 description: Drive development of care coordination interventions with the data.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Analyze report data and recommend care coordination interventions. Monitor progress through care coordination work group.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
PreManage notifications of emergency department visits are reviewed by a nurse and members are referred to case management as appropriate.	Identify care coordination interventions.	07/2020	Implement care coordination interventions.	12/2020

Activity 4 description: Reevaluate the quantitative result to develop new care coordination interventions to reduce readmissions and improve member outcomes.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Analyze report data and recommend care coordination interventions. Monitor progress through care coordination work group.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
We provide interventions through case management.	Identify care coordination interventions.	03/2021	Implement care coordination interventions.	12/2021

A. **Project or program short title**: Project 13: Improving the Accessibility of Hepatitis C Care

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): Grievance and appeal system
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:

Through our case management program, we have identified members who experience barriers to accessing care for hepatitis C virus (HCV), and the state epidemiological profile suggests that HCV is underreported. The geographic size of the EOCCO service area presents challenges for members to participate in the monitoring required for HCV treatment. EOCCO seeks to increase community-based HCV screening and linkage to care and treatment.

D. Project or program brief narrative description:

EOCCO will identify the prevalence of HCV in its service area relative to the members accessing care for HCV. We will measure the availability of testing and treatment through area providers and public health departments to identify gaps. We will work with community partners to increase access to HCV screening and treatment in the EOCCO service area. We will monitor appeals and grievances data to redirect members seeking care and eliminate barriers to HCV services. This data will also help identify gaps in HCV services.

E. Activities and monitoring for performance improvement:

Activity 1 description: Identify the areas in need of HCV testing and treatment.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Data is organized by county to assess need.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
We have not identified the prevalence of HCV in the service area. Members accessing HCV treatment are identified individually through case management.	The data for HCV prevalence and members seeking treatment are identified and organized by county.	04/2020	The data for HCV prevalence and members seeking treatment are identified and organized by county.	04/2020

Activity 2 description: Identify providers in the EOCCO service area who are screening for and/or treating HCV.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: A list of providers screening for and/or treating HCV is generated.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)

We do not have a comprehensive list of providers to whom to refer members.	We have identified providers screening for and/or treating HCV by county.	09/2020	We have generated a list of providers to support care coordination.	09/2020

Activity 3 description: Identify areas to target for increasing provider availability for HCV screening and treatment by comparing the provider availability to the needs identified by county.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Data is organized by county to assess gaps in provider availability.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Areas to target for intervention have not been identified.	Areas to target for intervention are identified.	12/2020	Areas to target for intervention are identified.	12/2020

Activity 4 description: Partner with communities to expand HCV screening and treatment. Set a baseline once provider availability has been identified and set goals for increasing capacity throughout 2021 based on the needs identified.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Measure increased provider availability for HCV screening and treatment.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
To be determined.	To be determined.	06/2021	To be determined.	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.